

2017

Entire Issue

Meredith Nelson

Louisiana State University Shreveport

Peter Emerson

Southeastern Louisiana University

Follow this and additional works at: <https://digitalscholar.lsuhs.edu/ljc>



Part of the [Rehabilitation and Therapy Commons](#)

Recommended Citation

Nelson, Meredith and Emerson, Peter (2017) "Entire Issue," *Louisiana Journal of Counseling*: Vol. 24: Iss. 1, Article 1.

Available at: <https://digitalscholar.lsuhs.edu/ljc/vol24/iss1/1>

This Article is brought to you for free and open access by LSU Health Digital Scholar. It has been accepted for inclusion in Louisiana Journal of Counseling by an authorized editor of LSU Health Digital Scholar. For more information, please contact jllloyd@lsuhsc.edu, dtrill@lsuhsc.edu, rholle@lsuhsc.edu.

Nelson and Emerson, Entire Issue
Louisiana

Journal of Counseling

Volume XXIV

Fall 2017



A Branch of the American Counseling Association

Peter Emerson, Meredith Nelson
Editors

Louisiana Journal of Counseling

CO-EDITOR

Peter Emerson

Southeastern Louisiana University

CO-EDITOR

Meredith Nelson

LSU Shreveport

EDITORIAL BOARD

Mary Ballard

Southeastern Louisiana University

Reshelle Marino

Southeastern Louisiana University

Tim Fields

Louisiana State University

Hsin-Ya Tang

LSU Shreveport

Kacie Blalock

LSU Shreveport

Adrienne Frischhertz

University of Mississippi

Krystal Vaughn

Louisiana Health Sciences

June Williams

Southeastern Louisiana University

LCA OFFICERS

Christine Ebrahim – President

Vinetta Frie – Pres.-Elect

Adrienne Trogden – Pres.-Elect-Elect

Iman Nawash – Past President

Stephanie Robinson – Parliamentarian

Vickie Thompson – Secretary

LCA STAFF

Diane Austin – Executive Director

Austin White – Business Manager

353 Leo Ave.

Shreveport, LA 71105

1.888.522.6362

LCA WEBSITE

www.lacounseling.org

The **Louisiana Journal of Counseling**

(LJC) is the official journal of the Louisiana Counseling Association (LCA). The purpose of LCA is to foster counseling and development services to elementary, high school, college, and adult populations. Through this united focus, LCA maintains and improves professional standards, promotes professional development, keeps abreast of current legislation, and encourages communication among members.

Manuscripts: See inside back cover for guidelines.

Membership: Information concerning LCA and an application for membership may be obtained from the Executive Director.

Change of Address: Members should notify the Executive Director of any change of address.

Advertising: For information concerning advertising contact the co-editor: Meredith Nelson, LSUS, One University Place, Shreveport, LA 71115 or by email at mnelson@lsus.edu or pemerson@selu.edu. LCA reserves the right to edit or refuse ads that are not appropriate. LCA is not responsible for claims made in ads nor does it endorse any advertised product or service.

Copies: The LJC is published electronically as a member service. Additional copies may be purchased from the Executive Director for \$15.

Louisiana
Journal of Counseling

Fall 2017 • Volume XXIV

- 4 **Editorial & Guest Authors:** The Use of Technology in Counseling
*Shannon Fowler LSUS Graduate Student, Morgan Matthews LSUS
Graduate Student, and Meredith Nelson*

Section I: Professionals' Articles

- 9 Educating Counselors-in-Training to Work with Parents of Minors
Krystal M. Vaughn, Erin M. Dugan, and Kellie G. Camelford
- 15 Integration of Play Therapy with Insecurely Attached Adolescents
Megan Long, Erin Dugan, and Kellie Camelford
- 27 School Counselors' Wellness Behavior and its Effects on Compassion
Fatigue, Burnout, and Compassion Satisfaction
Mary G. Mayorga, Sabina DeVries, and Ann Wardle

Editorial

The Use of Technology in Counseling

Shannon Fowler

Graduate Student, Louisiana State University in Shreveport

Morgan Matthews

Graduate Student, Louisiana State University in Shreveport

Meredith Nelson

Counseling Program Director, Louisiana State University in Shreveport

Text messaging (TM) is one of the world's most popular forms of communication. With TM being so prevalent in our society, mental health providers question the feasibility and ethical reasoning regarding TM correspondences with clients. Counselors must consider if TM communication is an appropriate form of correspondence for the client. Setting boundaries and time availability are topics that should be discussed with clients at the onset of counseling (Sude, 2013). The relationship of the client and counselor must contain trust and professionalism. Social media is another area where boundaries can be compromised. Social media posts can be controversial, misinterpreted and cause strain on professional relationships between clients and counselors especially if they are connected on personal social media. All ethical standards caution its use as communication between counselor and client and advise the separation of professional accounts from personal accounts.

Keywords: technology, ethics

Technology has become the way of the world. Smartphones and cellphones are in the hands of more than six billion people worldwide (Lauffenburger, 2016). Short message service (SMS), best known as text messaging (TM), is one of the most popular forms of communication to date (Neimark, 2009). In 2014, there were roughly 18.7 billion text messages sent worldwide on a monthly basis (Burke, 2016). With such substantial figures and continual growth, mental health clinicians are left to consider if TM is an appropriate and ethical form

of communication when corresponding with clients.

Some clinicians are choosing to communicate via TM to reduce the number of missed appointments. Dealing with "no-shows" as a clinician can be a frustrating aspect of the job, as certain time slots are more popular and often have clients waiting for those times to become available. In addition, missed appointments create additional work for the clinician and administrative staff when contacting

clients and rescheduling appointments (Defife et al., 2010).

TM can also be an option for clients who are more comfortable receiving help without meeting face-to-face. The stigma of talking with a counselor is lessened due to the anonymity of text-only interactions, which can lead to clients being more straightforward in the counseling process (Sude, 2013). Having the time to think and write out responses before sending the TM can be helpful for clients in processing and expressing thoughts and emotions (Sude, 2013). Since cellphones are popular in today's society, counseling via TM can be convenient and assessable for both the client and counselor at any time (Sude, 2013). Along with accessibility, TM counseling is easily documented, since the replies and responses from both the therapist and client are in textual form (Sude, 2013).

Another alternative is for therapists to incorporate counseling via TM alongside face-to-face therapy. Counselors could use TM communication to remind clients of skills learned in face-to-face sessions to prevent relapse between meetings (Sude, 2013). Having communication between face-to-face meetings can be beneficial for the client. It can be a tangible way to remain connected to the counselor, which can put the client at ease (Sude, 2013). Since TM is such a standard and widely accepted form of communication, the boundaries between client and therapist could easily cross into the client viewing the therapist as a friend rather than a professional. Counselors would need to inform the client of their availability to respond to TM correspondence and establish appropriate boundaries at the onset of TM communication, with the understanding that there may only be

certain days of the week set aside for returning messages.

It is crucial that counselors take the time to assess the client and make the best decision before starting communication via technology and/or TM. The American Counseling Association (ACA) (2014) Code of Ethics states in section H.4.c. that "counselors should make reasonable efforts to determine that clients are intellectually, emotionally, physically, linguistically, and functionally capable of using the application and that the application is appropriate for the needs of the client." Sanghara et al. (2010) state that it may be necessary to provide training for clients in the use of TM for possible future trials of TM interventions. With TM clients, it is always best to keep in mind the dynamics of the clientele before choosing that method of correspondence. Every client will not be suited for communication via TM. Obtaining consent would be necessary before participating in TM with clients. Caution may be warranted until technology develops to the point that generally available texting meets HIPAA standards of secure electronic communication (Dejong et al., 2014).

Another area of digital concern is social media management. For example, "Mark" is an older gentleman that has been in the counseling profession for over twenty years. Recently, he created a Facebook account to interact with family and friends. As he met new people, he would add them to his Facebook friends list. This gave him an opportunity to communicate on a more personal level than email and to experience less frustration with unanswered phone calls. However, he also added his clients as friends on his Facebook account.

The ACA Code of Ethics (2014) no longer prohibits dual relationships, but §A.5.e Personal Virtual Relationships with Current Clients states:

“Counselors are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g. through social and other media).” Since “Mark” is adding his clients as friends on his personal social media page, he is in direct violation of the ACA Code of Ethics. He is also in violation of other sections of the code: §C.2.e Consultations of Ethical Obligations, and §H.1.a Knowledge and competency: “Counselors who engage in the use distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g. special certifications, additional course work),” (ACA, 2014).

NAADAC (2016) VI-20 Social Media principle states: “Addiction Professionals shall clearly explain to their clients/supervisees, as part of informed consent, the benefits, inherent risks including lack of confidentiality, and necessary boundaries surrounding the use of social media. Providers shall clearly explain their policies and procedures specific to the use of social media in a clinical relationship. Providers shall respect the client’s/supervisee’s rights to privacy on social media and shall not investigate the client/supervisee without consent.” Under principle VI-8 Non-Secured, NAADAC states: “Therapy shall not occur using text-based or email-based delivery.”

The National Board for Certified Counselors (NBCC) provides the following principles related to social media and digital technology: “NCCs shall recognize the potential harm of

informal uses of social media and other related technology...NCCs develop written practice procedures...and these shall be incorporated with the information provided to clients before or during the initial session. [These] procedures shall specify that personal accounts will be separate and isolated from any used for professional counseling purposes... procedures shall also address “friending” and responding to material posted. NCCs shall not use social media...to provide confidential information...” (NBCC, 2017).

As with TM, many clients may feel more comfortable using social media in the counseling process. The use of social media and other technology may aid in social skills development and belongingness after group therapy for mental illnesses. (Spradler, Butler, Bunce & Carrier, 2017; Grieve, Indian, Witteveen, Tolan, & Marrington, 2013). A study by Spradler and colleagues (2017) showed increased levels of extraversion and social connectedness with the use of Facebook in persons with high introversion. Grieve (2013) and colleagues’ research revealed lowered levels of anxiety and depression with the use of Facebook. A 2015 Israeli study (Ziv & Kiassi, 2016) found that Facebook can increase mental well-being in young adults and adolescents who have low mental resiliency by giving them a new avenue for social connectedness without the anxieties of traditional face-to-face socializing. “Facebook may act as a separate social medium in which to develop and maintain relationships, providing an alternative social outlet associated with a range of positive psychological outcomes,” (Grieve, Indian, Witteveen, Tolan, & Marrington, 2013).

