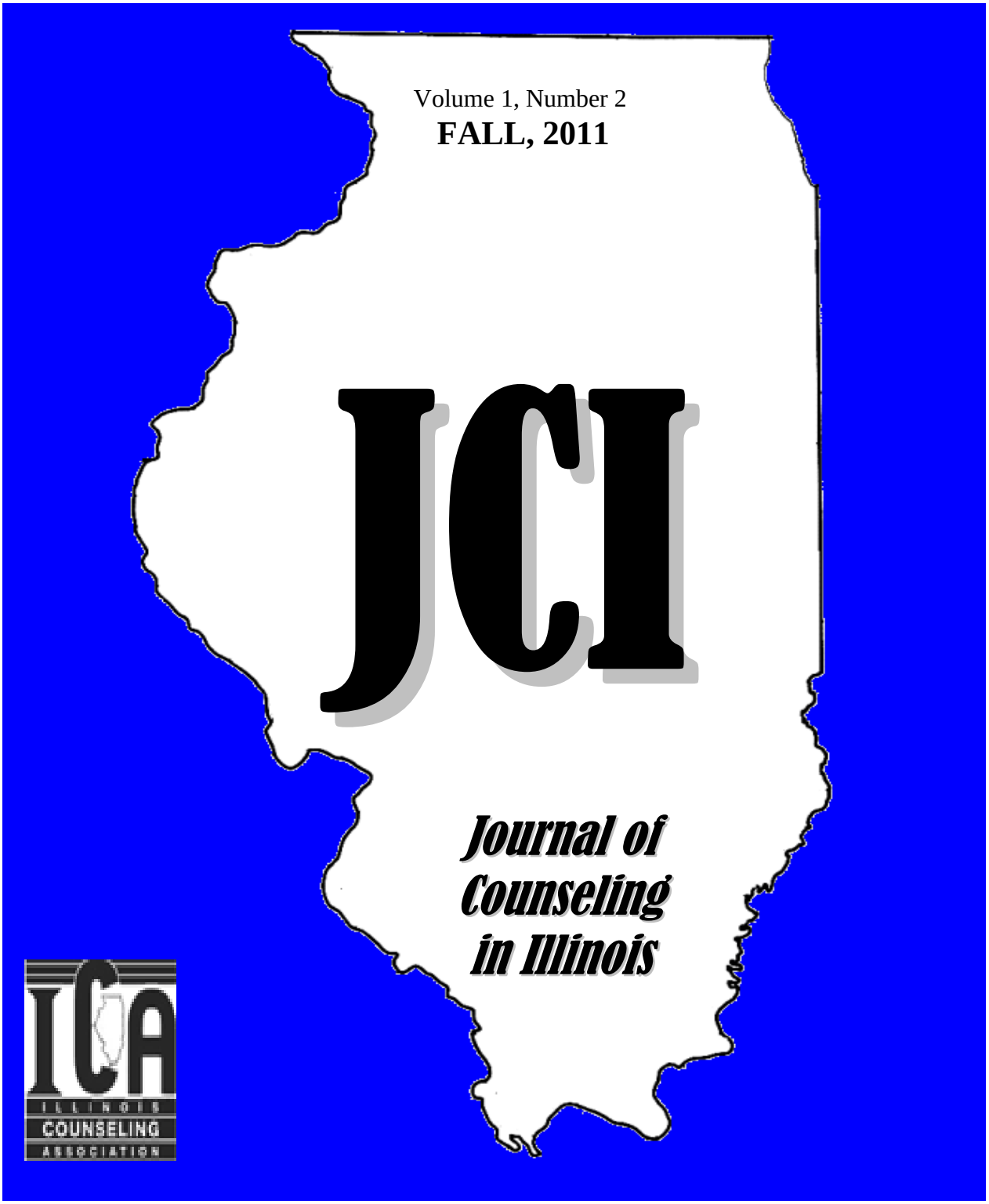

The *Journal of Counseling in Illinois* is a publication of the Illinois Counseling Association

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CO-EDITORS NOTES: THE *JOURNAL OF COUNSELING IN ILLINOIS*

What does it mean to be published in the *Journal of Counseling in Illinois*? What is the role of the *JCI* Editorial Board and how are articles selected? What is *JCI* looking for in a submission? As we begin to settle into the new look that we hope the *JCI* brings to our state and to the profession, we want to briefly answer these questions in order to demystify the publication process. We are very excited about the number of submissions we had for this publication and want to encourage all interested professionals and students to consider sending a manuscript to *JCI* for review.

Let's start with information on the submission process. All submitted manuscripts should be formatted using APA-Sixth Edition. Manuscripts should be sent to the co-editors electronically. (Specific directions for submission can be found on the ICA website at www.ilcounseling.org under publications). Once the manuscript is received, it is reviewed by a co-editor and sent to two members of the editorial board for review and commentary. The editorial board member is expected to read the manuscript carefully and offer extensive comments suggesting ways to improve the manuscript. This should provide important feedback to the author and help to improve their writing style, development of ideas, and clarity. Each editorial board member also indicates one of three responses regarding the manuscript to the co-editors: to accept it with minor revisions, to accept it with major revisions, or to not accept. These comments are then reviewed by the co-editors and a final decision is made by the co-editors. The manuscript is then returned to the lead author with the comments from the co-editors. If revisions are requested, the author should make these revisions and resubmit the manuscript. In the case of minor revisions, the co-editors will review the resubmission and if accepted, the manuscript is ready for print. For manuscripts requiring major revisions, it is possible the editors may ask for more editorial board members to review the manuscript and the process is repeated. All decisions as to what is published are under the direction of the co-editors of the journal.

Regarding what JCI is looking for, first and foremost, we want a high quality submission representing good scholarship, knowledge of existing literature, critical thinking, and clear ideas. We want meaningful topics that represent the needs of our profession and are relevant to our diverse readership. To be published in the JCI means that you have written a well-developed, good quality, professional article that has been critiqued, reworked and is ready to be shared with other professionals. Hopefully, this information clarifies the publication process and will encourage you to develop your ideas into a manuscript. Additionally, we think the development of the five sections of the JCI listed below may inspire you in the type of manuscript you are most interested in creating. Let us briefly describe these as well as discuss those articles representing these sections in this edition.

- **Research:** These articles will focus on qualitative and quantitative research studies that are useful to counseling practice. Studies can include preliminary findings that will lead to larger projects. Criteria for these articles include rigorous data analysis standards and a discussion of the clinical significance of the results. We are pleased to have two research based articles. Julie Russo and her colleagues, Jeff Edwards and Donna Mahoney, have used a Delphi methodology to investigate the supervision of mental health counselor interns. Heidi Larson, with the help of several co-researchers, discuss their findings on the effects of using relaxation and deep-breathing techniques with high school students.

- **Practice:** Articles in this section will focus on innovative approaches and techniques, counseling programs, ethical issues, and training and supervision practices. They are grounded in counseling or educational theory and empirical knowledge and should offer ideas and techniques for immediate application to practice. With an emphasis on practice, Allison Kupferberg shares empirically validated treatment interventions for female sexual trauma survivors.

- **Professional Exchange:** These articles are designed to provide information about significant current issues and/or trends in the counseling field. Two articles that emphasize the role of advocacy in counseling make up this section with Grace Wambu and Scott Wickman offering their suggestions for promoting school counseling in Kenya. Amanda McCarthy and Scott Wickman raise important current issues around advocating for students with disabilities and what we can do as they transition to college.

- **Professional Dialogue:** These articles will stimulate dialogue, discussion, and debate related to critical issues of the *JCI* readership and includes a well-reasoned, thought-provoking article on a topic of interest. In this edition, we are pleased to feature Nayeli Chavez-Duenas, Hector Torres, and Hector Adames' work on barriers that inhibit mental health utilization among Latino/as as well as some recommendations to address this concern.

- **Media Review:** These articles review current media relevant to mental health professionals.

We continue to be excited about the *JCI,* and we hope you will enjoy reading it. Our vision is for *JCI* to offer a spirit of cooperation, connection, and solidarity for the counseling profession in Illinois, where members serve in a variety of counseling roles, while providing care for others.

TONI TOLLERUD **FRAN GIORDANO**
Editor **Editor**

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The Supervision of Mental Health Counselor Interns: A Delphi Study

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Abstract

This study used a sequential mixed methods Delphi survey method to examine the perceptions of 21 experienced counselor educators and counselor supervisors with respect to the competencies important for the effective supervision of mental health counselor interns. Implications for curriculum development in graduate training programs, professional development, and research are offered on the basis of these results.

For graduate students in a counselor training program, the internship experience is generally the culmination of the academic sequence leading to a degree in mental health counseling. It is an exciting, challenging time which many students anticipate with mixed emotions. Student interns find themselves moving into unfamiliar situations, engaging in emotionally intense encounters, and processing a range of powerful feelings. During this capstone experience, students train at a field site under the direct supervision of a licensed counselor, social worker, marriage and family therapist, psychologist, or psychiatrist. This clinical supervision of counseling students is a central component in the development of competent counselors. Indeed, supervision is recognized as an essential component at all levels of training in the professional helping fields.

Due to the critical function of supervisors, the field of mental health counseling has become increasingly aware of the importance of training for this role. Currently, the Association for Counselor Education and Supervision's ethical guidelines (Supervision Interest Network, 1993) and standards (Supervision Interest Network, 1990) stipulate that supervisors receive training in supervision prior to initiating their roles as supervisors. This stipulation came in response to the increasingly apparent observation that effective counselors are not necessarily effective supervisors. Specialized training was noted as not only desirable, but perhaps necessary.

Despite this emphasis, it appears as though the bulk of counselor training programs do not offer formal coursework for students in clinical supervision in spite of the fact that research indicates that most supervision of mental health counseling interns is conducted by master's level practitioners (Nelson, Johnson, & Thorgen, 2000). In fact, there are many situations in which newly graduated and employed mental health counselors find themselves in positions that require supervision of internships that they may have only

recently completed themselves. A result of this rather haphazard approach to training supervisors in the mental health field has been a growing awareness of the need for diversity in approaches to, and opportunities for, training and support in the practice of supervision. Fundamental to the development of new training approaches is the identification of key competencies on which such training should focus.

Current Study

The primary goal of this research was to generate a discussion of specific *areas of knowledge* and *types of skills* that experts in this area have found to be most indicative of successful supervision of mental health counselor interns as a distinct and unique category of supervisee. Findings from this study will inform future training models, courses, programs, workshops, and materials directed toward supervisors of counselor interns.

Method

The Delphi method was chosen for data collection due to its ability to address a complex topic by eliciting the input of varied experts in the area of interest. Delphi research uses participant opinions to identify critical issues in the professional domain in which the panel members hold expertise (Strauss & Ziegler, 1975). This technique allows for the solicitation and sharing of opinions of such a group of individuals in spite of the fact that they are geographically dispersed (Linstone, 1978). The present study employed a modified Delphi approach with a panel of twenty-one professionals with experience and expertise in the field of counselor education and supervision. Instead of relying on the more traditional Delphi approach consisting of mail surveys sent in multiple rounds, both rounds of this Delphi survey were administered via the World Wide Web (Internet).

Participants

The creation of an appropriate panel of participants is critical to the strength and validity of any Delphi study (Clayton, 1997). For this study, careful consideration was given to identifying specific groups that could best contribute information on counselor internship supervision competencies. Because our study was designed to formulate a rich description of important competencies in the supervision of interns, it was determined that the panel should consist of those who are providing both academic and field site supervision of the counselors-in-training. Therefore, the population for this study included two groups of professionals, both associated with supervision of counselor interns: (a) counselor educators who provide academic supervision for counseling program students who are completing practicum and internship requirements, and (b) field site supervisors who provide on-site supervision for these students.

To identify an initial pool of possible panelists, the researchers first developed a list of master's level counseling programs in the state of Illinois by utilizing the information provided on the Illinois Mental Health Counselors Association (IMHCA) website. For each master's level counselor training program registered with the IMHCA, the researchers located the program-specific web page in order to determine the department chairperson. Initial research correspondence was then sent via email to the identified individuals, describing the research project and requesting the names of faculty members at their respective institutions who

currently assumed responsibility for academic supervision of counselor interns. For purposes of this study, respondents were included as panelists only if they met the following criteria: (1) individual is a current faculty supervisor or site supervisor of a master's level counselor intern, (2) individual demonstrates experience in counselor supervision, as evidenced by number of years of supervision practice, and (3) individual demonstrates knowledge of supervision training, as evidenced by reported graduate level coursework in supervision and/or CEU completion. The final sample group included 21 professionals with experience and training in the field of counselor education and supervision. This group consisted of 7 counselor educators and 14 field supervisors.