Many professionals, as well as ethical guidelines, suggest creating a

social media policy to be included in informed consent documents.

Information in this policy would include whether the counselor will accept friend requests, deny requests, un-friend clients, consent to access client's social media if applicable, and consent to interact via social media (Crtalic, Gibbs, Sprong, & Dell, 2015).

It is clear to see that technology has a significant impact on the way we not only communicate with our peers, but how we are merging our professional correspondences in our daily work environment. Social media and TM communications are here to stay and the challenges and opportunities associated with them need to be assessed by applying long-established professionalism and clinical principles with clients on a case-by-case basis (Dejong et al., 2014). Practitioners must keep themselves informed of policy and ethical standards changes since the use of social networking media has recently been incorporated into standards and principles for many professionals.

References

- American Counseling Association. (2014). *ACA Code of Ethics*. Alexandria, VA: Author.
- Crtalic, A. K., Gibbs, R. L., Sprong, M. E., & Dell, T. F. (2015). Boundaries with social media: Ethical considerations for rehabilitation professionals. *Journal of Applied Rehabilitation Counseling, 46*(3), 44-50. Retrieved from <https://search-proquest-com.ezproxy.lsus.edu/docview/1728268404?accountid=39991>
- Dejong, S. M., & Gorrindo, T. (2014). To text or not to text: applying clinical and professionalism principles to decisions about text messaging with clients. *Journal of the American Academy of Child & Adolescent Psychiatry, 53*(7), 713-715. doi:10.1016/j.jaac.2014.05.002
- Grieve, R., Indian, M., Witteveen, K., Tolan, G. A., Marrington, J. (2013). Face-to-face or Facebook: Can social connectedness be derived online? *Computers in Human Behavior, 29*, 604-609. <http://dx.doi.org/10.1016/j.chb.2012.11.017>
- Kobak, K. A., Mundt, J. C., & Kennard, B. (2015). Integrating technology into cognitive behavior therapy for adolescent depression: a pilot study. *Annals of General Psychiatry, 14*(1). doi:10.1186/s12991-015-0077-8
- NAADAC, the Association for Addiction Professionals (2016). *NAADAC/NCC AP Code of Ethics*. Alexandria, VA: NAADAC.
- National Board for Certified Counselors (NBCC). (2017). *NBCC Code of Ethics*.
- Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., McHugo, G. J., & Bartels, S. J. (2017). Facebook for supporting a lifestyle intervention for people with major depressive disorder, bipolar disorder, and schizophrenia: An exploratory study. *Psychiatric Quarterly, 88*(1), 1-10. doi:10.1007/s11126-017-9512-0
- Sanghara, H., Kravariti, E., Jakobsen, H., & Okocha, C. (2010). Using short message services in mental health services: assessing feasibility. *Mental Health Review Journal, 15*(2), 28-33. doi:10.5042/mhrj.2010.0369
- Seidman, G., Langlais, M., & Havens, A. (2017). Romantic relationship-oriented Facebook activities and the satisfaction of belonging needs. *Psychology of Popular Media Culture, 16*(1), 1-10. doi:10.1037/ppm0000165
- Spradlin, A., Cuttler, C., Bunce, J. P., & Carrier, L. M. (2017). #Connected: Facebook may facilitate face-to-face relationships for introverts. *Psychology of Popular*

Media Culture,
doi:10.1037/ppm0000162
Sude, M. (July 2013). Text messaging
and private practice: ethical
challenges and guidelines for
developing personal best practices.
Journal of Mental Health
Counseling, 35(3), 211-227.

doi:10.17744/mehc.35.3.q3712236u
p621713
Ziv, I., & Kiasi, M. (2016). Facebook's
contribution to well-being among
adolescent and young adults as a
function of mental
resilience. Journal of
Psychology, 150(4), 527-541.

Section I: Professionals' Articles

Educating Counselors-in-Training to Work with Parents of Minors

Krystal M. Vaughn

Louisiana State University Health Sciences Center

Erin M. Dugan

Louisiana State University Health Sciences Center

Kellie G. Camelford

Louisiana State University Health Sciences Center

Counselor education programs offer numerous opportunities for students to receive the necessary knowledge, skills, and experiences to become professional counselors. However, due to limited time, there are areas in the program that are not covered in-depth for various reasons. One such area where students may lack educational or clinical training is in the preparation of working with minors, and more specifically, the treatment of minors surrounding parental consultation practice patterns. The purpose of this article is to define parent consultation, review ethical and legal considerations when working with minors, and to provide counselor educators considerations to utilize when preparing counselors-in-training to work with parents of minor children. This article outlines a guided model when working with clients and their families, including parental consultations and considerations for stakeholders.

Keywords: Children, Adolescents, Parent Consultation

Vaughn, Krystal M., is a Licensed Professional Counselor Supervisor and Registered Play Therapist Supervisor at the Louisiana State University Health Sciences Center where she is an Assistant Professor in the Department of Clinical Rehabilitation and Counseling and clinician in the Child & Family Counseling Center.

Dugan, Erin M., is a Licensed Professional Counselor Supervisor and Registered Play Therapist Supervisor at the Louisiana State University Health Sciences Center where she serves as the Associate Dean of Academic Affairs in the School of Allied Health Professions, Interim Department Head of the Department of Clinical Rehabilitation and Counseling, and the Director of the Child & Family Counseling Center.

Camelford, Kellie G., is a Licensed Professional Counselor Supervisor and Nationally Certified Counselor at the Louisiana State University Health Sciences Center where she is an Assistant Professor in the Department of Clinical Rehabilitation and Counseling and clinician in the Child & Family Counseling Center.

Counselor education programs, accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), offer numerous opportunities for students to study, practice, and specialize in the art of counseling. Under the 2016

CACREP standards, Section 5 accentuated specialty areas of the counseling field by their foundations, contextual dimensions, and practices including addiction; career; clinical mental health; clinical rehabilitation; college and student affairs; marriage,

couple and family; and school counseling. Based on the CACREP standards, counselor educators create academic curricula and fieldwork opportunities for students to gain the necessary knowledge, skills, and experiences to become professional counselors. Although much time is spent creating curricula and fieldwork experiences, there are often areas in the program(s) that are not covered in-depth. Due to this oversight or lack of time spent, students may not receive the appropriate education, knowledge, and/or training of skills and techniques necessary to equip them to work with specific presenting issues/challenges in clients, diagnoses, settings, or populations.

One particular area where students may lack educational or clinical training is regarding the preparation of working with minors. Working with children and adolescents requires knowledge of ethical decision making, laws surrounding treatment of minor children, and parental consultation practice patterns. Counselors-in-training may have minimal understanding of the multifaceted components and factors related to the need to develop a supportive working relationship with parents of minors. The purpose of this article is to define parent consultation, to review ethical and legal considerations when working with minors, and to provide counselor educators with considerations to utilize when preparing counselors-in-training to work with parents of minors.

Parent Consultation

Any communication between the parent and caregiver may be defined as consultation. More specifically, consultation may allow the professional an avenue to discuss progress, teach skills/techniques, and inquire about changes within the client's environment (e.g. school, home, etc.). However, it is

important to differentiate between interventions, therapy, and consultation (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 1999; Lin & Bratton, 2015). For example, interventions or parent education may include filial therapy, parent-child interaction therapy, or family play therapy. Individual therapy wherein the parent is the identified client would also be different from parent consultation. Parent consultation may include consultation at intake, ongoing while providing services to the child/family, and as needed.

Intake

While providing consultation services, the professional may consult with a parent during the intake session where information is gathered including, but not limited to developmental milestones, medical history, educational history, social history, family history, and presenting issues. Other points of discussion should include confidentiality, consistency of coming to sessions, therapeutic process and structure, and recommendations for assessments and/ or other services, if applicable (Vaughn & Dugan, 2017). This initial consultation practice may allow the counselor to speak with a parent without impacting either the parent-child relationship or the therapeutic working alliance with the minor child. During the initial consultation, the primary goal may be to establish a relationship with the caregiver; however, other tasks must be completed.

As part of the initial consultation, professionals should establish treatment plans, which may look somewhat similar to those provided for adults, such as name, age, date of birth, identification of presenting issues, measurable goals/objectives, interventions, and the estimated length

of service. However, during the initial consultation, it may also be important to note the responsible party (e.g., client, parent, teacher) for each intervention and setting (individual, group, parent consultation) in which the intervention should be provided (Ray, 2011).

Ongoing and as Needed

Working with the parents allows the counselor to gather information on those challenges, as well as the progress of treatment and new parental insights. Ongoing consultation may follow in a predictable manner wherein the professional requests to meet with the parent every three to five sessions as recommended (Ray, 2011; Schottelkorb, Swan & Ogawa, 2015). Cates, Paone, Packman, and Margolis (2006) believed parent consultations allow counselors the opportunity to provide updates on the child's progress, assessment of treatment goals, education, recommendations, and ultimately termination.

Once engaged in ongoing parental consultations, parents may request consultations more often; or conversely, parents may have difficulty focusing on child centered behaviors or concerns. If these difficult behaviors continue, Ray (2011) recommended referrals for individual counseling for the parent(s). For counselors with minimal experience, this may be an uncomfortable conversation. Kottman (2011) reminded counselors that parents may present with anxiety and self-blame for the child's challenging behavior(s). Therefore, counselors must provide a supportive environment that fosters a safe, non-threatening working alliance. Additionally, this supportive environment may also convey that the parents are the expert regarding their child (Axline, 1947). Once the parent feels supported in the consultation, the counselor may be able to provide skills

or education to promote healthy child development and/or enhancement of the child-parent relationship. Dugan, Swanson, and Short (2011) stated that caregiver concerns, therapeutic goals, and established therapeutic recommendations should drive the skills or educational components of a consultation session.

Lastly, professionals may also need to be aware of the developmental stages of the consultation relationship. Steen (2010) identified four stages of consultation: engagement, cooperation, incorporation, and termination. During the engagement phase, professionals may actively listen and empathize to support parents as they may experience a variety of emotions. As the consultation process enters the cooperative phase, parents may begin to show insight and seek advice. As parents begin to seek advice, they may soon enter the third phase of incorporation wherein they begin to try out the techniques of skills advised by the professional in additional areas, settings, and/or with other children in the home environment. As parents incorporate skills, take responsibility, and make changes in the client's natural environment, the consultation process may lead to the final stage of termination (Steen, 2010).