Data Collection

Round one. Procedures for each round of data collection were developed on the basis of principles introduced in the Beginning On-Line Delphi Ethnographic Research (BOLDER) method (Edwards, 2003). This approach introduced a unique blend of Delphi procedure, qualitative methodology, and online technology. While traditional Delphi procedure has typically occurred via mail, this approach utilizes Internet technology for each step of the process, from recruitment through "discussion" by panelists on a Multi-user domain (MUD). A MUD is a *multi-user domain or multi-user dimension,* both of which are referring to an environment where multiple people may be logged on and interacting with one another. Interaction can occur in real-time, similar to an online chat, or they can interact through postings on discussion threads. With this method, both costs and processing time are decreased.

After the potential participants in each group were identified, a letter of invitation to participate was sent to each of them via email. The letter outlined the importance of the study, the Delphi method, panel member qualifications to be included in the study, and the amount of time required to complete the study. Included in the introductory letter was an embedded link to the location of the survey questions.

Following the submission of demographic information, panelists were presented with a series of questions arranged in four topic area groups: areas of knowledge, types of skills, forms of training, and methods of assessment. The survey was administered through an online survey host, SurveyMonkey.com, and consisted of questions using a Likert-scale with an ordinal level of measurement, as well as open-ended questions. Using statements derived from the research on competencies (Falender et al., 2004), the participants were asked to rank each statement's level of importance from 1 = *irrelevant* to 5 = *essential*. The survey instrument instructions also invited participants to respond to two open-ended questions designed to encourage elaboration on areas of competency believed to be most significant for the supervision of mental health counselor interns.

Round two. The second round questions were constructed based on new information emerging from the first Delphi round. These questions were introduced with background information on the nature and origin of the topic for discussion. The first question asked panelists to comment on how the setting of supervision might affect areas of knowledge needed to effectively supervise counselor interns. The second question asked panelists to comment on conflict in the supervisory relationship.

Data Analysis

Panelists' demographic information and responses to Likert-scale questions were reported using statistical means and standard deviations. There were two primary purposes served by the collection of quantitative data in this study. The first purpose was to focus the attention of panelists on a list of supervision competencies and related processes supported by recent research. The second was to produce concrete, concise, and readily interpretable descriptive categories of panelist responses to these components of supervision.

The second stage of data collection consisted of qualitative methods. Open-ended questions were asked in both the first and second rounds of this Delphi. The purpose of the qualitative approach was to allow for more depth and detail in the responses of the expert panel. Patton (1990) stated that qualitative methods allow the researcher to gather a wealth of detailed information, which assists with better understanding the meaning of individual variation. Qualitative methods were well-suited for this study due to the exploratory nature of the research question.

Results

Round one. The group of expert panelists was first asked to rate five areas of knowledge competency items in terms of their perceived importance in the area of intern supervision. Minimal supervisory competence would include knowledge in areas specific to the responsibilities of supervision. Panelists' mean answers indicated that most felt that the knowledge areas assessed in the survey were essential for successful supervising of interns. Knowledge of ethics and legal issues was the most highly ranked competency area (M = 4.81, SD = 0.60), followed by knowledge of professional/supervisee development (M = 4.54, SD = 0.60), knowledge of diversity in all of its forms (M = 4.33, SD = 0.80), knowledge of evaluation and process outcome (M = 4.24, SD = 0.77), and knowledge of models, theories, modalities, and research on supervision (M = 4.23, SD = 0.56).

Second, the panelists were also asked to rate six areas of skill competency in terms of their perceived importance in the area of intern supervision. Supervisory skills are multifaceted and involve a range of functions. Questions were designed to address skills specific to supervision modalities (e.g., individual vs. group supervision) as well as more universal skills, such as those used to build and sustain a strong supervisory relationship and to address conflict within the relationship. Skills in relationship-building were the most highly ranked competency area (M = 4.90, SD = 0.30). The abilities to provide effective feedback (M = 4.57, SD = 0.51), to assess developmental needs (M = 4.52, SD = 0.60), and to facilitate conflict resolution were also found to be essential in supervision (M = 4.29, SD = 0.64). Skills in teaching (M = 3.71, SD = 0.56) and in scientific thinking (M = 3.71, SD = 0.60) were found to be important, but not essential.

Third**,** the panelists were asked to rate five methods by which competency in supervision is frequently assessed. For example, panelists were asked to rate the extent to which successful completion of a course in supervision would be a demonstration of competency. Panelists' mean answers indicated that most felt that several of the methods of assessment presented in the survey were important for demonstrating competence. Coursework in supervision (M = 3.62, SD = 1.07) and documented supervisee feedback (M = 3.62, SD = 1.20) received the highest rankings. Providing evidence of direct observation of supervision, such as an audio recording or videotape, was found to be the least important method of assessing supervisory competence (M = 2.79, SD = 1.03).

Finally, the panelists were asked to rate four of the most prevalent formal supervision training methods in terms of their perceived importance. Panelists' mean answers indicated that most felt that several of the training methods assessed in the survey were important for achieving competence in the supervision of counselor interns. The completion of master's level coursework in supervision was the most highly ranked method of training (M = 4.14, SD = 1.06). Continuing education credits (M = 3.90, SD = 1.09) and supervision of supervision (M = 3.76, SD = 0.94) were also ranked as important means by which a supervisor could attain and maintain supervisory competence. Doctoral level training was ranked as the least important method by panelists (M = 2.90, SD = 1.37).

In addition to the Likert-scale questions, panelists in the first round of this Delphi study were posed two open-ended questions. These questions were designed to provide an opportunity for panelists to expand on their reasoning for the level of importance attributed to the supervision competency items described in the Likert-scale questions. Three primary themes emerged from the responses of the panelists.

The first theme to emerge was that of foundational areas of competence, or "building blocks", in supervision that are essential for effective supervision of counselor interns. Examples of these areas included (a) the ability to adapt the style of supervision to the unique developmental needs of an intern, (b) the ability to effectively teach, and (c) knowledge of the models and theories specific to supervision.

The second theme to emerge from the data centered on the importance of the interpersonal skills of the supervisor. Based on their experience, panelists provided detailed descriptions of specific skills they believed had a significant impact on the quality of the supervisory relationship. These skills targeted specific areas of supervisory behavior, particularly interpersonal interactions with their interns. The skills mentioned most extensively by these panelists fell into the broader categories of: (a) relationship building, (b) ability to assess developmental stage, and (c) diversity sensitivity.

Third, panelists in this research study identified several important professional skills that they suggested were necessary to successfully supervise counselor interns. These skills could be described as falling into the following specific categories: (a) the assessment of competence; (b) legal and ethical obligations; and (c) commitment to continuing education, development and growth.

Round two. The second round of this Delphi study requested that the panelists elaborate on various themes that emerged during the first round of the process. In this round, only open-ended questions were presented to the panelists for their response. These questions were designed after analysis of the data from round one, with the primary intent of eliciting additional information on three primary topic areas: the importance of the setting in which supervision occurs, assessing competence in supervision, and conflict resolution skills.

The first area of discussion in the second round of the Delphi study was the manner in which the setting of supervision impacts outcomes; in other words, the extent to which environment in which the supervision takes place shapes how knowledge and skills are transmitted. Panelists noted that "interactions occur within a context/setting and the context influences the nature of interactions and the persons involved." Panelists commented that "knowing the organizational culture and how well it is managed provides the supervisor with valuable information" that allows supervisors to "provide an internship environment that is safe and conducive to learning." Counselor interns are a unique type of supervisee due to the fact that supervision during the course of their training occurs in two cooperative, yet inherently different,

settings. Panelist One suggested that this symbiotic relationship maximizes intern development when supervisors utilize distinct skill sets, stating that:

> I do think there are distinctions in skills when there are different types of supervision being provided. For example, if a student has a direct supervisor on site and has an academic supervisor. These two roles may draw out different skills. The direct supervisor will by necessity handle a greater amount of case oversight, technical skills, and administrative management. The academic supervisor may have the opportunity to help the supervisee step back and look at the how one is growing in supervision and in the clinical setting (panelist one).

The second topic of discussion was the assessment of competence in supervision. Much like counseling competency, this is a difficult quality to assess and evaluate. Its absence is often more easily identifiable than its presence. Responses by panelists to this question indicated that while most found the assessment of competence important to the profession, few individuals felt confident in knowing how best to do this type of evaluation. Additionally, panelists noted the complications inherent in evaluating an ever-changing situation, pointing out that "supervision is not static, so a supervisor cannot keep the process the same throughout its lifespan." Other panelists added that, "the process of supervision is clearly more of an art than a skill"; "the (supervision) alliance is never simple to measure"; and that, in terms of self-assessment, "if my supervisees grow, my sense of competence is affirmed." However, as is the case with counseling, Panelist Two emphasized the importance of articulating goals and objectives, stating that:

> Assessing supervisor competence might best be explored by examining the extent to which the process accomplishes identified goals. Supervisors should have observable and measurable goals and objectives that can be used to evaluate competence on a continuum. The personal qualities exhibited by the supervisor accounts significantly to the supervisor/intern relationship and might be assessed by examining the working alliance (panelist two).

Third, panelists in this round of the Delphi were asked to elaborate on the importance of conflict resolution skills. In particular, panelists were asked to discuss their views on how supervisors of counselor interns should approach conflict in the supervisory relationship. Responses highlighted the importance of supervisors knowing how to initially sense and respond to discord in the relationship; for example, of being able to "note a change in the relationship or 'atmosphere' of the supervision," "bring the conflict to the surface," and "inquire about the process." One panelist noted that it is important to "demonstrate that this is a relationship where conflict can and must be addressed. Given the hierarchical or power differences in the relationship, the supervisor must give permission and set the groundwork and rules for conflict resolution." It was also suggested that supervisors should teach interns how to sense the presence of conflict; that "it is critical for the supervisee to develop their internal GPS system for sensing and locating conflict. This is an essential counseling skill and so it can be practiced in the supervisory relationship."

In general, panelists appeared to view incidents of conflict in the supervisory relationship as normal occurrences that present the supervisor with teachable moments. For example, a panelist observed that when a conflict occurs in supervision, the supervisor is "given the

opportunity to work on developing conflict resolution skills with the supervisee as openness, genuine empathy, and honest communication are modeled and taught."

Discussion

This study was designed to begin the process of identifying and discussing key competencies for supervisors of mental health counselor interns, as a unique group of supervisees, using the language and preferences of practitioners in this area of professional practice. It therefore was exploratory and intended to provide a foundation of knowledge that would both inform future studies about counselor intern supervision and also build theory. As with any study, there are limitations that should be considered when interpreting the results. First, participants in the study were counselor educators and counselor supervisors at the master's level of training programs who volunteered to participate in the study. They were recruited primarily through contact lists of one Illinois professional association. A limitation of this method is the exclusion of counselor educators and supervisors affiliated with institutions not belonging to this association. Second, similar to other Delphi studies, this was a sample of convenience based on criteria of expertise. As it turned out, all but two of the survey participants identified as "Caucasian." As a result, the generalizability of the findings may be limited.

The competencies identified as most significant by the survey panelists provide important information about the supervision of mental health counselor interns. These competencies are consistent with results from previous competency studies (Falender et al., 2004; Sumerall, Lopez, & Oehlert, 2000). Additionally, these findings extend the previous research by providing important information about conflict resolution and the impact of the supervisory setting on the tasks of supervision and have important implications for the training, assessment, and professional development of internship supervisors.

In the area of supervision of counselor interns, it is not surprising to learn that counselor educators and counselor supervisors highlighted the critical nature of recognizing the developmental process of becoming a professional counselor. Supervision research supports the idea that there are specific levels of training that essentially correspond with the supervisee's level of professional development (Bernard & Goodyear, 2004). In supervision, interns present a special challenge. They are individuals with intellectual confidence but few practical skills, yet they are eager to learn and are often quite passionate about their future careers. They have much to learn and a relatively brief period of time remaining in their graduate training to conquer the myriad of skills necessary to make them effective and confident counselors. In this study, both site supervisors and university supervisors gave primary emphasis to understanding the early stage of development in a counselor intern. The primary principle underlying this developmental approach to supervision is the assumption that the intern experiences on-going growth and that the supervisor must structure goals and tasks accordingly. Participants in this study emphasized the importance of this synchronized process of change. Panelists suggested that the process of helping supervisees navigate the balance between too much fear and not enough caution was a critical skill when supervising counselor interns.

The results of this study also highlight the fact that the approach to supervision also differs as a result of setting. Counselor interns are a unique type of supervisee due to the fact that supervision during the course of their training is provided by individuals, or groups of individuals, located in two separate environments (i.e., on campus or in the field). The advantage of this is exposure to multiple perspectives and special expertise.

However, a disadvantage of the overlapping but separate environments is that the lines of responsibility may be blurred, thereby creating a stressful environment for a student who is more accustomed to the traditional, clear lines of authority that are most common in university supervision contexts. Bernard and Goodyear (2004) explained that supervision goals within graduate training programs tend to be characterized by teaching and learning. Due to the fact that a graduate program has primary objectives tied to teaching and training, the dynamics of supervision on campus are a product of the surrounding culture. As a result, the supervisory relationships are more clearly defined as teacher-student. On the other hand, the field site is a system in which supervision goals can differ from the system of the training institution. The system goals of the field site are more closely related to the services delivered by the agency, as well as the population served by the agency (Bernard & Goodyear, 2004). The supervisory relationship at the field site might be more accurately described as supervisor-trainee. Although the goals between the two systems can differ from one another, it is necessary for them to interface in a cohesive manner in order to provide a mutually beneficial experience. Panelists recognized the importance of both supervisors, while emphasizing the value of collaboration and communication between supervisors working in different settings.

Finally, the topic of competency in conflict resolution discussed by the panelists in this study contributes uniquely to the larger, generalized body of existing knowledge about supervisory competencies. Nelson, Barnes, Evans, and Triggiano (2008) stated that one reason supervisors may neglect or mishandle conflict is that they may lack the important skills required to address it appropriately. Most supervisors receive very little formal training for developing successful conflict management skills. While it is likely that practicing supervisors will gain experience and competence in this area from dealing with a myriad of challenging situations, these authors suggested that the field of clinical supervision needs a clearly defined conflict resolution skill set that can be used by supervisors. Panelists in this study agreed that training in conflict resolution would be beneficial for supervisors of mental health counselor interns.

Implications

If the findings of this study accurately represent key competencies for supervisors of mental health counselor interns, then the results have important implications not only for graduate preparation programs, but also for assessment and credentialing programs, and continuing professional development programs. It will be important for the field of mental health counseling to allocate sufficient time, talent, and resources to the provision of flexible training programs for supervisors of counselor interns. The identification of competency areas and unique challenges of this group is the beginning of the process. Translating this knowledge into training opportunities accessible to the supervisors is the next necessary step in working towards competence. While existing research demonstrates the emergence of brief training formats more suitable to the needs of practicing supervisors (Britton et al., 2002; Culbreth, 2001; McMahon & Simons, 2004), future training efforts must include issues most relevant to supervisors who work with mental health counselor interns.

Polanski (2000) made the case for teaching supervision at the master's level, at a time when the future supervisors are in the academic mindset of preparing for the field.

For the future supervisor, it is crucial to learn how to shift from thinking like a counselor to thinking like a supervisor in order for both supervisor and counselor-in-training to succeed. Course work in supervision for counselors entering the field can teach them how to ask for what they need and influence their own supervision experiences. Trainees learn firsthand about the importance of mutuality in the supervision relationship. In short, students receiving this training become more educated consumers of supervision, and they have a better understanding of the practice of supervision when they take such a role in the future.

For researchers, the present findings may provide a starting point for a variety of research endeavors. First, future researchers may want to determine if these findings can be replicated in a survey conducted with a larger, more diverse group of participants. For example, a Delphi panel comprised of professionals from other areas of the country or other cultural groups may have different views on the supervision of counselor interns. Second, with the growing emphasis on performance outcomes, it may be important to establish the relationship between specific supervision competencies and supervisee development. There may also be both outcome and process research that could help determine which of the key competencies have the most salience for supervisees. Third, continued research on conflict resolution and skills training may have direct and lasting benefits to both supervisors and supervisees in this group. Finally, more research is certainly warranted on communication and coordination of services within the complex and critical relationship of field supervisor, university supervisor, and mental health counselor intern.

Conclusions

To date, there has been a significant amount of research done on effectiveness in general supervision for academic and doctoral students but significantly less research done on the topic of supervision of mental health counselor employees and interns in the trenches. Though many articles on the topic of supervision have emphasized a common core of supervision competencies, the findings from this study provide a perspective on competencies with this unique group of supervisees. This study suggests that for effective supervision of mental health counselor interns the competencies of general supervision may not be sufficient. Specific competencies in the coordination of services with academic supervision and conflict resolution skills were also found to be important for effectiveness in supervision of counselor interns. Future research on the perceptions of this group of supervisees would add to this topic. For example, a study from the viewpoint of the mental health counselor intern on the value of similarities and differences in academic and site supervision could serve to improve approaches in both realms.

This study demonstrated consensus, thus saturation, among counselor educators and counselor supervisors regarding several competencies identified as important for the effective supervision of mental health counselor interns. For additional context and clarification of competencies, this study also discussed the impact of setting on supervision.

This research was undertaken with the same enthusiasm for counselor intern supervision that emerged from the participants, and with the hope of contributing to continuous improvement in the counseling profession, and ultimately improving results

for mental health counselor interns, their supervisors, and the clients they join together to serve. Mental health counselor interns are the future of the profession. Research on the important task of providing supervision to this unique group of supervisees will help ensure the integrity of the field.

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Effects of Relaxation and Deep-Breathing on High School Students: ACT Prep

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Abstract

The purpose of this study was to relieve test anxiety in high school juniors preparing to take the ACT: a high-stakes, college admissions, standardized test. Participants included 81 eleventh grade students (25 males, 56 females) from a Midwestern public high school. Results demonstrated that relaxation training in the experimental group significantly lowered student's perceptions of test anxiety from pre-test to post-test. Further research regarding systematic deep breathing and relaxation techniques is needed.

Key words: test anxiety, high stakes testing, ACT, high school students

Treatment of anxiety as a disorder has received a high rate of efficacy in alleviating symptoms, despite the different components which include cognitive, somatic and behavioral pieces in terms of how anxiety affects an individual. Indeed, treatments include cognitive behavioral therapy, systematic desensitization and rational emotive therapy to name a few. These treatment options work to reduce irrational thoughts and avoidance behaviors. However, these methods alone fall short in addressing the physiological component of anxiety. Physiological components of anxiety include**,** but are not limited to, sudden arousal, heart palpitations, sweating, dizziness, hyperventilating, and tense muscles (Muris, Mayer, Fraher, Duncan & Van den Hout, 2010). Personality traits can also exacerbate the direct physiological manifestation of anxiety. For example, negative affect (neuroticism) has been shown to correlate with higher reports of physical symptoms associated with anxiety (Howren & Suls, 2011). Thus, treatment options that focus on cognitive restructuring are essential, however, not holistic to the construct of anxiety and its direct effect on an individual.

In accordance with the DSM-IV-TR (American Psychiatric Association, 2000), extreme levels of test anxiety meet criteria for axis I, generalized anxiety disorder (Bögels, Alden, Beidel, Clark, Pine, Stein & Voncken, 2010). It is important to understand that test anxiety is a situation-specific anxiety that occurs only when performance is being evaluated (Putwain, 2008). Students may not suffer from anxiety in other aspects of their lives, but when asked to complete an examination, they may begin to experience the cognitive, emotional, and physiological components of anxiety.

Test Anxiety

As a personality trait, test anxiety can be seen as the situation-specific trait in which a student finds testing to be threatening (Spielberger, & Vagg, 1995; Putwain, Connors, & Symes, 2010). Anxiety, as a personality trait, has been linked to maladaptive perfectionism (Rice,

Leever, Christopher, & Porter, 2006), where the greater the pressure placed on the student to do well on a given test, the more anxious the student would become (Mulvenon, Stegman, & Ritter, 2005). Students with personality trait anxiety will seek to gain approval through their test scores from either parents or teachers, while at the same time this student will feel that regardless of their scores they will never meet those expectations (Rice et al, 2006). Anxiety occurs pre- and post-test because students think that their abilities to retain and remember information will fall short of their own expectations and of their instructors.

Test anxiety, as an emotional state, is exhibited among students who are not necessarily predisposed to other forms of pathology with regard to the anxiety they experience on the day of the test. These circumstances are test specific and include negative self-belief about performance on a test which may be linked to poor study habits, an emotional anomaly during the course of study for that specific test, and avoidant behaviors for the test (Putwain, 2008). Students who do not commonly have test anxiety may experience it if they do not feel prepared for the test.

High-Stakes Testing

Test anxiety is unique because it affects the predictor and criterion related validity of cognitive abilities testing (Wicherts & Scholten, 2010). In other words, the components of test anxiety directly interfere with the outcome of those who must complete an examination to obtain a job, recruit into the military, or go to college (Berry, Clark & McClure, 2011). There is an enormous amount of pressure regarding the results of certain cognitive abilities tests (i.e. ACT, SAT, GRE, ASVAB). Given that the scores have huge implications for those who take them, it is important that these measures accurately represent what is being assessed, and to be able to do this consistently, while minimizing the threat of other variables that may interfere with the score.

For the purposes of this study, participants were preparing to take the ACT exam in pursuit of obtaining college entrance. The American College Testing (ACT) organization was founded in 1959 and created the ACT test to help students better figure out what college to attend and also create an admission standard for colleges (ACT, 2010). In 1966, the American College Testing organization officially changed their name to ACT and began adopting a broader scope of work that branched into other nations. There are four portions of the ACT test: English, Math, Reading, and Science that contain a total of 215 questions (ACT, 2010). There is also an option of taking an additional writing section. The ACT test has been administered in all fifty states since 1960. There are twenty-seven states where at least fifty percent of high school students take the ACT test. Subject matter on the test is based on curriculum mandated to high schools rather than IQ or aptitudes like many other standardized tests (ACT, 2010).

The implications and assertions that are made based on the scores of ACT's, can have fruitful and negative outcomes for those who take it, especially when the scores are not accurately representative of the student's actual cognitive abilities. In fact, one study that examined testing anxiety specifically with ACT scores, found that test anxiety and self-concept uniformly affected academic achievement (Williams, 1992). Another study concluded that test anxiety affected memory processing in terms of speed and accuracy of declarative memory; and depicted the conflict associated with timed, high-stakes testing, like the ACT's and the in-ability to recall information (Lee, 1995). More and more studies conclude a basic premise that test anxiety is significant and impactful on true test scores and can likely influence the outcome (Bradley, McCraty, Atkinson, Tomasino, Daugherty, & Arguelles, 2010; Everson Smodlaka & Tobias, 1994; Putwain, 2008; Sawyer & Hollis-Sawyer, 2005).

Treating Test Anxiety

There are varied ways to treat and cope with test anxiety (Stowell, Tumminaro, & Attarwala, 2008). These strategies range from cognitive (extra time spent studying), behavioral (systematic desensitization), biological (controlling cortisol levels), to emotional techniques and tools (relaxation techniques) (Kondo, 1997; Stowell, Tumminaro, & Attarwala, 2008). There has recently been some advancement in developing other methods to help students prepare for tests. For example, one study implemented an eight-week, group-counseling format with fifteen African American participants from a Georgia high school (Bruce, Getch, & Ziomek-Daigle, 2009). It was a structured group focusing mostly on discussion and interaction among members to promote higher achievement in test scores. In Georgia, previous data had revealed African-Americans students scoring at a significantly lower rate when compared to their White peers on their high school exit exam. Results of the study found that twelve out of fifteen participants passed all four sections on their Georgia High School Graduation Test (Bruce et al., 2009).

Kondo (1997) found that the use of relaxation techniques was the most effective in treating people with high levels of test anxiety. This is most likely due to the fact that individuals with high test anxiety have difficultly suppressing worried thoughts for cognitive and behavioral methods to be effective. If a student who is highly test anxious cannot control his/her anxiety, extra time spent studying may only lend to greater worry and lower performance, and behavioral methods have not been able to reduce task irrelevant thoughts (Kondo, 1997). However, relaxation is able to help the student control and suppress emotional and physiological anxieties, allowing the student to concentrate better and thus better prepare for and take the examination (Austin, & Partridge, 1995; Kondo, 1997). In 1984, The Broad of Trustees at the University of Illinois recommended that its professors use relaxation techniques to help reduce their students' test anxiety and tension (Bass, Burroughs, Gallion, & Hodel, 2002).

Progressive relaxation had its start in the early 20th century by Edmund Jacobson who introduced a physiological way of dealing with tension and anxiety (Bernstein, Borkovec, & Hazlett-Stevens, 2000). Jacobson wrote, "You Must Relax," in 1934 for those interested in learning about muscle relaxation in a way simple enough to follow as a layperson (Jacobson, 1934). His actual research came together in 1938 in an extensive book-length technical instruction of, "Progressive Relaxation." Since then, a plethora of research has emerged supporting the uses of a systematic relaxation technique on a multitude of symptoms that ranges from anxiety to speech distortions to blood glucose levels in the management of diabetes (Detling, 2008; Ganesan, 2009; Grant, 1980).

Rasid and Parish (1998) conducted a study examining the effects of two types of relaxation training using 55 high school students with varying levels of anxiety in an experimental-control group design. Results showed that both behavioral relaxation and progressive muscle relaxation techniques produced significantly lower anxiety scores in the experimental group as compared to the control group. The authors also found that the use of progressive muscle relaxation led to reduced test anxiety in high school juniors in preparing for the ACT. The present study tested two hypotheses: 1) That pre-test and post-test differences for the experimental group will show a significant decrease in anxiety level, and 2) pre-and post-test differences for the control group will show no significant decrease in anxiety levels.