Ethical Considerations

The American Counseling Association (ACA) *Code of Ethics* (2014) established the ethical obligations for the counseling field and provides clinicians with guidelines when working with clients of all ages. The Code states, "the primary responsibility of counselors is to respect the dignity and promote the welfare of clients" (American Counseling Association, 2014, Standard A.1.a), yet when working with minors, counselors-in-training become unsure as to "who" is the client. Informed consent becomes

the first important task for a counselor-in-training to master when working with minors. Under Standard A.2.d, inability to give consent, the Code specified “when counseling minors...unable to give voluntary consent, counselors seek the assent of clients to services and include them in decision making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect their clients and make decisions on their behalf” (American Counseling Association, 2014). Therefore, counselors-in-training need to practice appropriate communication with the minor client and the parents regarding the process of counseling and parent consultations.

Furthermore, under Section B, confidentiality and privacy, the Code addressed the responsibility to the minor client by protecting confidential information in the counseling relationship (American Counseling Association, 2014, B.5.a.), yet under the responsibility to parents and legal guardians counselors are tasked to create an “appropriate, collaborative relationship with parents/guardians to best serve clients” (American Counseling Association, 2014, B.5.b.). Counselors-in-training need to consider what is and is not appropriate to share with parents during a parent consultation and learn to balance the minor client’s right to confidentiality with the parents’ right to be informed about their child.

Finally, it is imperative that counselors have knowledge of ethical decision making models. The Code specified that when counselors face ethical issues, they must utilize an ethical decision making model and document the process (American Counseling Association, 2014, I.1.b.)

Although many models exist, on the ACA website, clinicians and counselors-in-training are directed to the Forester-Miller and Davis (2016) model. At a glance, the Forester-Miller and Davis (2016) model described the following steps “1) identify the problem, 2) apply the ACA *Code of Ethics*, 3) determine the nature and dimensions of the dilemma, 4) generate potential courses of action, 5) consider the potential consequences of all options and determine a course of action, 6) evaluate the selected course of action, and 7) implement the course of action” (p. 5). This model will assist counselors-in-training when working with minors, and help counselors-in-training to decide the structure and information shared during parental consultations.

Legal Considerations

In addition to ethical standards, counselors-in-training should have an understanding that laws in each state guide the counseling process of working with minors regarding treatment, consent, and parental rights. For example, in Louisiana, a parent who is named on a child’s birth certificate, but does not actively participate in parenting practices, may still have the right to consent to counseling treatment of said minor child (Polowy & Felton, 1994). Consent may not be necessary if the child is presenting for emergency care at a hospital. However, this difference may cause legal and ethical dilemmas for counselors with limited experience, in smaller practices or rural areas. Once the decision has been made to provide counseling for a minor child, one should also determine how to work with the legal guardian/caregiver.

Preparing Counselors-in-Training for Parent Consultation

Parent consultations are held in order to allow the counselor to provide

the parent(s) feedback and an opportunity for the parent to report noted observations such as increases/decreases in behavior(s) of concern. Educators should prepare counselors-in-training to conduct parental consultations and inform counselors-in-training of the many ways in which one may be providing consultation around children's challenging behaviors or concerns. Seasoned counselors and supervisors can assist counselors-in-training regarding the preparation and performance of parent consultations. Supervisors may conduct role-plays and mock consultations to prepare their counselors-in-training in the development of confidence and competency.

A standardized form is an example of a tool used in parent consultation which serves as a guide for both the counselor-in-training and the parent prior to the scheduled consultation session. Dugan et al. (2011) concluded that the use of standardized forms may assist novice, intermediate, or advanced level practitioners in preparing for parent consultations. This form may include such information as the parents' observation of significant happenings in regard to their child, positive changes noted, presenting issues that have remained the same, noted changes of concern, stressors evident in the child's/parent's life, the parents' contributions to their child's growth, the parents' hindrances in their child's growth, what the parents are learning about their child, what the parent wishes to speak about during the consultation, the parent's part in the therapeutic process, what changes the parent is making or has made, the parent's needs, their child's needs, and any other additional information needed to be shared (Dugan et al., 2011).

Stakeholder Considerations

There are three main stakeholders in the preparation of new clinicians in regards to parent consultation, including counselor educators, site supervisors, and counselors-in-training. Counselor educators need to be aware of the gaps within their programs, such as working with minors, and offer students additional resources, training, and opportunities to remedy these deficiencies. Before counselors-in-training perform clinical tasks, site supervisors should evaluate the counselor-in-training's knowledge and experiences so that scaffolding techniques can be incorporated to allow the counselor-in-training to gain exposure to various types of clients, including working with minors and their parents. Finally, counselors-in-training need to have awareness of their own educational journey, regarding the strengths and weaknesses of their program, and seek opportunities to build clinical skills based on self-motivation.

Conclusion

Although counselor education programs offer the foundation required for students to become clinicians, there may be deficits in such programs where students will lack the required education and experience necessary to work with minors until counselors-in-training enter into the fieldwork component of their respective programs. Counselor educators and site supervisors need to work together to provide further opportunities for counselors-in-training regarding the importance of parent consultation, including the ethical and legal considerations. Through having a clear definition of parent consultation, counselors-in-training can then grapple with the ethical and legal considerations regarding working with minors and communicating information

to their parents through consultation. Finally, through guided experience with clients and their families, counselors-in-training will gain the required knowledge needed to effectively work with parents of minors.

References

- American Counseling Association (2014). *ACA Code of Ethics*. Alexandria, VA: Author.
- Axline, V. (1947). *Play therapy*. New York: Houghton-Mifflin.
- Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy and filial therapy with children: Summary of the meta-analytic findings. Retrieved from <http://www.a4pt.org/download.cf>
- Cates, J., Paone, T., Packman, J. & Margolis, D. (2006). Effective parent consultation in play therapy. *International Journal of Play Therapy* 15(1), 87-100.
- Council for Accreditation of Counseling and Related Programs. (2016). *2016 CACREP Standards*. Retrieved from: <http://www.cacrep.org/for-programs/2016-cacrep-standards/>
- Dugan, E., Swanson, K., & Short, E. (2011). Play therapy caregiver consultations. *Play Therapy*, 6(4), 22-25.
- Forester-Miller, H., & Davis, T. E. (2016). *Practitioner's guide to ethical decision making*. Alexandria, VA: Center for Counseling Practice, Policy, and Research. Retrieved from <http://www.counseling.org/docs/default-source/ethics/practitioner's-guide-to-ethical-decision-making.pdf?sfvrsn=0>
- Kottman, T. (2011). *Play therapy basics and beyond*. Alexandria, VA: American Counseling Association.
- LeBlanc, M., & Ritchie, M. (1999). Predictors of play therapy outcomes. *International Journal of Play Therapy*, 8(2), 19-34.
- Lin, Y., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling and Development*, 93(1), 45-58. doi:10.1002/j.1556-6676.2015.00180.x
- Polowy, C., & Felton, E. (1994). *Working with children: The many layers of consent to treat*. National Association of Social Workers California.
- Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice*. New York: Routledge.
- Schottelkorb, A., Swan, K., & Ogawa, Y. (2015). Parent consultation in child-centered play therapy: A model for research and practice. *International Journal of Play Therapy* 24(4), 221-233.
- Steen, R. L. (2010). *Parent consultation: Beyond engagement*. Association for Play Therapy October Mining Report. Published October, 10, 2010.
- Vaughn, K. & Dugan, E. (2017). *Emerging Research in Play Therapy, Child Counseling and Consultation*. Steen, R. (ed.). Hershey, PA: IGI Global

Integration of Play Therapy with Insecurely Attached Adolescents

Megan N. Long, PLPC, CRC

Graduate Student, Louisiana State University Health Science Center

Erin M. Dugan, Ph.D., LPC-S, NCC, RPT-S

Associate Professor, Louisiana State University Health Science Center

Kellie G. Camelford, Ph.D., LPC-S, NCC

Assistant Professor, Louisiana State University Health Science Center

The purpose of this study was to develop a better understanding of play therapists' methods for screening adolescents for attachment disorders, as well as determining the effectiveness of integrating play therapy in treating adolescents who are insecurely attached with their primary caregivers. This study attempts to determine the theoretical orientation of play therapists who utilized play therapy in treating insecurely attached adolescent clients. This study sought to determine if there are any current trends among play therapists, in regard to providing play therapy services to insecurely attached adolescents. The primary goal of this study was to gain greater depth of understanding in the use of play therapy in treating adolescents. Literature indicates that most play therapists, who were providing play therapy services to adolescents in this incidence, were not assessing the attachment relationship prior to initiating services; thus the need for providing increased education and training for play therapists when assessing presenting issues/challenges and disorders in their patients.

Keywords: Attachment, Insecure Attachment, Play Therapy, Registered Play Therapist, Registered Play Therapist Supervisor, Secure Attachment

Attachment plays an important role in the lives of children, and the need for a secure attachment, between a child and caregiver does not end in childhood. Attachment continues to play a crucial role in the overall development of an individual through adulthood (Ainsworth 1970; Martin 2007). Securely attached adolescents explore their changing environment, and are less likely to engage in risk-taking behaviors and have mental health concerns (Moretti & Paled, 2004). When compared to peers who have an insecure attachment style, securely attached adolescents have improved social skills and coping mechanisms (Moretti & Paled, 2004).

Mental health practitioners who engage attachment theory in their practice can use the attachment between child and caregiver to facilitate growth for their adolescent and adult clients.

To provide best practices in developing treatment plans, mental health practitioners are encouraged to assess the attachment relationship between the child and his or her caregiver. So as to fully assess the child-parent relationship, Martin (2007) reinforced the need to use advanced assessment techniques before clients begin to participate in services. Registered play therapists (RPTs) and registered play therapist supervisors (RPT-Ss), upon initial assessment and to develop more effective treatment

plans, often explore and assess the attachment relationship between the child and caregiver. Through a thorough understanding of the parent-child attachment, the clinician can more accurately determine the direction of services (Martin, 2007). This framework allows the clinician to develop treatment plans facilitating a deeper, more meaningful change in those served by addressing the presenting concern through an attachment-informed lens. Clinicians can select therapeutic interventions, such as determining whether filial therapy or child-parent relationship therapy, that are more suitable for the attachment relationship and a beneficial addition to the treatment plan.