Method

Participants

All eleventh-grade students from a Midwestern high school were invited to participate in the study. Those students who returned a signed parental consent form were included. A signature line for the high school students was included on the parental consent form to indicate participant's assent for the study. Volunteers who participated for this study included 11th grade students from a Midwestern public high school (25 males, 56 females; median age = 17 years). Of the 91 participants, self-declared ethnicities were as follows, 72 Caucasian, 3 African American, 2 Hispanic, 1 Asian American, and 3 who declared themselves as Other. The initial sample size was 85, however, four students unexpectedly dropped out of the study.

Measures and Instrumentation

Westside Test Anxiety Scale. The Westside Test Anxiety Scale (WTAS: Driscoll, 2007) was originally designed to identify students suffering from anxiety impairments who could benefit from anxiety reduction. The WTAS consists of 10 items, each using a Likert response scale where 1 = "never true" and 5 = "always true." It yields an overall anxiety score and measures anxiety impairments with six items assessing incapacity (i.e., memory loss and poor cognitive processing) and four items measuring worry and dread (i.e., catastrophizing) which interferes with concentration (Driscoll, 2007). Scores for the two subscales, incapacity (items 1, 4, 5, 6, 8, & 10) and worry (items 2, 3, 7, & 9), are obtained by summing the respective item responses. A total score is then obtained by adding up the scores and dividing by 10 (Grimes & Murdock, 1989) where higher scores indicate a greater level of test anxiety. In the present study, the total score was obtained in order to measure a general level of test anxiety.

Deep breathing instructions were obtained from an online reference (Anxiety Community, 2010). Selection for this method was utilized due to the simplicity and applicability to high school students under a limited amount of time. The guided progressive muscle relaxation technique was selected for the purposes of focusing on all parts of the body from feet to head.

Procedures

All participants were given the WTAS (pre-test) and a short demographic questionnaire to complete during their physical education (PE) class and participant's pre-test scores were rank-ordered from highest to lowest and then divided in half. Participants with the highest anxiety scores were then assigned to the experimental group (N = 37), and the rest of the participants were assigned to the control group (N = 44).

The control group participated in PE as normally expected while the experimental group met in the wrestling gym where there were mats available for the students to lay down on and the lights were dimmed to create a relaxing environment. Training took place at school, two days a week, over a five-week period butting up to the actual standardized testing date. On training days, the researchers began by discussing the upcoming standardized **test,** which included the ACT to elevate levels of anxiety. During training, relaxing music was played in the background. While in training, participants in the treatment group were taught both deep breathing exercises and progressive muscle relaxation. Participants practiced breathing exercises for five to ten

minutes at the beginning of each session and then proceeded through the progressive muscle relaxation for the following 15-20 minutes. At the conclusion of the five weeks, participants in both the experimental and control groups completed the Westside Test Anxiety Scale as a post-test measure of anxiety.

Results

Comparisons of pre- and post-test measures of test anxiety between the experimental and control groups are presented in Table 1. An independent-samples t-test was conducted to examine differences between the pre-test and post-test scores of several groups: Experimental, Control, Honors, and Non-honors. A significance value of .05 was utilized. Results revealed a significant difference between pre- and post-test mean scores for the experimental group ($t(36) = 4.06$, $p < .05$). There was no significant difference found between pre- and post-test mean scores for the control group ($t(43) = 1.26$). Therefore, the treatment of relaxation training in this sample appeared to have a significant effect on lowering overall test anxiety between pretest ($M = 3.59$, $SD = .59$) and post-test ($M = 3.06$, $SD = .11$) for the experimental group. Further analyses revealed no significant difference between the pre- and post-test scores for students enrolled in the Honor's program who were also part of the experimental treatment group. However, the same was not true for students not enrolled in Honors classes. In other words, there was a statistically significant difference between the pre-test and the post-test scores of students in the experimental group who were not enrolled in Honor's classes.

Table I
Comparison of pre- and post-test measures of anxiety for the experimental and control groups

Group	Mean / sd (pre-test)	Mean / sd (post-test)	*t*-value (pre-post)	df
Experimental	3.59 / .59	3.06 / .11	4.06 *	36
Control	2.42 / .10	2.31 / .11	1.26	43
Honor's	3.22/ .63	2.94/ .71	1.26	10
Non-Honor's	3.70/ .49	3.20/ .56	3.75*	23

* $p < .05$

Discussion

The present study investigated the effects of relaxation techniques on test anxiety in high school students. Juniors in high school were taught two relaxation techniques; after which the treatment group reported a significant decrease in anxiety as compared to a group of their peers receiving no training. Participants in this study were from ages 16 to 19 years and results supported earlier findings that relaxation techniques can be learned and utilized successfully by children and young adults (Zaichkowsky & Zaichkowsky, 1984; Lohaus & Klein-Hessling, 2003). Students completing relaxation training reported a significant reduction in test anxiety

scores, whereas students in the control group reported no significant change in levels of anxiety. In addition to improvements in anxiety levels, another study demonstrated that the use of yoga and relaxation improved self-confidence and communication in children (8-11 years) with emotional and behavioral difficulties (Powell, Gilchrist & Stapley, 2008). Other studies have supported the use of relaxation and deep breathing in young children and young adults for a range of issues that affect school performance (Armstrong, Collins, Greene, & Panzironi, 1988; King, Ollendick, Murphy, & Malloy, 1998; Lohaus & Klein-Hessling, 2003).

Students in American public schools need interventions to combat the adverse behavioral, cognitive and physiological effects of high stakes testing (Carter, Williams, & Silverman, 2008). The increase in test anxiety among students may be attributed to the increase in distribution of high-stakes testing in American public schools (No Child Left Behind Act, 2002; Black, 2005). This higher anxiety can result in students becoming overly concerned with the consequences of failure (Spielberger & Vagg, 1995), thus adversely affecting their ability and desire to learn (Cheek, Bradley, Reynolds, & Coy, 2002).

It is unlikely that high-stakes testing will be eliminated or significantly reduced in the near future (No Child Left Behind Act, 2002; Triplett & Barksdale, 2005). Schools can play a role in addressing test anxiety by incorporating intervention programs such as relaxation training into the curriculum (Cheek et al., 2002). School counselors and teachers can have a scheduled time of day to teach students how to respond to physiological and psychological responses to anxiety and stress through the utilization of relaxation training. The interventions discussed in this article are brief and not difficult for children to learn. These interventions and techniques can be implemented in the academic environment to mediate anxiety and can be generalized to life skills.

Results of this research should alert administrators, parents, and teachers that students are experiencing adverse effects from having pressure to perform and that there is a need to address this with students (Cheek et al., 2002). Principals, administrators, and teachers can model for children how to respond to stress and anxiety and thus impact student's responses to pressure and anxiety. If performance anxiety is not addressed in elementary school, it could continue through the adult years and impact quality of life and career paths (Miller, Morton, Driscoll, & Davis, 2006). Principals have an incentive to lead their school to success on high-stakes testing in order to continue receiving funding for their schools. The principals in effect, give teachers the responsibility to promote desired results on high-stakes testing. As a result, teachers experience pressure to produce high test scores which relates to their job security. Consequently, this causes teachers to feel disempowered, anxious, and alienated (Triplett & Barksdale, 2005).

Suggestions for further research include more effective control of testing effects, as comparisons of ACT scores and pre- and post- measures from other schools were not included. It was possible that students may have disseminated information among cohorts therefore a diffusion of treatment may have taken place. Students receiving relaxation training may have shared their learning with peers assigned to the control group. Thus, by learning the relaxation techniques, some of the students in the control group may have out-performed students in the treatment group. A salient and applicable incentive to the research should also be considered as post- questionnaires were not all completed. The participants who completed both pre- and post-test measures were entered in a drawing to win fifty dollars; however, not all completed the full procedure.

An unexpected finding during the time of analysis was that Honors students who participated in this study did not receive any benefits associated with the treatment. In other

words; Honors students reported no change in levels of anxiety after treatment was implemented. These findings may contribute to Rice, Lever, Christopher and Porter's (2006) findings regarding adaptive and maladaptive perceptions in high achieving and gifted students. High achieving students with maladaptive aspects of perfectionism (depression, physiological stress, overly self-critical) were found to be more emotionally stressed than those who were able to adapt to demanding events. However, analyses regarding traits that contribute to adaptive and maladaptive behaviors, as well as perfectionist constructs were not examined in this study.

Further research into the psychological markers that contribute to the lack of successful intervention is needed in addition to gender implications (Wicherts & Scholten, 2010). Eum and Rice (2011) found that of their 134 participants, women who were maladaptive perfectionists were those who were more likely to be test anxious. Other studies do note the gender differences associated with test anxiety, suggesting that being female serves as a better predictor for test anxiety than being male, and the ratio of test anxiety to gender specific criteria is much higher for young girls as well (Cassady & Johnson, 2002; Elliott & McGregor, 1999; Hancock, 2001; Putwain, 2007).

There is also little known regarding the direct effects that relaxation and deep breathing have on actual test scores. Not enough research emphasizes gender in the context of high stakes testing. However, the inclusion of this in any replication of relaxation and deep breathing treatment methods can be effectively incorporated into a study such as this. Further investigation into appropriate treatment methods for Honors students when other methods are unsuccessful is needed.

Although the research supporting relaxation in the schools as an effective means in reducing anxiety is plenty (Deuskar, 2008; Donato, 2009), further emphasis on the different methods of relaxation and deep breathing as well as its systematic properties also need to be addressed and further explored. Broota and Sanghvi (1994) found that a specific type of relaxation with Yoga techniques was more effective than the Jacobson progressive muscle relaxation technique. With a clear indication that different methods are indeed being utilized, working towards forming a systematic approach that can be useful to school counselors should be pursued given the outcomes of much of the research today.

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Empirically Validated Treatment for Female Sexual Trauma Survivors

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Abstract

In the field of psychology, a myriad of psychotherapies exist. Often, differing professionals in the field utilize various psychotherapeutic approaches in the treatment of a singular psychopathological issue. Contemporary practitioners are starting to focus their efforts more and more on empirically validated treatment: treatment with evidential research to prove its efficacy in psychotherapy. This article investigates an empirically validated treatment for women who have survived sexual trauma. Alliance and empathy, evidence based aspects of psychotherapeutic relationships, are an invaluable part of treatment with female sexual trauma survivors. Prolonged exposure therapy is a highly researched, evidence based treatment that has been proven greatly effective for women who have experienced sexual trauma. Psychoeducation and psychotherapy are crucial components in addressing sexual violence, and they are highly successful in treating the psychological suffering in the aftermath of trauma.

Keywords: empirically validated, evidence based, prolonged exposure therapy, sexual trauma, sexual violence

Instances of significant and severe trauma often leave indelible marks on those who suffer, and sexual trauma is no exception. The psychological damage that manifests after an experience of rape attests to just how terrorizing the crime is. The symptoms of traumatic stress that persist often chronically disrupt the lives of survivors (Jaycox, Zoellner, & Foa, 2002). While over 500,000 rapes are reported annually in the United States, many more are thought to occur and remain unreported. Rape is both psychologically devastating and shockingly prevalent in western, American society. As clinicians, we must investigate empirically validated, powerful methods of treatment and implement them to help women overcome these overwhelming, harrowing tragedies. In the following article, the author will explore effective treatment for female survivals of insular or singular episodes of sexual trauma, acknowledging that treatment often would be differently developed if the client has experienced multiple episodes of sexual traumata or systematic sexual abuse in childhood.

Common Factors

Within the context of the psychotherapeutic relationship, certain quintessential phenomena are crucial to treatment success. For the treatment of women who have suffered sexual trauma, *empathy* resides as a profound underpinning of the psychotherapeutic relationship. Experts define empathy as "(a) an emotional simulation process" in which the therapist mirrors the client's physiological, visceral emotional experience through brain

activation in the therapist's own limbic system, "(b) a conceptual, *perspective-taking* process," and "(c) an *emotion-regulation* process" during which the therapist soothes her own distress in order to compassionately help her client in her time of need (Elliott, Bohart, Watson, & Greenberg, 2011, p. 43). Elliott et al. (2011) conducted a meta-analysis of the efficacy of empathy in psychotherapeutic outcomes and found it to be significantly effective with moderate predictive strength, especially when the client or an outside observer noted its presence. In the treatment of women who have experienced sexual trauma, empathy lies at the crux of a powerful psychotherapeutic working relationship. A woman who has been sexually traumatized feels tremendously violated and vulnerable; she needs to know that her therapist has compassion and a caring understanding in her approach to her client and the therapy work. Because women often feel shameful and guilty after surviving sexual trauma, the therapist will help the client accept herself and realize that she is not guilty or worthy of shame by accepting her and her experience empathically.

Alliance

Alliance, or a collaboration and consensus between therapist and client in working toward mutually agreed-upon goals, has also been proven an effective, evidence based practice through meta-analysis (Hovarth, Del Re, Flückiger, & Symonds, 2011). Collaboration and consensus are valuable for sexual trauma survivors because they operate from an *empowerment model* in which the client's choice and agency are nurtured (Elliott, Bejaljac, Fallot, Markoff, & Glover Reed, 2005). A collaborative alliance also includes psychoeducation to inform the client in order to empower her as an arbiter of her own treatment and recovery. Alliance also involves a strong relationship between client and clinician, a relationship built upon trust and confidence in the therapist as a "potent source of help" (Horvath et al., 2011, p. 10). The client must experience the relationship as warm, supportive, and caring. These aspects are imperative to relationships between clinicians and sexual assault survivors in order to ensure that clients feel *safe* throughout therapy (Herman, 1997). These factors also provide the intimacy that lays the foundation for successful therapy work, personalizing the manual-based treatment and subsequently easing the practitioner's resistance to the use of manual-based treatment.

Evidence Based Practice

Dr. Edna Foa, from the University of Pennsylvania, has revolutionized treatment for PTSD in rape survivors through her development of prolonged exposure therapy, a trauma-informed CBT-based manualized treatment, which two decades of research has proven to be empirically validated (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Almost half of female rape survivors meet the diagnostic criteria for PTSD three months after the trauma, and many more are in need of treatment (Jaycox et al., 2002). Because of how many women suffer at the clinical level, the short-term nature of prolonged exposure therapy may prove useful in quickly and effectively treating a higher volume of survivors than other, longer forms of psychotherapeutic treatment. Additionally, it has been empirically validated continually in comparison with psychological controls and other psychotherapeutic approaches (Powers et al., 2010).

Prolonged exposure therapy for female rape survivors consists of 9 to 12 one-and-a-half-hour individual therapy sessions and is comprised of the following four components: (1)

psychoeducation about PTSD symptoms and theories of treatment, (2) imaginal and in-vivo exposures to trauma and confrontations of feared situations, (3) breathing relaxation techniques, and (4) the restructuring of maladaptive cognitive distortions. The first sessions focus on establishing a strong therapeutic alliance, providing psychoeducation, and teaching relaxation skills. Throughout treatment, the client is informed of the theoretical rationale and explanation for prolonged exposure therapy. In-vivo exposure homework assignments begin in session two, and imaginal exposure begins in session four. Therapist and client collaboratively devise a hierarchy of feared situations, systematically conquering successively greater fears through repeated in-vivo exposure throughout the therapy. Progress is evaluated during the ninth session. If the client has significantly improved such that her symptoms have lessened or dissipated, the majority of session nine focuses on reviewing the techniques utilized in therapy, evaluating their helpfulness, and discussing issues of termination. If the client has not experienced a 70% symptom reduction and therefore has not significantly improved, she has the option of three additional therapy sessions (Jaycox et al., 2002).

The psychoeducational component of prolonged exposure therapy comforts clients in teaching them that their symptoms are "common reactions to trauma" (Jaycox et al., 2002, p. 894). During the first session, the therapist teaches breathing retraining to help the client learn how to utilize breathing relaxation techniques to manage overwhelming feelings of anxiety and stress. Clients are encouraged to practice the breathing retraining exercise twice daily to enforce physiological calming through activation of the parasympathetic nervous system. At least 45 minutes of the second therapy session is dedicated to psychoeducation, investigating various PTSD symptoms, the role of anxiety and fear, and other psychological reactions to trauma, including shame, guilt, anger, feelings of worthlessness, disruptions in relationships, sexual problems, and a sense of powerlessness. The therapist provides the client with reading material summarizing these reactions, and the client is encouraged to discuss it with significant others in her life.

The next sessions in therapy confront the trauma through imaginal and in-vivo exposure. By activating the trauma-related fear and anxiety, prolonged exposure work in therapy helps the client habituate to trauma-related stressors and modify the pathological elements that allow PTSD to persist (Jaycox et al., 2002). Confronting the traumatic images and feared situations provides the client with the opportunity to fully process the trauma and integrate various images and details, the repression and disintegration of which may contribute to intrusive aspects of PTSD. When the conscious mind ignores, represses, or avoids details and images of the trauma, the survivor has failed to fully process and comprehend their impact on her. Without a comprehensive, integrated narrative, these aspects lurk in her subconscious, fragmented and disintegrated. Experts van der Kolk, McFarlane, & Weisaeth, among others, suggest that avoiding these aspects and details causes them to resurface in the form of nightmares, flashbacks, and other intrusive symptomology (1996). *In-vivo exposure* consists of instructing the client to confront real life, feared situations, which are objectively safe. Clients may have developed irrational fears about going out in public places such as the grocery store, and these fears are not only excessive and unrealistic, but also debilitating. The therapist and client construct a hierarchical list of real life exposures to confront safe but frightening situations, starting with the easiest and working toward the most feared circumstances. Repeated exposure lessens anxiety as the client begins to realize that she is safe and that her expectations of danger are inaccurate. Without a sense of danger and with repeated experiences, the client will no longer feel

heightened levels of anxiety. In-vivo exposure tasks are assigned as homework between sessions and the client is encouraged to repeat them many times (Jaycox et al., 2002).

Imaginal exposure occurs during therapy sessions and consists of the client's vivid and detailed retelling of the sexual trauma. The therapist asks her client to close her eyes and remember her trauma in the present tense, speaking as if the trauma were currently happening. The client must emotionally engage in the experience as to overcome it. Processing the trauma helps the client habituate to it, lowers her anxiety, increases her sense of safety by reinforcing that she is not actually reexperiencing the trauma, and allows her to differentiate it from other similar but distinct situations. Processing the trauma through prolonged exposure also provides the client with an enhanced sense of personal competence and control – instead of being controlled by intrusive thoughts, she now controls them in her mastery of the traumatic material. Clients tell the whole story of their sexual trauma and then start over again when they have finished. The therapist also tapes the client so that she may listen to her narrative throughout the week at home. The prolonged imaginal exposure itself lasts approximately 45 to 60 minutes in the therapy session, and the majority of the time allows the client to extensively engage the memory with her therapist and to experience a reduction in anxiety. If the client becomes overwhelmed and flooded, her therapist will reduce her distress by asking her to open her eyes and reminding her that she is safe. Clients are continually reminded that they are in complete control of their experience. Frequently throughout the "reliving," the therapist asks the client to rate her anxiety level. The therapist also asks the client to rate the vividness of the storytelling on a scale from 0 to 100 to assess how real the image feels (Jaycox et al., 2002, p. 896). As therapy progresses, the therapist and client collaboratively select the most challenging aspects of the trauma and focus on them to catalyze a more rapid reduction in anxiety. Following a reliving, clients discuss their reactions during and after the exposure (Jaycox et al., 2002).

The clinician also restructures cognitive distortions throughout the therapy work. The therapist must assess the client's beliefs in trauma-related distortions in order to address them. Common cognitive distortions include the client's belief that the sexual trauma was her fault and that she is weak and unable to cope with the traumatic stress and with her symptoms. The therapist engages her client, asking her to voice these erroneous beliefs and then facilitating cognitive restructuring through the Socratic method. In utilizing this method, the therapist challenges her client's beliefs through a series of logical questions (i.e. "What is the evidence for this idea?") and assists her client in replacing the irrational belief with a more realistic thought (Jaycox et al., 2002, p. 897).

The therapist may struggle to challenge cognitive distortions, experiencing an overwhelming need to caretake. She may even worry that she is taking on the role of the perpetrator and being unfairly antagonistic. However, in carefully and thoughtfully challenging her client, the therapist is, in fact, surrendering her therapeutic power as "caretaker" to the client. She is teaching the client to empower and care for herself. Cognitive-behavioral prolonged exposure therapy works from an *empowerment model*, as it encourages the client to become agentic in finding her own voice and learning to self-care. Therapists must also remember self-care and advocate for their own supervision during this time. Vicarious trauma is also a concern, especially when hearing shocking and unfamiliar material that is graphic and violent in nature. Therapists may need to seek out their own therapy. Group consultations with other trauma therapists are also highly recommended.

Numerous studies have proven prolonged exposure therapy to be highly effective in the treatment of PTSD for female sexual trauma survivors (Jaycox et al., 2002; Powers et al., 2010).

During the treatment itself, the clinician must continually evaluate her client and determine the status of her symptomology. However, since the fear response must be activated to be treated, clients may show more distress and more severe symptomology in the beginning of treatment. They may get worse before they get better. By the end of treatment, clients' symptoms often diminish by at least 70%. The psychoeducational and collaborative approach to therapy also empowers the client to become her own therapist after treatment has ended and continue the work independently, and her symptoms may continue to decline, often to the point of no longer qualifying for a clinical diagnosis of PTSD (Jaycox et al., 2002). Effective treatment for female sexual trauma survivors is an integral aspect of feminist advocacy and the promotion of healing.

Conclusion

This article has reviewed the use of prolonged exposure therapy in the treatment of insular or singular episodes of sexual trauma. The article has discussed the importance of the relationship between the therapist and the woman as an aspect of the common factors component of treatment as well as reviewing the need for clinician self-care. It is the hope of the author that a detailed exploration of the use of this technique will increase the likelihood of traumatized women receiving the support and treatment they need.

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Advocacy for Kenyan School Counselors and the School Counseling Profession

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Abstract

School counseling in Kenya is a relatively new concept. For a long time, the role of Kenyan "guidance counselors" has remained unclear and questionable. Some schools maintain counselors who have not received any formal training beyond attending workshops and seminars. To date, the Kenyan education system considers school counselors as teachers first and counselors second. This article outlines steps toward advocating for Kenyan school counselors to improve counseling services available to all students in Kenyan schools.

School counseling in Kenyan schools is a relatively new concept and only became officially recognized by the government in 1971 (Tumuti, 1985). Consequently, Kenyan school counseling remains far from becoming a well structured profession. School counseling is treated as an ancillary extra-curricular program, as opposed to an essential core-curricular requirement. In many Kenyan schools, no specific time is scheduled for counseling during normal school hours. Consequently, school "guidance" counselors commonly meet with students during recess, lunch breaks, and after school. In practice, this restriction means that school counselors have no time to rest between other classes they are teaching. School counselors in Kenya are still referred to as guidance counselors; hence these terms will be used interchangeably.

In this article, we describe strategies for advocating for school counselors and the school counseling profession in Kenya. However, we recognize that change cannot occur simultaneously nationally. These strategies could be implemented in one school and later generalized to other schools. The first author (Wambu) is a Kenyan who worked as a school counselor for fourteen years; hence, information contained in this article is not only from Kenyan literature, but also from firsthand experience.

School counselors in Kenya are first and foremost classroom teachers (Tumuti, 1985), with counseling as an ancillary service teachers provide to students in need. As a result of this dual responsibility, most school counselors find themselves overloaded with work, leading to lack of motivation, frustration, and job dissatisfaction. To further complicate matters, the Kenyan government does not provide any stipend or salary differential for teachers who also participate as school counselors. School counselors, therefore, have felt unappreciated, leading to a great migration of counselors from school to community mental health counseling, where counselors can easily engage in private practice.

The aforementioned factors all pose serious barriers to provision of effective school counseling services to Kenyan students. Among the most serious barriers are the inherent dual relationships of school counselors with students whom counselors also teach and provide an academic grade (Ajowi & Simatwa, 2010; Tumuti, 1985). The relationship between the subject teacher and students is quite different from American counselors conducting classroom guidance. Although failure to complete homework in a regular class may have serious repercussions, such

is not the case if similar offenses were committed with regard to classroom guidance. Consequently, this dual relationship may hinder some students dealing with social-emotional, academic, or career issues from seeking counseling services from the same teacher who might have given the student a detention in class. Unfortunately, this scenario is very real in most Kenyan schools.

Lack of support from the administration, faculty, and staff has also contributed to the low morale of Kenyan school counselors. Additionally, poor or lack of appropriate counseling facilities, such as counseling rooms and supplies, have hindered guidance counselors from performing their counseling roles effectively (Ajowi & Simatwa, 2010; Nyutu & Gysbers, 2008). A negative perception of counseling in general only makes the situation worse. Furthermore, university guidance and counseling curricula also need revision (Nyutu & Gysbers, 2008) to reflect the roles that guidance counselors play.

Given the above concerns, Kenyan school counselors need advocacy, not just for themselves but for students and the future of the school counseling profession in Kenya.