Play therapists can use many modalities to incorporate attachment theory into their practice; thus, facilitating stronger attachment between adolescents and parents. More specifically, it is of interest to play therapists who treat adolescents, to understand the most effective ways in which to assess an adolescent's attachment style. Also, it provides an intriguing means to determine the most effective ways to improve the maladaptive behavior associated with the insecure attachment to the primary caregiver.

This study strived to gain a better understanding of the common practices that RPTs and RPT-Ss use to develop treatment plans and provide services to adolescents. This study sought to determine the theoretical orientation of practices that RPTs and RPT-Ss utilized in treating insecurely attached adolescent clients. The primary goal of this study was to gain a greater understanding of how play therapists integrated play therapy in treating adolescents. Lastly, this study searched for current trends existing among play therapists regarding their most

common treatment approaches for adolescents with insecure attachment styles.

Review of the Literature

A brief literature review provided insight regarding the integration of play therapy with insecurely attached adolescents. Green, Myrick, and Crenshaw (2013) defined attachment as, "a dynamic pattern of cognitions, affect, and associated behaviors that result from a caregivers' ability to meet an infant's need for warmth, nurturance, and safe physical closeness" (p. 91). According to this definition, the parent's ability to meet their infant's need is significant. A parent who is unable to provide warmth, nurturance, and safe physical closeness may produce an insecure working relationship with their child. As a child develops into adolescence, the parent-child relationship will build off of the shaky foundation set in childhood. If the parent continues to reinforce behaviors that promote an insecure working relationship, the adolescent may replicate ineffective relationships with peers and other individuals in his or her life. An inability to develop effective relationships with others can impact many facets of the adolescent's life.

According to Ainsworth and Bell (1970), secure attachment is:

An affectional tie that one person or animal forms between himself and another specific one—a tie that binds them together in space and endures over time. The behavioral hallmark of attachment is seeking to gain and to maintain a certain degree of proximity to the object of attachment, which ranges from close physical contact under some circumstances to interaction or communication across some distance under other circumstances. (p. 50)

Understanding a secure attachment relationship illuminates the significant impact that the parent-child relationship has on an individual. This foundational relationship is pivotal in the development of the adolescent's worldview (Martin 2007). A secure attachment with the primary parent in early childhood and adolescence provides a framework for other valuable relationships in the adolescent's life (Corbin 2007). This pilot study sought to explore the various play therapy approaches used to enhance the parent-child relationship.

Counselors working with insecurely attached adolescents would greatly benefit from becoming familiar with the three types of insecure attachment. The first, *insecure-ambivalent/anxious*, can be described as when "the child seeks to remain near the caregiver to increase chances of contact" (Escobar et al., 2013, p. 2). The second type, *insecure-avoidant*, can be described as when the child has an inner working model depicting "the caregiver as consistently failing to provide security" (Escobar et al., 2013, p. 2). The third type, *disorganized attachment*, can be defined when the child views the "caregivers as a possible threat, causing the child to adopt to fearful or disoriented behavior" (Escobar et al., 2013, p. 2). Understanding types of insecure attachment relationships allows the clinician to explore ways in which each attachment style can impact a child's well-being and relationships.

Current literature concerning insecure attachment styles among adolescents focused on three concerns. First, much attention was paid to the impact of insecure attachment on the neurobiology of the adolescent (Corbin, 2007; Finn, 2012; Friend, 2012; Galynker et al., 2012; Green & Myrick, 2014; Levy, 2011). The literature described the lasting impact on a

disrupted attachment in early childhood. That can impair an individual's ability for their Hypothalamic-Pituitary-Adrenal (HPA) axis ability to manage stressful emotions, events, and feelings. This perspective describes attachment in yet another way; it was described as a regulatory theory (Corbin 2007; Schore 2000). It is important to understand the role the HPA axis performs in regulating stress: it regulates cortisol. An impaired ability to regulate cortisol can have an effect on physical and mental illness later in life (Corbin 2007). Additionally, cortisol reactivity can be linked to behavior issues in adolescents. It is interesting to note that increased symptoms of anxiety disorders and social withdrawal were noted after a disruption in the parent-adolescent relationship (Shirtcliff et. al. 2005). Next, the literature focused on the ways in which trauma impacts an adolescent's attachment style (Anderson & Gedo, 2013; Corbin, 2007; Friend, 2012; Green & Myrick, 2014; Green et al., 2013; Hill 2006). Also, the limitations of using attachment theory in psychotherapy are discussed (Zilberstein, 2014). Early neglect and abuse both impact an individual's ability to develop effective relationships, but it is possible that neglect is more harmful. This amplifies the importance of fostering secure attachments in childhood, as well as implementing effective approaches to remediate insecure attachments between parents and adolescents (Corbin 2007). Finally, the literature addresses treatment options for insecurely attached adolescents (Anderson & Gedo, 2013; Corbin, 2007; Friend, 2012; Green & Myrick, 2014; Green et al., 2013; Hill, 2006). By discovering the ways in which attachment styles impact adolescents, mental health practitioners can focus on the development of brain functioning.

These functions influence the child's behavior, the impact of stressors affecting the child-caregiver relationship, and the implementation of treatment approaches used to enhance security within the relationship. This is vital to promoting wellness among adolescents because insecure attachments to primary caregivers in early childhood can cause difficulty in an individual's "ability to self-soothe, self-organize, regulate affect, and engage in healthy relationships" (Corbin 2007).

Play therapy researchers noted support of an integrated approach with other therapeutic techniques, such as trauma-focused cognitive behavioral therapy (CITE which researchers here). This approach is emphasized in the literature because of the ways that both approaches can foster the therapeutic alliance as well as promote a resolution to traumatic experiences (Green & Myrick, 2014). Understanding the need for an integrated approach can empower counselors to incorporate play therapy with children and adolescents that have experienced trauma.

Limitations include a void in the literature concerning research between attachment and adolescence, especially regarding the efficacy of play therapy in treating insecurely attached adolescents. Instead, the young child or adult is the main focus of available literature on attachment. This pilot study sought to obtain data on ways that play therapists developed treatment plans for this population.

Method

In this study, after Institutional Review Board (LSUHSC-IRB) approval was received, an online survey questionnaire consisting of nine items via SurveyMonkey, an online survey platform, was sent to all RPTs and RPT-Ss in the United States. The authors obtained the email addresses for

participants through the Association for Play Therapy (APT). Through SurveyMonkey, a link was e-mailed to participants with one follow-up request to participate. The survey was sent to 2,166 RPTs, and 307 responses were received. While some of those individuals who were sought out responded that they were uninterested in participating in this study, many others responded that this was a topic they wished to learn more about. The response rate was 14.17%. The data was exported and analyzed with Microsoft Excel (Microsoft Excel 2013). A list of the survey questions is located in Appendix I. For questions involving theoretical orientation or assessment methodology an "other" answer choice was provided. Participants were able to fill in their preferred answer, if it differed from the provided choices. This method was selected to gain both qualitative and quantitative information to understand the experiences RPTs and RPT-Ss have in serving this unique population. This study may be replicated.

Results

The results of this questionnaire provided insight into the practices of those RPTs and RPT-Ss who provided services to insecurely attached adolescents. For question one, 43% of the participants selected the RPT option and 57% selected the RPT-S option. It was of interest to learn how many adolescents were on each participant's caseload. The majority of participants reported one to five adolescents on their caseload (38%), followed by six to 10 adolescents (29%), 15+ adolescents (14%), 11 to 15 adolescents (10%), and lastly, zero adolescents (8%). Of those clinicians, the results determined how many clients had an identified insecure attachment with their primary caregiver. The vast majority reported zero to five adolescents with identified

insecure attachment on their current caseload (75%), followed by six to 10 adolescents (18%), 11 to 15 adolescents (4%), and finally, 16+ adolescents (2%).

The next questions sought to gain insight into the theoretical orientation prescribed to by participants. It also studied differences in practices between adolescents and children. The majority of participants endorsed person-centered theory as their primary theoretical orientation (61%) followed by cognitive-behavioral theory (41%). Participants also endorsed an "Other" category with the option to fill in a theory not mentioned in the choices (25%). Participants used a comment box to include: experiential and filial, integrative/prescriptive: CBT and psychodynamic, narrative, reality, non-direct play therapy, contextual family therapy, family systems, solution-focused, sand tray, emotionally focused therapy (EFT), prescriptive, and dialectical behavior therapy (DBT). Following "Other," Adlerian theory (18%), nearly correlated with psychodynamic theory (17%). Gestalt theory and behavioral theory were both indicated at the same rate (10%). Finally, participants endorsed existential theory (7%). In regard to theoretical orientation when working with an adolescent population, the results were distributed similarly.

Next, participants were asked if they used play therapy with adolescents with an insecure attachment to their primary caregiver. The majority of participants reported Yes (86%). Most participants endorsed nondirective play therapy (59%) or directive play therapy (56%). Next, family play therapy was endorsed (47%), followed by Theraplay (22%) and filial play therapy (21%). Others report using sand tray, solution-focused, filial therapy, child parent relationship therapy (CPRT), prescriptive, somatic experiencing, and

eye movement sensitization and reprocessing.

Respondents responded if they incorporated other theories with play therapy when working with insecurely attached adolescents. Many play therapists endorsed trauma-focused cognitive behavioral therapy (55%) and cognitive behavioral therapy (45%). Others reported in a free-text comment box using canine assisted play therapy, emotion-focused family play therapy, eye movement sensitization and reprocessing art therapy, dyadic developmental psychotherapy, and narrative therapy.

Finally, participants commented on assessments used with insecurely attached adolescents. Most reported "Other," and listed: emotion-focused therapy attachment questions, art therapy family assessment, kinetic family drawing, family play genogram, child attachment checklist, adolescent dissociative survey, PHQ-9 depression scale, adult attachment interview (with parents), UCLA PTSD assessment, child behavior checklist, and inventory of parent and peer attachment (46%). Participants reported the parent relationship questionnaire (34%), Marschak Interaction Method-rating (MIM) scale (22%), strength and difficulties questionnaire (16%), relationship questionnaire (10%), self-administered dependency questionnaire (6%), and test of family attitudes (3%).