The Need for Professional Advocacy

Advocacy has been defined as the process of pleading or arguing for a cause and includes social activism as well as the promotion of a profession (Myers & Sweeney, 2004). Advocacy involves identifying unmet needs and taking actions to change the circumstances that continue to contribute to the problem of inequality (Trusty & Brown, 2005). Most advocacy literature in school counseling has focused on the role of counselors as advocates for students (Akos & Galassi, 2004; Baker, et al.; 2009; Bemak & Chung, 2008; Dixon, Tucker, & Clark, 2010; Field & Baker, 2004; Galassi & Akos, 2004; House & Martin, 1999; Trusty & Brown, 2005). However, there is a dearth of research relative to advocacy on behalf of the counseling profession in general (Myers & Sweeney, 2004) and none exists for the school counseling profession (Myers, Sweeney, & White, 2002). On the contrary, counselors need to become agents of social change, not just for their clients and students, but for the world around them (Myers et al., 2002).

Previous authors have stressed the need for school counselors to become agents of social change (ASCA, 2005; Lee & Rodgers, 2009; Ratts, DeKruyf, & Chen-Hayes, 2007; Ratts & Hutchins, 2009; Myers et al., 2002). The American Counseling Association Governing Council endorsement of advocacy competencies (Lewis, Arnold, House & Toporek, 2002) further emphasized the role of counselors as social justice advocates. However, if school counselors are to be successful in advocacy for students, the school counseling profession must have credibility with all the stakeholders (Myers et al., 2002). Advocacy for students and for the school counseling profession should receive equal emphasis. The establishment of a legitimate position for professional school counselors is necessary for counselors to be perceived as credible and empowered as effective advocates for students and agents of social change (Chi Sigma Iota, 1998; Myers et al., 2002). This necessity is as true in the United States as it is in Kenya.

The issues facing Kenyan school counselors require intervention in the three different levels of the American Counseling Association Advocacy Competency Domains (Lewis et al., 2002): individual, school/community, and public. Each advocacy level contains two dimensions that emphasize *advocacy with* and *advocacy on behalf of*. The *individual level* of advocacy involves empowering individuals to speak out for themselves or speaking on their behalf. The *school/community level* of advocacy emphasizes community collaboration and systems change,

whereas the *public arena level* of advocacy is concerned about informing the public about systemic barriers that affect student development and how school counselors can help shape public policy (Ratts & Hutchins, 2009). Although this model was developed for advocacy for students, the model will be adopted for advocating for school counselors. Advocacy for counselors is as important as advocacy for the students/ clients (Myers et al., 2002). For an advocacy plan to be successful, all stakeholders at each level need be incorporated in the plan. These levels are described below.

Individual Level

Advocacy at the individual level entails empowering and helping school counselors acquire skills to advocate for themselves (Crethar, 2010). Empowerment reflects advocacy action taken in collaboration with the individual and involves assisting him or her to recognize the external forces that affect his or her development (Toporek, Lewis, & Ratts, 2010). Advocacy at this level can occur with the individual and/or on behalf of the individual (Ratts & Hutchins, 2009). Advocacy at the individual level begins with identification of current needs or problems and the motivation to take action (Myers et al., 2002). Addressing these problems is the responsibility of individual counselors as well as organizations representing the profession (Myers et al., 2002). For this advocacy plan to be successful, school counselors in Kenya must be willing to get involved in the process.

Becoming active in advocacy is part of professional counselor identity (Myers et al., 2002). School counselors have a responsibility to advocate not only for the students, but for themselves. Teaching advocacy skills to school counselors would empower them to better advocate for the profession (Myers et al., 2002). These empowerment strategies enable individual school counselors to find their voice and, in turn, create new self awareness (Ratts & Hutchins, 2009). In other words, a primary objective of this advocacy dimension is to empower individuals to speak for themselves and refuse to be intimidated.

Advocating on behalf of individuals is also part of this advocacy level. Professional counseling associations have a responsibility to advocate on behalf of their members (Myers et al., 2002). At present, Kenyan school counselors lack a unified professional identity. Counselor advocacy begins with a sense of identity (Myers, et al., 2002). School counselors belong to the national counseling organization, the Kenya Counseling Association (KCA), which is a national body encompassing all counseling fields. The association is yet to be divided into specialty divisions to address the unique needs of each group. Consequently, school counselors lack a common forum wherein issues affecting their service delivery would be addressed. A professional organization would be instrumental in advocating for school counselor needs (Myers et al., 2002). Advocating for the inclusion of a Kenya School Counseling Association (KSCA) division within the national association could be a great step towards ensuring the unique needs of school counseling are addressed**.**

School and Community Level

Advocacy at the school and community domain involves identifying issues of oppression or systemic barriers within a school or community (Toporek et al., 2010). To be successful in eradicating these barriers, school counselors need to collaborate with and seek support from the school community, including teachers, staff, school nurses, and administrators (Ratts et al., 2007;

Toporek et al., 2010). The school counselor role would be that of an ally as well as a facilitator (Toporek et al., 2007).

Teachers and staff. The first group on which to focus collaboration efforts is other school teachers and staff. Given that teachers directly encounter students with academic, behavior, and personal-social issues more than anyone else in schools, their understanding of how school counselors can assist in this endeavor can provide a great relief. Presentations to teachers and staff can focus on benefits of having full time school counselors in schools and how school counselors can be instrumental in student academic performance improvement. According to the American School Counselor Association (ASCA, 2005) *National Model*, school counselors have a primary responsibility to advocate for the academic success of every student; hence, having Kenyan school counselors not doubling up as class teachers allows school counselors sufficient time to accomplish this goal.

Parents. The support of parents cannot be underestimated. According to the ASCA (2005) model, a successful school counseling program requires collaboration of school counselors, parents, students, staff, administrators and other school personnel working together for the benefit of every student. Consequently, advocacy for school counselors should include parents. Toward this end, school counselors could purposely attend annual Parent-Teachers Association (PTA) meetings with an aim of presenting the benefits for children having full-time school counselors (free from teaching responsibilities) and doing so in collaboration with principals. Parental support is crucial because their children are direct recipients of counseling services. If parents do not think counseling is necessary, all other efforts will be futile.

However, working with parents could pose the greatest challenge. Most high schools in Kenya are boarding schools and students come from all over the country. Parents hardly come to school unless for major functions. As noted earlier, counseling is a relatively new profession in the country and still struggling to gain acceptance. Counseling is more accepted in some cultures as a means of resolving personal, social, and emotional issues while in other cultures people have no understanding of what counseling really is. Often, these communities seek help from their elders, pastors, and priests to resolve any issues that may be of concern to them as opposed to a professional counselor. Given that students in the schools come from such a diverse cultural background, (Kenya is made up of 42 different cultural groups), getting all the parents to support counseling services for the students will be a great challenge. By collaborating with all stakeholders, school Kenyan counselors will gain a greater voice in advocating for systemic change.

Systemic change. Advocacy at the school and community level also calls for systemic change within the schools. Toporek et al. (2010) suggested that this level of advocacy may be necessary if individuals within a group do not have similar access to resources or are not in a position to make change. This need is even more serious when counselors have to advocate within the same institution. In this case, Kenyan school counselors are a "minority" group within educational systems. Kenyan school counselors feel overwhelmed due to the increased work they do beyond normal school hours, yet lack a voice to present their concerns. To correct this anomaly would require making structural school curriculum changes. Providing data to support the need for change would "buy in" principal support (Toporek et al., 2010).

Principals. Most Kenyan principals do not understand the role school counselors play and interpret counseling as akin to an extracurricular responsibility teachers can have, similar to being an athletic coach for a school sports team. Therefore, school counselors must educate administrators regarding their role. Without a clear school counselor role definition, school

principals will continue to dictate what a school counselor can and cannot do, with total disregard of school counselors' training (Dodson, 2009). School counselors in Kenya require administrative support to carry out their roles effectively (Nyutu & Gysbers, 2008). School principals are the source of systemic power within the school. No change can be effected in school without endorsement from the principal. For this reason, seeking collaboration and forging partnerships with principals is essential in effecting systemic change in schools. With principal support, advocacy efforts can be directed to district education officials.

District education officials. Other education officials at the district level can also present barriers to advocating for school counselors, so the support of these officials needs to be highly sought. According to Ratts et al. (2010), efforts toward teaming and collaboration outside of a school context require administrative support. For that reason, school principals' support is essential in reaching out to district officials. Once district support has been obtained, the next move involves contacting national Kenyan education officials. This level of intervention may be the most challenging aspect of transforming Kenyan school counseling, as it calls for changes in government policies and has financial implications. Consequently, research findings that demonstrate evidence of full-time school counselors' impact on student academic, career, and social-emotional achievement are essential. To justify policy change requiring every school to have at least one trained full time school counselor, contrasting data from the ASCA model, for example, needs to be provided. Winning principal and district official support would be a great asset toward public arena advocacy.

Public Level

The goal of advocacy at the public level is to increase public awareness, affect public policy, and influence legislation (Lewis et al., 2002). This advocacy level requires addressing external barriers on a macro-level through raising public awareness of these circumstances (Toporek et al., 2010). To effectively implement public information as a form of advocacy, school counselors need skills in developing multimedia information materials and understanding how to effectively share these materials with the public (Toporek et al., 2010). In Kenya it is evident that the public lacks awareness of who school counselors are and the services they provide to students.

One significant way to increase public awareness is to disseminate information through a variety of media outlets (Lee & Rodgers, 2009). The use of television, print media, and the Internet are powerful tools to inform stakeholders of the issues affecting school counseling and creating a sense of urgency for change.

Another effective method of raising public awareness is to stage public demonstrations, such as marches and rallies (Lee & Rodgers, 2009). Such demonstrations attract the attention of leaders and policy makers. Unfortunately, advocacy in the public arena cannot be accomplished by an individual or a small group of people; hence this strategy poses a challenge with Kenyan school counselors, given the lack of a professional organization. However, school counselors can seek support of the Kenya Counseling Association as well as build collaborative relationships with other stakeholders such as the parent-teacher association and school board members.

In addition to written and printed materials, school counselors need to seek out forums for informing the public about the benefits of having trained counselors performing duties consistent with their preparation and how doing so would impact student academic achievement. Such information could help change school counselor role perceptions and ultimately reduce

opposition (Crethar, 2010). Such presentations could be made during school district board meetings, community meetings, and religious organization meetings.

The current situation affecting school counseling in Kenya is embedded in policies governing education. The interventions mentioned above all require educational policy change. Providing data and evidence of student success as a result of school counseling interventions will help change perceptions and gain support for appropriate counseling roles, which ultimately will result in greater student success (Dodson, 2009; Lopez-Baez & Paylo, 2009). Such a change will allow Kenyan school counselors to effectively serve all students in the three domain areas, academic, career and social/personal, as proposed by the ASCA *National Model*.

Potential Challenges in Implementing the Advocacy Plan

Implementing the proposed advocacy plan in Kenyan schools would definitely be faced by many challenges. The most critical barrier to implementing an advocacy plan for Kenyan school counseling is resistance/readiness for change. This barrier will probably come from the district and national levels, as any policy change requires financial input, for which the government might not be prepared. The ministry of education has in past years maintained that there is a lack of resources to hire enough teachers, let alone school counselors. Transforming teacher-counselors to performing school counseling duties alone means schools will need to hire an additional teacher, a situation for which the ministry of education may not currently be prepared. The only way to overcome this barrier is to provide strong data showing how full time school counselors impact academic achievement. Similar to the United States, Kenyan schools are academic oriented, and school principals are under pressure to raise standardized test scores. Consequently, any effort that could help principals accomplish raising scores is likely to be supported.

Another barrier to full time Kenyan school counselors could be administrative pressure to maintain the status quo. According to Crethar (2010), many stakeholders in a school system do not like change and are unwilling to adapt, so they oppose change automatically, regardless of its nature or potentially positive impact. Having school counselors perform only counseling duties necessitates some adverse changes in schools, including losing one classroom teacher, whom the district may or may not replace. Kenyan teachers are employed under one organization and are transferred from one school to another, depending on need. Additionally, schools will need to provide all required resources for counseling, such as an office, equipment, and supplies, all of which may not be allocated in principals' budgets.

In addition, some school counselors may not yet be ready for change and may perceive a full time counseling position to mean additional work. Some school counselors may resist professional changes as a way of maintaining what Bemak and Chung (2008) called "the nice counselor syndrome." The idea of counselors planning a curriculum for all students may be new to some Kenyan school counselors because they are used to the traditional model of only attending to at-risk students. These teacher-counselors would therefore need some in-service training before they could take up full responsibilities as school counselors.

Other barriers to transforming Kenyan school counselors may be associated with the risks engaging in such advocacy may bring about. Engaging in advocacy may be construed by some school administrations in Kenya as equivalent to abandoning the teaching responsibilities teacher-counselors are first and foremost trained to provide. In Kenya, the requirement of a teaching certificate before becoming a school counselor remains in effect. Many school

counselors may therefore not want to "rock the boat" and hence may be unwilling to participate in an advocacy plan for fear of jeopardizing jobs or being transferred to schools where they may not wish to teach.

Despite these challenges, the potential benefits of having effective school counseling programs and school counselors who are motivated to provide counseling services to all students in Kenya makes this advocacy plan a worthwhile endeavor.

Conclusion

School counselors' role in the United States has undergone tremendous changes in the past, evolving from a position of extracurricular duties performed by a teacher to the current efforts of school counselors initiating comprehensive school counseling programs (Akos & Galassi, 2004; Bemak & Chung, 2008; Galassi & Akos, 2004; Gysber & Henderson, 2001). However, to date not every school or school district has adopted these changes as expected. A national study conducted by Martin, Carey, and DeCoster (2009) on the status of state school counseling models found that out of 50 states, 17 have established school counseling models, 24 are in progress toward implementation, and ten are at the beginning stage of model implementation. These results speak to the notion that any role changes in any profession take considerable time to be enacted in practice (Walsh, Barret, & Depaul, 2007). By extension, changes in Kenyan school counselor roles are likely to take some time. However, for these changes to happen, advocacy is needed at all levels.

Sadly, the structure for guidance and counseling in Kenyan schools is similar to the United States in 1924, where guidance teachers counseled along with their regular teaching duties (Gysbers, 2001). American school counselors still stuck in the traditional guidance model of school counseling who continue to perform non-counseling duties may wish to utilize strategies we've suggested and advocate for change in their schools.

One initial change that must occur in all school systems is revising the title *school guidance counselor* to *professional school counselor* to reflect the shift in role and responsibilities (Bemak, 2000). In Kenya, the need for a structure that provides counseling services to all students is also long overdue. Counseling needs to be an integral part of the educational system, as opposed to the ancillary role it has played in the past. This change will only come through professional advocacy. Kenyan school counselors might need help from international school counseling organizations, such as ASCA, to lobby for this change. By providing data on academic achievement from American schools that have implemented comprehensive school counseling programs, Kenyan school counselors might more readily elicit support for these changes from school policy makers.

In this article, we have provided concise strategies to advocate for school counselors and the school counseling profession in Kenya at the individual, school/community, and public domain levels, based on the ACA Advocacy Competency Domains. We have also suggested methods of coping with potential barriers and challenges to advocacy plans. Our overall objective is to make systemic changes to remove barriers to effective counseling and make school counseling a respectable profession for current and future Kenyan school counselors. Consequently, this plan ensures that the academic, career, and social-emotional needs of all students will be addressed, leading to improved academic performance.

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Advocating for Students with Disabilities Transitioning to College

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Abstract

Transitioning from high school to college can be challenging for anyone. When the transitioning student is also a person with a disability, additional obstacles may exist. Using the American Counseling Association Advocacy Competency Domains as a framework (Lewis, Arnold, House, & Toporek, 2003), suggestions for high school and college counselors to advocate for students with disabilities will be presented. Specifically, possible interventions will be discussed at the individual, school, and public area levels.

Transition from high school to college can be a challenging experience for students, parents, and teachers. When compared to their nondisabled peers, students with disabilities often face additional challenges in successfully transitioning from high school to postsecondary education (Gil, 2007). *Independent living*, *safety*, *social skills*, *coordination of service providers*, *accessing college disability services*, and *medical care* are only some issues that may need attention when working with students with disabilities transitioning to college. The Individuals with Disabilities Education Improvement Act (2004) mandates that high school students with disabilities are provided with the opportunity to prepare for postsecondary education. Despite directives, college students with disabilities are less likely to complete college than their peers without disabilities (Gil, 2007). Counselors at the high school and college level are often integral to a student's transition to college. Therefore, counselors at both the high school and college level are encouraged to develop advocacy strategies to assist students with disabilities.

Given the large gap in college graduation rates between students with and without disabilities, advocacy is needed for this underserved population. Using current literature, ideas for systemic change (Toporek, Lewis, & Crethar, 2009), and the American Counseling Association (ACA) Advocacy Competency Domains (Lewis, Arnold, House, & Toporek, 2003), we have developed potential strategies to advocate for students with disabilities as they transition to college. The plan involves potential advocacy interventions at the Lewis et al.'s student/client, school/community, and public/policy levels. School and college counselors can utilize interventions discussed. The interventions discussed can be utilized by students, parents, counselors, and other service providers.

Advocacy at the Student Level

Advocacy at the individual level involves working with or on behalf of individuals to meet their needs (Toporek et al., 2009). Due to the gap in postsecondary educational attainment (Gil, 2007), many students with disabilities may benefit from individual advocacy. Assisting students to understand various disability systems and their own disabilities are some of the ways school and college counselors can advocate for students with disabilities.

Understanding the System

Negotiating disability systems can be overwhelming for students with disabilities and their parents. Students and their support systems understanding the differences between special education services provided in high schools and postsecondary disability accommodations is essential in navigating a successful transition to postsecondary education (Gil, 2007). Counselors play essential roles in educating students and their parents on the differences between high school entitlement systems and eligibility-based adult services.

One important difference between high school and college services is each system's purpose. Special education legislation mandates high schools provide necessary interventions to assist students in graduating. Alternatively, postsecondary institutions are only required to provide *reasonable accommodations* under the Rehabilitation Act Amendments (1973). Therefore, the main difference between high school and postsecondary disability services is that postsecondary services have no mandates for students to graduate. Instead, college students with disabilities are provided a "level playing field" through reasonable accommodations. The difference between special education and college disability services often causes misunderstandings between students and service providers, and impacts service provision. Counselors can advocate for students with disabilities by educating them on the differences between disability services at the high school and college levels.

Teaching Self-Advocacy Skills

Student-level advocacy for persons with disabilities may also involve teaching self-advocacy and self-determination skills at the high school and college levels (Eiseman & Chamberlin, 2001; James, 2007). Success in higher education often depends on an ability to be self-driven in meeting needs and goals. Getzel and Thoma (2008) suggested students need to develop problem-solving and goal-setting skills to self-advocate. Such skills can be taught at the high school or college level. For example, counselors can encourage student's active involvement in goal-setting activities early in transition planning.

Problem-solving (e.g., how to find information about different colleges) skills can be fostered throughout the transition process. For example, counselors can help students find resources instead of simply telling them exactly where to locate them. College counselors may assist students by teaching self-advocacy skills. Helping students develop the skills to work with faculty to get the reasonable accommodations they need to be successful is an example of how counselors can advocate for students. In sum, self-advocacy skills are essential for success in higher education as students are often left to their own responsibility to ensure they get the services they need to graduate. This is often different from the way it was for students in high school. Counselors are encouraged to help students with disabilities develop self-advocacy skills.

Understanding Own Disability

In conjunction with self-determination and advocacy skills, high school teachers and counselors need to help students understand their disability and its impact on learning (Getzel & Thoma, 2008). Self-awareness about disability has been found directly related to the ability to

self-advocate. Given this finding, students who do not understand their disability are not able to fully advocate for themselves.

To learn about their disability, many students in the Getzel and Thoma (2008) study of college students with disabilities reported using the Internet as a confidential way to learn more about their diagnosis. In addition to gaining information from external sources, students also reported needing trial and error to completely understand how their disability impacted learning in high school and college. Students often required modifying study habits several times to find methods that best worked for them. Being encouraged by teachers and service providers was particularly helpful in reflecting (i.e., considering what works and what does not) on their current learning strategies. Given the positive impact self-awareness can have on students with disabilities, counselors and teachers are encouraged to help students with disabilities learn about their own disabilities through a variety of methods.

School Advocacy

In addition to the individual level advocacy for students with disabilities, systems level advocacy may be a necessary component of a comprehensive plan (Toporek et al., 2009). Several systemic issues may prevent students with disabilities from gaining access to postsecondary education. First, instructors, financial aid advisors, and other university staff may need additional training related to working with people with disabilities (National Council on Disability, 2003). Providing staff members with adequate disability awareness training will assist in ensuring that students with disabilities receive needed services. For example, providing faculty and staff with an opportunity to learn about disability may be helpful. Often people are afraid of what they do not know about. Fear may impact the way faculty and staff interacts with a student. For example, if a high student has a visible disability the counselor may ask the student if the student and counselor can meet with select faculty to discuss their disability. Discussing this openly may help the faculty better understand the student's disability and help the student have more positive interactions with faculty and staff. This also models advocacy for the student. Appropriate disability language training (e.g., person first language) may help them interact effectively with people with disabilities. Providing faculty and staff with education on accessibility may also be helpful. For example, if a faculty member has an office in a narrow hallway it would be important for him to ensure his student that uses a wheelchair can access the office. Providing disability awareness training to faculty and staff may be helpful for eliminating attitudinal and environmental barriers to students.

Second, college and university administrators need to support research related to people with disabilities and postsecondary institutions (National Council on Disability, 2003). Data can guide service providers in facilitating success in higher education for high school and college students with disabilities. College counselors can collaborate with faculty members to write grants or conduct research studies in order to better serve students at their institution. Several systemic issues that act as barriers to people with disabilities in postsecondary education can be addressed through systems advocacy.

Public Arena Advocacy

Social and political advocacy can be employed at the public level to advocate on behalf of groups (Toporek et al., 2009). Students with disabilities in transition would benefit greatly

from public arena advocacy. Counselors can join organizations advocating for change with this population. For example, the Council of Parent Attorneys and Advocates is a national not-for-profit organization that advocates for quality special education, transition services, and postsecondary training for students with disabilities. Joining forces with an existing ally of change may be helpful (Toporek et al., 2009).

The American Counseling Association advocacy standards (Lewis et al., 2003) also suggested that counselors lobby legislators and other policy makers in order to promote change for groups. The Consortium for Citizens with Disabilities is a national group that works to promote changes for people with disabilities. A special task force exists within this organization that focuses on higher education for people with disabilities.

Conclusion

In this article, we have presented suggestions for assisting students with disabilities transitioning from high school to postsecondary education institutions. Advocacy at the student, systems, and public area levels are essential in the effort to provide parity and equal opportunity for success to students with disabilities. Counselors are encouraged to consider advocating for students with disabilities in their own institutions.

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Barriers to Mental Health Utilization Among Latino/as: A Contextual Model and Recommendations

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Abstract

Latino/as in the United States face a number of considerable barriers to mental health services. This article provides mental health professionals with an innovative framework to organize barriers to mental health utilization unique to Latino/as, including barriers at the system and individual level. Special attention is placed on current historical events and the impact that context has on both the systemic and individual level. Based upon the identified barriers, a number of strategies are offered to improve utilization.

Keywords: access, barriers, Latino/as mental health services, model, treatment utilization

In the last decades, the United States (U.S.) has undergone dramatic demographic shifts. The changes in ethnic group composition continue to affirm the fact that the U.S. is rapidly becoming a multicultural, multiracial, and multilingual society (Chapa, 2004; White & Henderson, 2008). Latino/as, one of the groups contributing to the demographic shifts, currently represent the largest and fastest growing ethnic minority group in the U.S. with a population size of 50.5 million comprising 16% of the total U.S. population (U.S. Bureau of the Census, 2011). It is projected that by the year 2030 the population size of Latino/as would increment to more than 73 million or 20% of the U.S. population (U.S. Census Bureau, 2004). However, despite their increasing visibility in the U.S., Latino/as continue to face a number of challenges that affect their access to social services including mental health care (Rios-Ellis et al., 2005; U.S. Department of Health and Human Services, 2001). Although mental health utilization is low in the general population, numerous studies have reported that Latino/as in particular underutilize mental health services when compared to their European American counterparts (Alvidrez, 1999; Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999; Rosenstein, Milazzo-Sayre, MacAskill, & Manderscheid, 1987; Wells, Klap, Koike, & Sherbourne, 2001). For instance, among Latino/as with a mental health disorder, less than 1 in 11 (9%) report seeking treatment from a mental health professional. This number is even lower among Latino/a immigrants with less than 1 in 20 (5%) receiving services from a mental health provider (U.S. Department of Health and Human Services, 2001). Furthermore, even when Latino/as do access mental health services, their attrition rate is high, with more than 70% not returning to psychotherapy after their first session (Aguilar-Gaxiola, 2005).

It is imperative for mental health providers to identify, comprehend, and develop strategies to address factors that may be contributing to Latino/as underutilizing mental health services. The goals of this paper are twofold. One, provide mental health practitioners with an innovative framework to help organize barriers unique to Latino/as in need of mental health services including: barriers at the system and individual levels, while considering the current historical context where the system and individuals are embedded. Two, offer providers of

mental health services to Latino/as recommendations to address both systemic and individual barriers. Overall, our aim is to continue to highlight the importance of addressing barriers to mental health services with this growing segment of the U.S. population, while expanding methods to understand the complex factors contributing to the maintenance of service underutilization.

Barriers to Mental Health Service Utilization by U.S. Latino/as

Different ways to organize barriers to the provision of mental health services for Latino/as have been proposed in the literature (Barrio, et al., 2008; Martinez & Carter-Pokras, 2006; U.S. Department of Health and Human Services, 2001). What follows is a description of a new model that provides a paradigm encompassing two domains: systemic and individual barriers. What makes this model innovative is the integration of the current historical events across time, which we propose helps contextualize how both domains (i.e., systemic and individual) are impacted, exacerbated, and/or maintained (see Figure 1).