Discussion

The results of this study demonstrated a need for increased training for play therapists, within their training program(s). It is important for RPTs and RPT-Ss to learn the similarities and differences between play therapy and evidence-based treatment modalities to develop the effective use of play therapy in appropriate circumstances when serving adolescents. Evidence-based

and evidence-informed mental health strategies are crucial in providing clients with an appropriate standard of care to maintain best practice as well as to individualize care to meet each adolescent's specific needs.

Researchers are currently working to delineate the use of play therapy for adolescents with an insecure attachment style to their primary caregivers. Through this work, a standard of care may be established through future studies examining the effectiveness of specific modalities of play therapy, especially when working with adolescents with insecure attachment styles. An example of such standard(s) would be to have standardized, dedicated assessment tools to screen for insecure attachments within the adolescent population. In following research-informed practices when using play therapy with adolescents who have insecure attachment styles, it may be possible to improve professional confidence and outcomes in using these techniques.

It is important to enhance the education and conceptualization of those therapists who most often treat adolescents with insecure attachment styles. By enhancing these areas through more focused educational efforts surrounding attachment theory in play therapy, students will be able to better discover more evidence-informed strategies to implement group play therapy, family play therapy, and individual play therapy sessions with clients. Others were interested in learning methods of incorporating play therapy for adolescents with an identified insecure attachment style in a school setting. Through developing a stronger research base on integrating attachment theory with varying treatment modalities, such as group play therapy, RPTs and RPTSs may be

more open to incorporating these crucial concepts in their practice.

Future Directions

This study's results yielded several interesting implications. First, without therapist awareness of the impact of insecure attachment styles in adolescence, it was difficult for play therapists to assess and treat clients who have developed an insecure attachment style to their primary caregiver. Second, due to a lack of standardized tools to assess secure attachment in adolescence, play therapists relied on less scientific modes of information gathering, such as unstandardized observation and relying on self-report from clients and their caregivers. This is troublesome because it requires play therapists to rely on intuition alone rather than with evidence-based, formal assessments. Clinicians need to be aware of and assess for attachment disorder(s) before the initiation of services to avoid the child, or perhaps the adolescent, from developing a more secure attachment with the therapist than to the caregiver (Martin, 2007).

This study opens the door to many future directions. One direction would be to continue measuring the success of play therapy in treating various types of clients, especially those experiencing insecure attachment with their primary caregiver. Much research is still needed to develop a strong research base on the effects of insecure attachment to the primary caregiver in adolescence. Another direction would be to learn about the reasons a secure childhood attachment may change to an insecure attachment style in adolescence. It is important for future studies to examine the sensitivity of assessment tools to measure attachment styles. For example, assessment tools not specifically intended to screen for insecure attachment styles in the

parent-adolescent relationship may either exaggerate or underestimate the prevalence of this phenomenon, resulting in an inability to appropriately address the cause of certain behavior and relationship concerns. As discussed in the literature review above, a disruption in the ability of the HPA axis to regulate cortisol levels can have lasting repercussions in the adolescent's life (Shirtcliff 2005).

Additionally, further information regarding the importance of the attachment style between the parent and adolescent must be presented to play therapists. While many future directions are possible, research should be done to examine the instruction of attachment theory to mental health practitioners. Without adequate knowledge of the implications of an insecure attachment style and resources about screening the parent-child dynamic, play therapists will be less able to effectively serve adolescents experiencing these concerns.

Conclusion

In conclusion, the authors gained greater understanding about the ways play therapy was utilized when working with adolescents who are insecurely attached to their caregiver primarily involved in their care. Through review of the literature, an emailed survey, and the presentation and discussion of these findings, evidence has been provided that attachment styles are often under or inadequately assessed in adolescents. Among those clinicians who do screen for attachment styles in adolescents, play therapy is an under-researched modality to resolve these concerns. While these are concerns, much more research is being conducted to learn about the impact insecure attachment has on neurobiology and development into adulthood. This is a hopeful message; play therapy has the

ability to facilitate lasting change in the lives of the adolescents.

References

- Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49-67.
- Anderson, S. M., & Gedo, P. M. (2013). Relational trauma: Using play therapy to treat a disrupted attachment. *Bulletin of the Menninger Clinic, 77*(3), 250-268. doi:10.1521/bumc.2013.77.3.20.
- Corbin, J. (2007). Reactive attachment disorder: A biopsychosocial disturbance of attachment. *Child and Adolescent Social Work Journal, 24*(6), 539-552. doi:10.1007/s10560-007-0105-x.
- Escobar, M. J., Rivera-Rei, A., Decety, J., Huepe, D., Cardona, J. F., Canales-Johnson, A. Ibanez, A. (2013). Attachment patterns trigger differential neural signature of emotional processing in adolescents. *PLoS One, 8*(8), e70247. doi:10.1371/journal.pone.0070247.
- Finn, S. E. (2012). Implications of recent research in neurobiology for psychological assessment. *Journal of Personality Assessment, 94*(5), 440-449. doi:10.1080/00223891.2012.700665.
- Friend, J. (2012). Mitigating intergenerational trauma within the parent-child attachment. *Australian and New Zealand Journal of Family Therapy, 33*(2), 114-127. doi:10.1017/aft.2012.14.
- Galynker, I. I., Yaseen, Z. S., Katz, C., Zhang, X., Jennings-Donovan, G., Dashnaw, S., & Winston, A. (2012). Distinct but overlapping neural networks subserve depression and insecure attachment. *Social*

- Cognitive and Affective Neuroscience*, 7(8), 896-908.
- Green, E., J., & Myrick, A. C. (2014). Treating complex trauma in adolescents: A phase-based, integrative approach for play therapists. *International Journal of Play Therapy*, 23(3), 131-145. doi:10.1037/a0036679.
- Green, E. J., Myrick, A. C., & Crenshaw, D. A. (2013). Toward secure attachment in adolescent relational development: Advancements from sandplay and expressive play-based interventions. *International Journal of Play Therapy*, 22(2), 90-102. doi:10.1037/a0032323.
- Hill, A. (2006). Play therapy with sexually abused children: Including parents in therapeutic play. *Child and Family Social Work*, 11(4), 316-324.
- Levy, A. (2011). Neurobiology and the therapeutic action of psychoanalytic play therapy with children. *Clinical Social Work Journal*, 39(1), 50-60. doi:10.1007/s10615-009-0229-x
- Martin, E. (2007). Understanding intergenerational attachment disorders: The use of filial therapy and child parent relationship therapy when treating insecure attachment styles. *VISTAS 2007*. Retrieved from <http://counselingoutfitters.com/vistas/vistas07/Martin.htm>. Microsoft Excel 2013
- Moretti, M. M., & Paled, M. (2004). Adolescent-parent attachment: Bonds that support healthy development. *Paediatrics and Child Health*, 9(8), 551-555.
- Schore, A. N. (2000). Attachment and the regulation of the right brain. *Attachment & Human Development*, 2(1), 23--47.
- Shirtcliff, E. A., Granger, D. A., Booth, A., & Johnson, D. (2005). Low salivary cortisol levels and externalizing behavior problems in youth. *Development and Psychopathology*, 17, 167-184. doi:10.1017/S0954579405050091
- Zilberstein, K. (2014). The use and limitations of attachment theory in child psychotherapy. *Psychotherapy*, 51(1), 93-103. doi:10.1037/a0030930.

Appendix I
Survey Questions

1.	<p>Are you a RPT or RPT-S?</p> <ul style="list-style-type: none"> • RPT • RPT-S
2.	<p>Do you provide services to adolescents? If yes, how many? If no, please select 0 and stop the survey.</p> <ul style="list-style-type: none"> • 0 • 1-5 • 6-10 • 11-15 • 15+
3.	<p>If yes, how many adolescents on your caseload have insecure attachment relationships with their primary caregiver(s)?</p> <p>Insecure attachment can be divided into three types. The first, insecure-ambivalent/anxious, can be described as when “the child seeks to remain near the caregiver to increase chances of contact” (Escobar et al., 2013, p. 2). The second insecure attachment type, insecure-avoidant, can be described as when the child has an inner working model depicting “the caregiver as consistently failing to provide security” (Escobar et al., 2013, p. 2). The third type of insecure attachment, referred to as disorganized attachment, can be defined as when the child views the “caregivers as a possible threat, causing the child to adopt to fearful or disoriented behavior” (Escobar et al., 2013, p. 2).</p> <ul style="list-style-type: none"> • 0 • 1-5 • 6-10 • 11-15 • 16+

4.	<p>What theoretical orientation do you prescribe to in your practice?</p> <ul style="list-style-type: none">• Psychodynamic Theory• Adlerian Theory• Existential Theory• Gestalt Theory• Person-Centered Theory/Client-Centered Theory• Behavioral Theory• Cognitive-Behavioral Theory• Other (please specify)
5.	<p>What theoretical orientation do you prescribe to, if different from the above answer, when working with adolescents?</p> <ul style="list-style-type: none">• Psychodynamic Theory• Adlerian Theory• Existential Theory• Gestalt Theory• Person-Centered Theory/Client-Centered Theory• Behavioral Theory• Cognitive-Behavioral Theory• Other (please specify)

Appendix I
Continued

<p>6.</p>	<p>Do you use play therapy with the adolescents who have insecure attachment relationships with their primary caregiver(s)?</p> <p>Insecure attachment can be divided into three types. The first, insecure-ambivalent/anxious, can be described as when “the child seeks to remain near the caregiver to increase chances of contact” (Escobar et al., 2013, p. 2). The second insecure attachment type, insecure-avoidant, can be described as when the child has an inner working model depicting “the caregiver as consistently failing to provide security” (Escobar et al., 2013, p. 2). The third type of insecure attachment, referred to as disorganized attachment, can be defined as when the child views the “caregivers as a possible threat, causing the child to adopt to fearful or disoriented behavior” (Escobar et al., 2013, p. 2).</p> <ul style="list-style-type: none"> • Yes • No • If you answered no, please comment in the space below as to what approach you do use. After, please stop the survey.
<p>7.</p>	<p>If your answer to question 6 was yes, what approach to play therapy do you use with insecurely attached adolescents?</p> <ul style="list-style-type: none"> • Directive Play Therapy • Nondirective Play Therapy/Client-Centered Play Therapy • Filial Play Therapy • Family Play Therapy • Group Play Therapy • Theraplay • Other (please specify)

Appendix I
Continued

8.	<p>Do you integrate play therapy with other theoretical orientations/approaches when working with insecurely attached adolescents?</p> <ul style="list-style-type: none">• Cognitive Behavioral Therapy• Trauma Focused Cognitive Behavioral Therapy• Other (please specify)
9.	<p>What assessments do you use with insecurely attached adolescents?</p> <ul style="list-style-type: none">• The Strength and Difficulties Questionnaire• The Relationship Questionnaire• Marschak Interaction Method-Rating Scale• Parent Relationship Questionnaire• Self-Administered Dependency Questionnaire• The Test of Family Attitudes• Other (please specify)

Appendix I
Continued

School Counselors' Wellness Behavior and its Effect on Compassion Fatigue, Burnout and Compassion Satisfaction

Mary G. Mayorga, Ph.D., LPC-S, NCC, CCDS, CART

Associate Professor of Counseling, Texas A&M University San Antonio

Sabina DeVries, Ph.D., LPC-S, NCC

Assistant Professor of Counseling, Texas A&M University San Antonio

Ann Wardle, LCP-S, RN

Assistant Professor of Counseling, Texas A&M University San Antonio

As stated by Myers (1992), wellness, prevention and developmental approaches in counseling are the cornerstone of the counseling profession. Wellness needs to be emphasized, not only from the client but also from the professional counselor perspective. The value of the wellness behavior for the helping professional is well documented by several entities including the American Counseling Association, which has embraced wellness from a comprehensive, holistic perspective (Myers, 2014). The aim of this study was to examine a group of school counselors to obtain data regarding compassion satisfaction, burnout, and compassion fatigue. Another goal was to determine the correlation between wellness behavior and compassion satisfaction, burnout, and compassion fatigue. Data was collected using the Professional Quality of Life Scale (ProQOL-Version 5, 2010), the Self-Care Assessment Worksheet, and a demographic questionnaire. The results indicated overall satisfactory professional quality of life and self-care behaviors. The data, showed a positive correlation between engaging in self-care behaviors and compassion satisfaction. A positive correlation was also found between burnout and compassion fatigue, and a negative correlation was found between burnout and those engaging in self-care behaviors.

Keywords: Wellness, Self-Care Behaviors, Compassion Satisfaction, Burnout, Compassion Fatigue

Wellness behavior is not a new concept in counseling (Myers, 1991). In fact, the American Association for Counseling and Development states that inclusion of a wellness component into the counseling process is highly recommended (AACD, 1991). As professional counselors, we encourage our clients to look at their current wellness behaviors and lifestyle to determine what changes can be made to live a healthier, balanced lifestyle, both physically and mentally. The counseling profession also recognizes that professional counselors need to review their own wellness behavior.

Many counseling professionals may not be engaging in a healthy, balanced lifestyle, although counselors are expected to maintain a sense of equilibrium while working and providing quality therapeutic services (Lee, Cho, Kissinger, & Ogle, 2010). If not engaging in wellness behavior, counseling professionals may experience the effects of engaging in poor and unbalanced lifestyles. This may lead to burnout impairment, which in turn may lower levels of compassion satisfaction and increase compassion fatigue. It behooves counseling practitioners to become more sensitive

to their vulnerability to personal and professional impairment, and seek out competent professional strategies that include learning improved methods of wellness behavior (Anderson, 1992).

Wellness behavior can be described as self-care that includes practicing the essentials of healthy living and maximizing of human potential through positive life-style choices (Myers, 1991). These positive lifestyles may include exercising, meditation, relaxation exercises, spending quality time with friends, and if needed, personal counseling (Evans, Carney, Shannon, & Strohl, 2012).

Wellness is not considered synonymous with health but rather refers to the merging of body, mind, and spirit (Stiles, 1984). It emphasizes a balanced life-style with self-care practices that range from something as simple as getting more sleep to engaging in restorative activities that will keep professional counselors vital and engaged in all aspects of their life (Wise, Hersh, & Gibson, 2011). Wellness behavior can be thought of as both a process and a goal, which all persons, including professional counselors continuously work toward (Warner, 1984).

The ACA code of ethics (2014) discusses impairment of counselors and states “counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems” (Standard C.2.g.). Therefore, professional counselors need to affirm and evaluate their own wellness behavior. By evaluating their own wellness behaviors professional counselors are better able to maximize positive life-style choices and make conscious and deliberate efforts to enhance their physical, mental and emotional health, which lessens the opportunity to experience impairment including compassion fatigue trauma (Ardell, 1988).

One of the struggles in making a case for wellness behavior for professional counselors is simply that counselors many times do not practice what they preach (O’Halloran & Linton, 2000). In their fast-paced lives, professional counselors may not equate physical symptoms with their own lack of wellness behavior. Some of the physical symptoms that may be experienced can range from chronic fatigue to increased illnesses, yet professional counselors may disregard these as part of life (Bourg-Carter, 2011).

Wellness behaviors can be viewed on a continuum; the more a person participates in wellness behavior (ie: exercising appropriately, eating appropriately, taking the time to de-stress appropriately), the less likely a person is to suffer burnout or develop lower levels of compassion satisfaction. The less a person participates in his/her own wellness behaviors the more likely this individual is to experience burnout symptoms such as physical and emotional exhaustion, feelings of cynicism and detachment, and a sense of ineffectiveness and lack of accomplishment. Left alone and not handled properly the person can experience a complete “crash” (Maslach, Schaufeli, & Leiter, 2001).

The value of wellness behavior for the helping professional is well documented by several entities including the American Counseling Association, which has embraced wellness from a comprehensive, holistic perspective (Myers, 2014). Well-known authors such as J. E. Myers, T. J. Sweeney and D. B. Ardell, have published seminal articles in the field of wellness (McMahon, S., & Fleury, J., 2012). It is also recognized that in the field of human services counselor’s self-care through wellness behaviors is a crucial concept that is important for continued ability to serve their

respective clients (Kostouros & McLean, 2006).

The paradox in the field of counseling in terms of wellness behavior is that it is easy for counselors to see and help other people, yet it is so difficult for counseling professionals to get off the treadmill of life and take care of themselves (Norcross & Barnett, 2008). Wellness behavior is so crucial for professional helpers because to service their respective clients they must first help themselves. A lack of care toward self may eventually lead to high levels of stress resulting in the phenomenon of compassion fatigue and burnout (Kostouros & McLean, 2006).

Compassion Satisfaction

Merriman (2015) found that one notable protective factor against compassion fatigue is compassion satisfaction. Compassion satisfaction is defined as the pleasurable satisfaction that a helping professional experiences from the ability to do one's work well. Stamm (2010) stated that professionals who feel pleasure from helping others through their work will experience compassion satisfaction.

Burnout

Burnout among counselors is not a new phenomenon. Maslach (2003) stated that professional health care workers have a high risk for burnout within their first 3 years of work due to work-related responsibilities. A survey conducted by Lawson (2007) indicated that counselors self-reported that they were satisfied with their work and what they were doing. None of the participants self-reported themselves as impaired, yet the survey analysis indicated that 30% of participants were at a high risk of impairment from burnout. Clearly, practicing counselors may not have a high level of self-awareness when it comes to their own burnout risk. A study conducted by

Osborn (2004) on counselor stamina indicated counselors are besieged with many demands on their time, along with helping clients that come into counseling with complex, severe problems. This can easily lead to lowered stamina, which may lead to impairment in their focused ability to do the work that their profession entails.

School counselors, along with other mental health counselors are at a risk for experiencing professional burnout (Bryant & Constantine, 2006). As mental health professionals, school counselors are faced with the task of supporting all students so that they may be able to participate fully in the following domains of their life: personal/social, career and academic (Dierling, 2015). If school counselors are on their way to burnout or are already experiencing burnout, these professionals will not be able to fully help the student through the student's own trauma or stress (Fontes, 2000). School counselors face a myriad of roles and responsibilities within school systems. Many of the school counselors also experienced an overwhelming increase in their job expectations leading to what is described as occupational stressors (Butler & Constantine, 2005).

Compassion Fatigue

The concept of compassion fatigue emerged in the 1990s when the term was first used in the field of medicine (Johnson, 1992). Figley (1995) defined compassion fatigue as a disorder that affects those who do their work well and which can result in secondary traumatic stress, another term that is used to describe this problem (Ray, Wong, White, & Heaslip, 2013). The compassion fatigue concept is also applicable to the counseling profession. Counselors tend to provide direct care along with a high degree of empathy,

support and intensive involvement with clients that bring into the therapeutic session complex and emotionally demanding situations (Portnoy, 2011). Over time this type of intensive involvement with clients will manifest itself in professionals experiencing anxiety, depression, physical complaints and other behaviors that will disrupt wellness stability for the counselor (Clark & Gioro, 1998).

Compassion fatigue manifests itself in caring professionals because of the absorption of the traumatic stress of those that they help (Boyle, 2011). Counselors find themselves in the position of being exposed to another person's painful narrative, leading emotional and empathetic overload (Portnoy, 2011). Stamm (1999) has researched compassion fatigue for many years and defines compassion fatigue as a clash of stress and burnout in the lives of professional counselors that stem from continuous exposure to client trauma. Therefore, professional helpers who display empathic behavior toward their clients' traumatic events may vicariously experience considerable pain, trauma, and suffering. This profound reaction to repeated exposure and vicarious trauma results in compassion fatigue (Coetzee, S. K., & Klopper, H. C. (2009).

A study conducted by Killian (2008) professional counselors, marriage and family therapists, and psychologist identified several key factors within their work environment that led to the development of compassion fatigue. The professional helpers indicated that personal trauma, lack of social support, and an increase in working with traumatized clients affected their level of compassion fatigue. The findings indicated that work life conditions do impact levels of compassion fatigue.