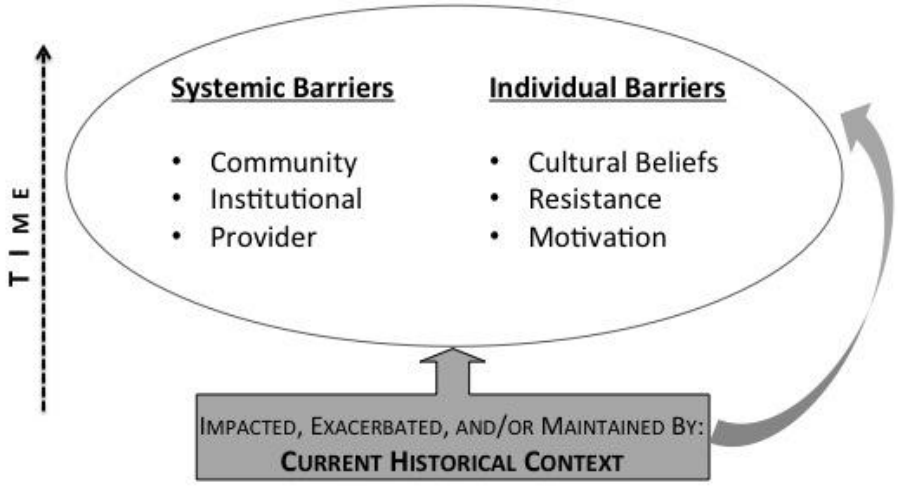

Figure 1. This model provides an illustration on how barriers to mental health utilization can be organized with an emphasis on integrating current historical climate to contextualize how different barriers are impacted, exacerbated, and/or maintained.

Within the system level, barriers are classified into three subdomains: community, institutional, and provider. At the community level, Latino/as experience a number of barriers to the receipt of mental health services. These barriers include the lack of information about where to seek treatment in a language that clients can communicate in. Another barrier related to the community level is the scarcity of treatment centers close to areas where services are needed; hence, making it difficult for clients to access services particularly when problems with transportation are also present. However, even when services are available in the community, clients are often placed on long waiting lists due to lack of therapists who are bilingual/bicultural and specifically trained to work with this population.

Additional challenges are faced at the institutional level. For instance, the literature posits that Latino/as living in communities not welcoming of their ethnicity often are fearful of accessing public health and human services (Gresenz, Rogowski, & Escarce, 2009; Moya & Shedlin, 2008). This fear may be due to mistrust of social and governmental agencies given past negative experiences, as well as the history of discrimination that communities of color have experienced from institutions. Such fear may be particularly heightened for undocumented Latino/a immigrants who are often worried about social service agencies reporting legal status information to the federal government. When fear or mistrust of public and human services is not a concern for Latino/as, insurance coverage becomes paramount. Generally, clients use their health insurance to cover health care expenses including mental health services. However, a disproportionately large number of Latino/as do not have health insurance coverage. In fact, in 2004, 33% of Latino/as were uninsured when compared to 11% of non-Hispanic Whites (U.S. Bureau of the Census, 2004). These figures increase for non-English speaking and immigrant Latino/as, making this group the highest uninsured in the nation (Collins, Hall, & Neuhaus, 1999; Rios-Ellis et al., 2005). Not surprisingly, uninsured individuals have poor health outcomes (Institute of Medicine, 2009). Such factors contribute to health disparities in the U.S. (American College of Physicians, 2004).

Key components to the systemic domain are barriers resulting from an inadequate system of education (White & Henderson, 2008). Our system of education lacks specific training to effectively assess and treat Latino/as. Such lack of specific training to work with individuals from the Latino/a community can be classified into three competency areas including: Spanish language proficiency, multicultural competency, and Latino/a specific cultural competency. Various reports show a lack of available Spanish-speaking providers who are both culturally and bilingually trained to meet the needs of U.S. Latino/as (Aguilar-Gaxiola et al., 2002). In fact, the norm is that there are few, if any, Spanish/English bilingual/bicultural staff in mental health agencies and fewer master's and doctoral level professionals (Adames, 2008; Guarnaccia, Martinez, & Acosta, 2005); thus, highlighting the need for mental health professionals who can provide services in Spanish is essential. The provision of services in the language of the client is not only ethically responsible but also directly linked to treatment outcomes. For instance, research has reported that clients who receive services from providers who do not speak their language are more likely to be non-compliant with medications and to miss their appointments, which often leads to poorer treatment outcomes (American College of Physicians, 2004; Thompson, 2005).

In addition to language proficiency, mental health professionals lack adequate training in multicultural competencies and Latino/a specific cultural competencies (Cho & Solis, 2001; White & Henderson, 2008). In order to optimize the level of care for Latino/as, more

consideration must be given to training programs designed to increase practitioners' awareness, knowledge, and skills in working with people from diverse backgrounds. We contend that it is imperative for providers to recognize both universal and relative Latino/a cultural factors that influence human development, diagnosis, and treatment (Casas, Pavelski, Furlong, & Zanglis, 2001).

As mentioned earlier, Latino/as seeking mental health services also face barriers at the individual level including, cultural beliefs, resistance, and motivation. Many Latino/as worry about the stigma associated with seeking mental health treatment (Guarnaccia, Martinez, & Acosta, 2005). As a result, Latino/as are likely to seek help for their mental health concerns from alternative **sources,** such as primary care physicians. Moreover, many Latino/as seek services that are more congruent with their cultural beliefs such as folk healers and religious/spiritual leaders (Applewhite, 1995; Comas-Diaz, 2006). Similar to other common factors, issues such as resistance, motivation, and readiness for change are also variables to consider at the individual level.

Considering Current Historical Events: The Role of Context

Traditionally, context has not been integrated into research that studies mental health service underutilization despite the agreement that systemic and individual barriers do not operate in isolation. Thus, in order to fully understand what impedes Latino/as from seeking mental health services, it is imperative to place both systemic and individual barriers within a current historical context. What follows is a description of two important areas to consider when contextualizing systemic and individual barriers to mental health service provision for Latino/as.

As noted earlier, the U.S. is in the midst of an unprecedented demographic shift which the literature refers to as the "Browning of America" (White & Henderson, 2008). These changes have made Latino/as more visible than ever in many spheres of U.S. society, which has its impact on the Latino/as community. In fact, there is evidence to suggest that such an increase in the U.S. Latino/a population, including both native born and immigrant Latino/as, is associated with anti-Latino/a sentiment (Rocha et al., 2011). Moreover, the Federal Bureau of Investigation (2004) reports that the number of anti-Latino/a hate crimes has increased by 35% since 2003. These alarming behavioral trends have the potential to cause increased levels of stress and anxiety, prompting the need for mental health care as well as increased sensitivity regarding this topic.

Another current historical event that may be a source of stress and anxiety for the general U.S. population, but for Latino/as in particular, is the economy. One of the most recent and significant historical events is the collapse of the housing market coupled with the collapse of U.S. banks. These events have negatively impacted consumer confidence and the world economy. Flores et al., (2008) documents the toll these harsh financial realities have on the mental health of U.S. Latino/as and underscores that Latino/a immigrants are often used as scapegoats during these difficult economic times. Although the U.S. economy appears to be climbing out of the recession, reports highlight that Latino/as have not benefited from such economic recovery as they are the only group of workers whose median earnings decreased during this time (Kochhar, Espinoza, & Hinze-Pifer 2010).

In addressing service delivery barriers of Latino/as, we propose that it is particularly important to understand the context in which they operate. Otherwise, identifying solutions to

address systemic and individual barriers is likely to be only partially successful; thus, the significance of the proposed model presented in this manuscript.

In general, the literature on Latino/a mental health service underutilization though growing is still quite limited specifically with regards to recommendations geared toward addressing systemic and individual barriers within a current historical context. The following section will present interventions that can be used to address barriers to mental health service provision among Latino/as.

Recommendations to Address Barriers to Mental Health Utilization for U.S. Latino/as

While the issue addressed in this paper has persisted for some time, it can be an easy problem to neglect in the press of day-to-day work with clients and the complexity of problems they present. As emphasized earlier, the goal of this paper is to highlight the importance of addressing barriers to mental health services to the growing U.S. Latino/a population while expanding methods to understand the complex factors contributing to the maintenance of service underutilization. The following recommendations, based on the model discussed in this article, provide a useful springboard to address barriers to mental health utilization by U.S. Latino/as. Consistent with our proposed model, the recommendations address challenges at both the systemic and individual levels.

Recommendations for Systemic Level Barriers

1. Increase the availability of Spanish-English bilingual mental health services. This recommendation is not a simple one, as the need for bilingual therapists is greater than the number of therapists available.
    a. There is a need to support and develop the future bilingual mental health workforce. However, many bilingual Latino/as face both financial and practical challenges that may prevent them from completing a degree in this field. Academic institutions can address some of these challenges by:
        i. Implementing discounted school registration, scholarships, loan repayment, and paid internships.
        ii. Helping students address some of the more practical challenges encountered by Latino/a students by implementing daycare programs, offering night and weekend educational programs, having satellite campuses in Latino/a communities, and providing academic support specific to issues related to bilingualism.
        iii. Developing mentorship programs to help students cope better with the challenges they face at school, increase their likelihood of graduating, while motivating them to pursue higher education.
    b. It is critical for agencies to invest in recruiting bilingual and bicultural mental health professionals. In order to do this successfully, it is essential for agencies to advertise through outlets most often used by Latinos/as to find job opportunities including: Latino/as organizations and associations, newsletters, and journals.
    c. Agencies should also consider using paraprofessional staff such as peer health promoters also known as "promotores de salud" in Spanish. These individuals can be very effective facilitating information, providing support, and connecting clients to important resources.
    d. When appropriate, it is important to provide clients with adequate interpretation services. Although the use of interpreters may not be the most effective option, due to the scarcity of bilingual mental health professionals, some organizations and professionals resort to this option. However, when using these services, both the interpreters and mental health

professionals should be formally trained in the process of using such services in counseling and assessment. Moreover, they should be able to take into account the variables that are impacted by this process including rapport building and nonverbal communication.

2. Increase mental health professionals' cultural competence.
    a. In order to provide effective mental health services, ongoing formalized training and specific education in areas of assessment and treatment of Latino/as and their families. Providers must understand the cultural factors that interact with Latino/as mental health and learn how to employ such knowledge in their clinical practice. Culturally responsive education should take place at both the formative and the continuing education level.
    b. Mental health providers must establish and maintain consultative relationships with other providers with whom they can obtain culturally appropriate consultation.
    c. It is also important for the field to hold providers and agencies accountable for their lack of cultural competence training, knowledge, and skills.
        i. Licensing boards should consider including specific questions about the Latino/a community in their examination of licensure candidates.
        ii. Accrediting bodies should be more strategic in their assessment of institutions' commitment to train students in areas of multicultural competence in general and Latino/as in particular.
        iii. Agencies providing services to Latino/as need to be accountable for hiring individuals who are competent to treat Latino/as or provide ongoing training and supervision.

3. Facilitate access to services. Agencies and mental health providers should revisit the manner in which services are provided (e.g., requiring clients to attend therapy once a week), the flexibility of their schedule (e.g., 9 a.m. to 5 p.m.), and their location (e.g., local office in the community, facilitate transportation, home visits).
4. Develop partnerships among local agencies and providers. Improving communication and developing collaborations among agencies and providers can result in positive outcomes that include the sharing of resources, reduction of waiting lists, and facilitation of referrals,
5. Recognize and reward agencies that have gone beyond the expectations to address the challenges Latino/as face when seeking mental health services. These agencies should receive public acknowledgement and when possible economic rewards such as grants.

Recommendations for Individual Level Barriers

1. Implement educational campaigns to reduce stigma towards mental health among the Latino/a community. Many Latino/as can benefit from social marketing campaigns that focus on normalizing mental health and help individuals to better understand the benefits of such services.
2. Given that Latino/a clients may not be familiar with the concept and the process of psychotherapy/counseling, it is imperative to educate Latino/a clients about the therapeutic process and clarify their expectations. Dedicating time to this process may reduce resistance and increase motivation in clients. Furthermore, Latino/a clients may benefit from spending additional time in the initial sessions getting oriented to process of psychotherapy/counseling while clarifying mutual treatment goals.
3. Both agencies and providers should strive to locate and obtain evidence-based practices for Latino/as by joining national organizations (e.g., National Latino/a Psychological Association) and subscribing to journals (e.g., Hispanic Journal of Behavioral Sciences; Journal of Latino/a Psychology) that specifically address the needs of this population.

Overall, we believe that although Latino/as have increased in size population; they continue to face significant challenges that prevent them from seeking and accessing mental health services. Nonetheless, there are many steps that can be taken to address such challenges and provide effective services to this growing segment of the population.

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