Another study on compassion fatigue conducted by Merriman (2015) indicated that counselor supervisors

needed to take time to educate their counseling interns and PLPC's on the issues of compassion fatigue. Research has indicated that new counseling professionals are especially susceptible to incurring compassion fatigue (Craig & Sprang, 2010). Therefore, it is important to help teach counselors-in-training strategies that could serve as protective factors from this phenomenon. Lyndall and Bicknell (2001) found that moderate rates of compassion fatigue were found in novice counselors, thus indicating that the counseling professionals, especially at the entry level, appeared to be affected by compassion fatigue.

Mental health professionals including school counselors have, in the past 20 years seen a continued increase of traumatic events in the school setting (Fontes, 2000). These events have included shootings, bomb scares, and school bus accidents that have resulted in the loss of students and continued problems with violence on the school campus (Dierling, 2015). These types of highly emotional events can contribute to the possible development of compassion fatigue among these mental health professionals (Killian, 2008). People in general vary in expectations brought to their job, but it seems that in the case of school counselors the expectations can be very high, both in terms of the nature of the work (e.g. challenging, frustrating, exciting) and the likelihood of success (e.g. helping students). Both can be either idealistic or unrealistic, leading to a high risk factor for burnout (Maslach, Schaufeli, & Leiter, 2001).

Purpose of the Study

The purpose of this study was to examine the relationship between school counselor wellness behaviors and their professional quality of life. In specific, it was hypothesized that school counselors who engage in higher levels

of wellness behaviors would report higher levels of compassion satisfaction, lower levels of burnout and lower levels of compassion fatigue.

Method Participants

A total of 94 school counselors were recruited from a southeast independent school district located in Texas, and 73 participants responded to all survey items. In terms of gender, 15.1% (11) were male and 84.9% (62) were female. Of the participants, 46.6% (34) worked at an elementary school, 21.9% (16) worked at a middle school, and 31.5% (23) worked at as high school. In terms of age range, 12.3% (9) were between 21-30 years old, 67.1% (49) were between 31-50 years old, and 20.5% (15) were over 50 years old. In reference to being employed as school counselors, 41.7% (30) served less than five years, 43.1% (31) served 5 – 15 years, and 15.3% (11) served over 20 years.

Materials and Procedures

For the purpose of this study the Professional Quality of Life Scale was used (ProQOL-Version 5, 2010).

The ProQOL is the world's most commonly used measure of the positive and negative aspects of helping others who have experienced loss or a traumatic event (Stamm, 2010) and has been translated into eight languages. The Professional Quality of Life Scale (ProQOL-Version 5) consist of 30 statements and the scale uses a 5-point likert scale with 1 indicating never, 2 indicating rarely, 3 indicating sometimes, 4 indicating often and 5 indicating very often. The scale assesses compassion satisfaction, burnout, and secondary traumatic stress. Subscale reliability for compassion satisfaction was reported as $\alpha = .88$, for burnout $\alpha = .75$, and for compassion fatigue is $\alpha = .75$

For the purpose of this study the Self-Care Assessment Worksheet developed by Dr. Karen W. Saakvitne and Dr. Laurie Anne Pearlman was slightly modified. The Self-Care Assessment worksheet was published in the workbook *Transforming the pain: a workbook on vicarious traumatization* (Saakvitne & Pearlman, 1996). The modified Self-Care Assessment Worksheet included 66 questions divided into six categories: Physical self-care (14 items), psychological self-care (12 items), emotional self-care (10 items), spiritual self-care (16 items), workplace or professional self-care (11 items), and balance (2 items). The research instruments as well as a demographic questionnaire were posted on survey monkey, which participants were able to access anonymously. After the data was collected it was downloaded and evaluated using SPSS.

Results

In terms of Professional Quality of Life Scale (PROQOL), results showed that 50.7% (37) of the participants scored average and 49.3% (36) scored high on the compassion satisfaction subscale; none of the participants scored low on this subscale. In addition, results showed that 41.1% (30) of the participants scored low and 58.9% (43) scored average on the burnout scale; none of the participants scored high on this subscale. On the secondary trauma subscale, 60. 3% (44) of the participants scored low, and 39.7% (29) scored average; no participants scored high on this subscale. In terms of the self-care assessment instrument, 32.9% (24) of the participants scored average and 67.1% (49) scored high, none of the participants scored low on this instrument.

A positive correlation was found between the compassion satisfaction subscale of the PROQOL and the self-

care assessment scale ($r = .461$, $N = 73$, $p < .01$, two-tailed). Effect size was moderate with 21.25% of the variation explained. A negative correlation was found between the burnout subscale of the PROQOL and the Self Care Assessment scale ($r = -.601$, $N = 73$, $p < .01$, two-tailed). Effect size is moderate with 36.12% of the variation explained. There was also a positive correlation between the burnout and the secondary trauma subscales of the PROQOL ($r = .546$, $N = 73$, $p = .01$, two-tailed). Effect size was moderate with 29.81% of the variation explained. In addition, there was a negative correlation between the compassion satisfaction subscale and the burnout subscale of the PROQOL ($r = -.656$, $N = 73$, $p = .01$, two-tailed). Effect size was moderate with 43.03% of the variation explained.

Discussion

Using a sample of 94 school counselors, this study examined the relationship between wellness behaviors and professional quality of life. Wellness behaviors were assessed using the Self-Care Assessment scale and professional quality of life was assessed using the ProQOL – Version 5. Overall, participant scores indicated that the participating school counselors performed well on the subscales of the ProQOL – Version 5 as well as the Self-Care Assessment scale. This indicated overall satisfactory professional quality of life and self-care behaviors. Furthermore, a positive correlation between the compassion satisfaction subscale of the ProQOL – Version 5 and the Self-Care Assessment scale indicated that the more the school counseling participants engaged in self-care behaviors, the higher their compassion satisfaction. Also, a positive correlation between the burnout and the secondary trauma subscale of the ProQOL – Version 5 indicated that the lower the burnout,

the lower experience of secondary trauma and vice versa. Lastly, a negative correlation indicated that the higher the compassion satisfaction, the lower the burnout.

Conclusions and Recommendations

It is imperative that counseling students are taught the value of prevention and the practice of self-care behaviors and healthy lifestyles to mitigate the negative effects of stress, burnout, and compassion fatigue. Wellness, prevention, and self-care behavior should be part of the curriculum in counseling programs. While some wellness texts focus on the wellness of the client, students need to understand the need to focus on their own wellness as well as the value of practicing self-care behaviors. Graduate students need to be urged to utilize the services of wellness/counseling centers if available on campuses, and to seek out consultation with a counseling professional once they become practicing counselors.

Practicing professionals also need to focus on self-care behaviors, such as, but not limited to meditation, exercise, attention to diet, practices that include spiritual and/or religious growth, and personal health. In their fast-paced lives, professional counselors may not equate their physical symptoms with lack of wellness behaviors. Some of the physical symptoms that may be experienced can range from chronic fatigue to increased illness, yet professional counselors may disregard these as part of life (Bourg-Carter, 2011). They need to be reminded to be sensitive to their vulnerability to personal and professional impairment and seek out competent professional strategies that include learning improved methods of wellness behavior (Anderson, 1992). School counselors have, in the past 20 years seen a continued increase of traumatic events

in the school setting (Fontes, 2000). Emotional responses or secondary trauma can certainly take its toll. This study has demonstrated that practicing wellness behaviors can increase their professional quality of life.

References

- American Counseling Association (2014). *ACA code of ethics*. Alexandria, VA: Author.
- American Association for Counseling and Development (1991). *AACD strategic plan*. Alexandria, VA: Author.
- Anderson, D. (1992). A case for standards of counseling practice. *Journal of counseling & Development, 71*, 22-26.
- Ardell, D. B. (1988). The history and future of the wellness movement. In J. P. Opatz (Ed.), *Wellness promotion strategies. Selected proceedings of the eight annual National Wellness Conference*. Dubuque, IA: Kendall/Hunt.
- Bourg-Carter, S. (2011). *High octane women, how superachievers can burnout*. Prometheus Books. USA.
- Boyle, D. A. (2011). Countering compassion fatigue: a requisite nursing agenda. *OJIN: The Online Journal of Issues in Nursing, 16*(1). DOI:10.3912/OJIN.Vol16No01Man02.
- Butler, S. K., & Constantine, M. G. (2005). Collective self-esteem and burnout in professional school counselors. *Professional School Counseling, 9*, 55-62.
- Clark, M., & Gioro, S. (1998). Nurses, indirect trauma, and prevention. *Journal of Nursing Scholarship, 30*(1), 85-87. DOI: 10.1111/j.1547-5069.1998.tb01242x.
- Coetzee, S. K., & Klopper, H. C. (2009). Compassion fatigue within nursing practice: a concept Analysis. *Nursing and Health Sciences, 12*, 235-243.
- Craig, D. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress, & Coping, 23*, 319-339. doi: 10.1080/10615800903085818
- Dierling, E. R. (2015). *Effects of childhood trauma on students: the role of school counselors*. (Unpublished master's thesis). Winona State University, Winona, MN.
- Evans, A. M., Carney, J. S., Shannon, D., & Strohl, DeLeana (2012). Counselors-in-training problematic behaviors: a pilot study. In *Ideas and research you can use. Vistas 2012*. Retrieved on January 25, 2017 from <http://www.counseling.org/Resources>.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: an overview. In C. R. Figley (Ed.), *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.
- Figley, C. R. (2002). Introduction. In C. R. Figley (Ed.), *Treating Compassion Fatigue* (pp. 1-14). Routledge: New York.
- Fontes, L. A. (2000). Children exposed to marital violence: how school counselors can help. *Professional School Counseling, 3*(4), 231-250.
- Johnson, C. (1992). Coping with compassion fatigue. *Nursing, 22*, 116-122.
- Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumology, 14*(2), 32-44. DOI:10.1177/1534765608319083.
- Kostouros, P., & McLean, S. (2006). The importance of self-care. *Online*

- Journal of the International Child and Youth Care Network*, 89. ISSN 1605-7406. Retrieved from <http://www.yc-net.org/cyc-online/cyc01-0606-mclean.html>.
- Lee, S. M., Cho, S. H., Kissiniger, D., & Ogle, N. T. (2010). A typology of burnout in professional counselors. *Journal of Counseling & Development*, 88(2), 131-138. Retrieved from <http://onlinelibrary.wiley.com>. DOI/10.1002/j.1556-6678.2010.tb0000.
- Lyndall, S., & Bicknell, J. (2001). Trauma and the therapist: the experience of therapist working with the perpetrators of sexual abuse. *Australasian Journal of Disaster and Trauma Studies*, 5, 543-551.
- Maslach, C. (2003). Job burnout: new directions in research and intervention. *Current Directions in Psychological Science*, 12(5), 189-192.
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397-422.
- McMahon, S., & Fleury, J. (2012). Wellness in older adults: a concept analysis. *Nursing Forum*, 47(1), 39-51. DOI: 10.1111/j.1744-6198.2011.00254.x
- Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling and Development*, 93(3), 370-399.
- Myers, J. E. (1991). Wellness as the paradigm for counseling and development: the possible future. *Counselor Education and Supervision*, 30(3), 183-193.
- Myers, L. (February, 2014). In search of wellness. *Counseling Today*. Retrieved from www.ct.counseling.org.
- Norcross, J. C., & Barnett, J. E. (2008). Self-care as ethical imperative. *The Register Report*. Retrieved from <https://www.nationalregister.org>.
- O'Halloran, T. M., & Linton, J. M. (2000). Stress on the job: self-care resources for counselors. *Journal of Mental Health Counseling*, 22(4), 354-364.
- Osborn, C. J. (2004). Seven salutary suggestions for counselor stamina. *Journal of Counseling & Development*, 8(3), 319-328. DOI: 10.1002/j.1556-6678.2004.tb00317.x.
- Portnoy, D. (2011). Burnout and compassion fatigue: watch for the signs. *Journal of the Catholic Health Association of the United States*, 47-50.
- Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: a workbook on vicarious traumatization*. Norton: New York.
- Stamm, B. H. (1999). *Secondary traumatic stress: self-care issues for clinicians, researchers, and educators*. Sidran Press.
- Stamm, B. H. (2010). The concise ProQOL Manual, 2nd Ed. Pocatello, ID. Retrieved from ProQOL.org.
- Stiles, C. A. (1984). The status of wellness programs in higher education. Unpublished manuscript, University of Florida, Gainesville. *Traumatology*, 19(4). 255-267. DOI:10.1177/1534765612471144. Retrieved from Questia.com.
- Warner, M. J. (1984). Wellness promotion in higher education. *NASPA Journal*, 2(3), 32-38.
- Wise, E., Hersh, M., & Gibson, C. M. (2011). Ethics and self-care: a developmental lifespan perspective.

The Register Report. Retrieved from
<https://www.nationalregister.org>.

Test Questions for Licensed Professional Counselors

A score of 100% is needed on the following items. You need to submit this test along with the request for a certificate to receive CE Clock Hours. Once scored, you will receive a certificate verifying **2.5 Continuing Education Clock Hours**.

CEU questions for The Use of Technology in Counseling article:

1. Which of the following forms of technology is suitable for counselor-client engagement?
 - A. Personal Facebook page
 - B. Twitter
 - C. Professional Facebook page
 - D. None of the above

2. How should counselors save electronic correspondence between clients?
 - A. Delete after being read
 - B. Print paper copies for client's records
 - C. Saved only online
 - D. None of the above

CEU questions for the Educating Counselors-in-training to Work with Parents of Minors article:

3. Consultation with parents may allow the professional an avenue to
 - A. Discuss progress
 - B. Teach skills/ techniques
 - C. Inquire about changes within the client's environment
 - D. All of the above

4. Parent consultation should be done:
 - A. During intake only.
 - B. After the intake session is done.
 - C. Consultation should be an ongoing process.
 - D. Consultation should be done during the intake session, ongoing, and as needed.

5. The stakeholders involved in preparing new clinicians for parent consultation are:
 - A. Counselor educators
 - B. Site supervisors
 - C. Counselors-in-training
 - D. All of the above

CEU questions for the Integration of Play Therapy with Insecurely Attached Adolescents article:

6. According to Green, Myrick, and Crenshaw (2013), the parent's ability to meet their infant's need is:
 - A. Important
 - B. Significant
 - C. Not necessary
 - D. Helpful

7. Counselors working with insecurely attached adolescents would greatly benefit from becoming familiar with all of the following types of insecure attachment EXCEPT:
 - A. Insecure-ambivalent/ anxious
 - B. Insecure-avoidant
 - C. Insecure-attached
 - D. Disorganized attachment

8. This impacts an individual's ability to develop effective relationships:
 - A. Abuse
 - B. Neglect
 - C. Both A and B
 - D. None of the above

CEU questions for the School Counselors' Wellness Behavior and its Effects on Compassion Fatigue, Burnout, and Compassion Satisfaction article:

9. One of the struggles in making a case of wellness behavior for professional counselors is that:
 - A. Counselors do not have the time for wellness
 - B. Counselors many times do not practice what they preach
 - C. Counselors just will not listen to anyone
 - D. Counselors are good at taking care of themselves already

10. Who is at risk for burnout?
 - A. School counselors
 - B. Mental health counselors
 - C. Counselor educators
 - D. All types of counselors

Credit Verification Form for Licensed Professional Counselors

The Louisiana Counseling Association awards **2.5 Continuing Education Clock Hours** for reading the *Louisiana Journal of Counseling (LJC)* and correctly completing the Study Questions. To receive a certificate verifying your participation in this easy and inexpensive way to earn valuable CE Clock Hours, LCA members may complete the form below and mail it, along with **\$10 (non-LCA members, \$25)** and your completed test questions, to the following address:

Diane Austin
LCA Executive Director
353 Leo Street
Shreveport, LA 71105

The Louisiana Counseling Association has been approved by NBCC as an Approved Continuing Education Provider, ACEP #2019. Programs that do not qualify for NBCC credit are clearly identified. LCA is solely responsible for all aspects of the program.

I verify that I have read the entire **FALL 2017** edition of the *Louisiana Journal of Counseling (LJC)* and am now applying for **2.5 clock hours** of continuing education credit in conjunction with correctly answering the Study Questions for this year's journal.

Name (PRINT – as you wish to have it appear on your certificate):

Mailing Address

Street

City

State

Zip

Phone __ (cell) _____ (other) _____

E-mail _____

Signature _____

Date _____

*Make checks payable to **LCA**

A Verification form with your clock hours will be mailed directly to the address provided on this form.

GUIDELINES FOR AUTHORS

The *Louisiana Journal of Counseling (LJC)* publishes articles that have broad interest for a readership composed mostly of counselors and other mental health professionals who work in private practice, schools, colleges, community agencies, hospitals, and government. This journal is an appropriate outlet for articles that (a) critically integrate published research, (b) examine current professional and scientific issues, (c) report research that has particular relevance to professional counselor, (d) report new techniques or innovative programs and practices, and (e) examine LCA as an organization.

MANUSCRIPT CATEGORIES

Manuscripts must be scholarly, based on existing literature, and include implications for practice. The following categories describe the nature of submitted manuscripts. However, manuscripts that do not fall into one of these categories may also be appropriate for publication. These categories were adapted from the American Counseling Association's *Journal of Counseling and Development (JCD)*.

1. **Conceptual pieces.** New theoretical perspectives may be presented concerning a particular counseling issue, or existing bodies of knowledge may be integrated in innovative ways.
2. **Research studies.** Both quantitative and qualitative studies are published in *LJC*. The review of the literature should provide the context and need for the study, followed by the purpose for the study and the research questions. The methodology should include a full description of the participants, variables, and instruments used to measure them, data analyses, and results. The discussion section includes conclusions and implications for future research and counseling practice.
3. **Practice articles.** Innovative counseling approaches, counseling programs, ethical issues, and training and supervision practices may be presented. Manuscripts must be grounded in counseling or educational theory and empirical knowledge.
4. **Assessment and Diagnosis.** Focus is given to broad assessment and diagnosis issues that impact counselors.

MANUSCRIPT REQUIREMENTS

All manuscripts must adhere to the guidelines set forth in the *Publication Manual of the American Psychological Association (6th ed.)*. The APA *Publication Manual* sets forth all guidelines concerning manuscript format, abstract, citations and references, tables and figures, graphs, illustrations, and drawings. Special attention should be given to the guidelines regarding the use of nondiscriminatory language when referring to gender, sexual orientations, racial and ethnic identity, disabilities, and age. Also, the terms “counselor” and “counseling” are preferred to “therapist” and “therapy.”

1. Submit an emailed, electronic, blind copy in Word of the entire manuscript to Meredith Nelson, mnelson@lsus.edu, Psychology Dept., One University Place, Shreveport, LA 71115 or three (3) clean, hard copies of the entire manuscript with an electronic version to Peter Emerson, *LJC* Editor, pemerson@selu.edu, SLU Box 10863, Hammond, LA, 70402.
2. Include a cover letter with your manuscript submission that contains your name and title, place of employment and position, address, telephone number, and e-mail address.
3. Manuscripts should not exceed 18 pages, including references.
4. Lengthy quotations (330-500 words) require written permission from the copyright holder for reproduction. Adaptation of tables and figures also requires reproduction approval. It is the author’s responsibility to secure this permission and present it to the *LJC* editor at the time of manuscript submission.
5. Once a manuscript has been accepted for publication, the author will be required to submit a final copy electronically.
6. The *LJC* is published annually in the Fall.
7. Material that has been published or is currently under consideration by another periodical should not be submitted.
8. Generally, authors can expect a publication decision within 3 months after the acknowledgment of receipt.
9. Manuscripts that do not conform to the APA *Publication Manual* guidelines will be returned without review.

Louisiana Counseling Association Journal Evaluation

Please indicate the degree to which this Journal met your needs by circling the appropriate number. Please return this evaluation for to the LCA office.

Title of Journal: Fall 2017 LCA Journal
Did the articles meet your needs:

	Low/Not Met			High/Met		
1. Practical Suggestions	1	2	3	4	5	NA
2. Innovative material	1	2	3	4	5	NA
3. Well Organized Articles	1	2	3	4	5	NA
4. Quality of Bibliography	1	2	3	4	5	NA
5. Increased awareness of subject matter	1	2	3	4	5	NA
6. If illustrations, charts, maps are used, are these relevant, clear, and professional looking	1	2	3	4	5	NA
7. Overall, the Journal was beneficial to me	1	2	3	4	5	NA

Comments:
