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The Alabama Counseling Association

J O U R N A L

ALABAMA COUNSELING ASSOCIATION

Enhancing human development throughout the life span

Promoting public confidence and trust in the counseling profession

Caring for self and others

Acquiring and using knowledge
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Encouraging positive change

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Letter From the Editor

If you are reading this journal, you are aware ALCA has moved from a "hard copy" to an "on-line" format. We are excited about this direction for our journal and look forward to maintaining the scholarly rigor, which previous editors and ALCA have worked hard to establish.

Moving to an electronic format was not an easy decision to make. The Executive Board and the Publications Committee had many discussions regarding this direction including exploring cost efficiency, credibility, and feasibility. After examining each of these areas thoroughly, it was decided ALCA could continue to publish a quality journal implementing this electronic format.

We are now working with ERIC to have our journal indexed. This is extremely important for our authors, both in the private and academic setting. Individuals, who wish to contribute to existing literature, should be assured professional colleagues are able to search and find their scholarly contribution. I expect this process to be completed within the next few weeks.

I wish to thank the members of the Editorial Board who have patiently "hung in there" with me as we continue to streamline our review process. ALCA has some of the best scholars on the Editorial Board. Their contribution to this journal is very much appreciated. Additionally, I would like to thank Ms. Rhiannon Reese, a graduate student at UAB for her help with making the transition to electronic format. Her assistance has been invaluable.

Lawrence Tyson, PhD, Editor

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Table of Contents

Articles — Page

What School Counselors Need to Know About Students Who Self-Injure

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Abstract

The following paper is a summary of the literature on self-injury focusing on knowledge useful to school counselors. The paper includes basic knowledge needed to assist the school counselor in making informed decisions and suggestions for helping the student through creating a supportive environment.

> "For many in the younger generation… the body is a critical message board, a way to convey in formation about the self" (2006, p. B8)
> "I hurt myself today…to see if I still feel…I focus on the pain…the only thing that's real" (Reznor, 1994,Stanza 1)

What Is Self-Injury?

The definitions of self-injury are as numerous and vary among the authorities. The definition most commonly found throughout professional articles describes self-injury as a "direct, deliberate destruction or alteration of one's own body tissue without conscious suicidal intent" (Favazza, 1996, p. 226). Put simplistically self-injury is purposely hurting oneself, without suicidal intent. Self-injury behavior has been listed in the literature as

> "autoaggression, intentional injury, symbolic wounding, malingering, Munchausen syndrome, deliberate self-harm, self-abuse, local self-destruction, delicate self-cutting, self-injurious behavior, aggression against the self, parasuicide, attempted suicide, and focal suicide" (p. 233).

Self-injury can include any one or more of the following means of harming oneself: cutting, scratching, picking at scabs or hindering healthy wound healing, skin carving, burning, abrasions, biting, self-punching, injecting/sticking objects beneath the skin or into the body, infecting oneself, branding, bruising, and breaking bones (S.A.F.E.. 2007"Self-injury facts,"). This list could possibly be extended as adolescents explore more methods of physical self-injuring to achieve the same emotional results.

Adolescents who self-injure typically cut into and on their skin. Froeschle and Moyer (2004) reported that the type of self-injury most commonly seen in adolescents is superficial damage to the skin, like carving marks, scratching or scraping, piercings done with needles, and slight burn mark. Austin and Kortum (2004) stated the most common method of adolescent self-injury is cutting with razor blades, knives, or burning with matches.

Favazza (2006) separated self-injury into two broad categories. The first of these is culturally sanctioned, which includes customs and ceremonial practices. The second is deviant-pathological, which is further split into three areas based on the amount of physical damage and the behavior's frequency and patterns.

Culturally sanctioned body modification includes culturally common rites of passage into adulthood such as circumcision, tattooing, lip piercing, ear piercing, and foot binding, which are parts of various cultures' healing, spirituality, and social order (Favazza, 2006). These body modification rituals are practiced in the belief that they will correct or prevent threats to the stability of the society: disease or angry gods. These culturally sanctioned practices are not considered to be self-mutilation.

Deviant-pathological self-mutilation is divided into three major areas: major, stereotypic, and moderate/superficial. According to Favazza (2006), major self-mutilation involves infrequent acts of self-destruction that result in great physical damage and are most commonly associated with psychosis and/or drug and alcohol use. Castration and limb amputation are included in this category. Stereotypic self-injury refers to repeated acts that seem to follow a pattern, such as head banging. Stereotypic self-injury is most commonly seen in "institutionalized mentally retarded persons" and individuals with Autism and Tourette's Syndrome Moderate/superficial acts of self-injury are the most common and usually result in little permanent physical damage and low risk of death. These acts include "hair pulling and skin scratching, picking, cutting, burning, and carving … (as) the most commonly encountered forms of self-mutilation" (p. 241). Moderate/superficial self-mutilation lacks a pattern and usually "requires the use of implements such as (matches, pins, or razors) in a complex sequence of events" (p. 233).

Favazza (2006) stated that the most common type of self-mutilation is the moderate/superficial category of injury. Strong (1998) agreed with Favazza that the most common type of self-mutilation falls under moderate/superficial, and she adds that the behavior usually exists of "controlled and relatively shallow cuts" (p. 27) in one's skin.

Favazza further breaks down moderate/superficial self-mutilation into three types: compulsive, episodic, and repetitive. "Compulsive self-mutilation occur(s) many times daily and (is) repetitive and ritualistic" (p. 242). Episodic self-mutilation is usually present alongside a mental disorder, like anxiety or depression. This type of self-mutilation follows a theme: to release tension, to snap back to reality, to gain a sense of control, to promote feelings of security and to feel special, to influence others' reactions or emotions, to deal with negative perceptions of oneself, to release pressure from multiple personalities, to enhance or repress sexual urges, to increase positive feelings and emotions, to vent anger, and/or to provide relief from alienating feelings (Favazza, 2006; Strong, 1998)

In the school settings, counselors will encounter youth who engage in episodic self-injury, which is often a learned reaction or coping mechanism in response to one of the above themes. Strong explains "the difference (between episodic and repetitive) is in the frequency and the importance these acts come to assume in a person's life" (p.27). As a coping skill for teenagers, episodic self-injury is used in place of healthier communication and emotional release.

Self-injury is observed more often in females than in males. Researchers suspect that just as many males self-injure as females. Males may be able to hide self-injury because of the ease of their ability to explain cuts or marks on their skin as a result of scuffling, fighting, or physical work but that is most likely a misconception (Alderman, 1997; Favazza, 1996; Strong, 1998).

The ages at which students begin and end self-injury vary. White-Kress, Gibson, and Reynolds (2004) stated self-injury begins in middle adolescence, with the first occurrence in most often occurring about the ninth grade. White-Kress, Drouhard, and Costin (2004) indicated that age eighteen is the average age self-injurious behavior ceases. Therefore, high school counselors are most likely to have daily contact with high risk adolescents within this self injurious behavior age range. High school counselors are in a position to intervene and to make referrals for students at the onset of self-injurious behavior and throughout high school.

What Is Not Self-Injury

Self-injury is very often misunderstood. Favazza (1996) said "all living creatures share in the struggle for survival and the avoidance of pain" (p. 226). Although self-injury appears to go against basic human survival and self-protection, the behavior is not suicidal. Accidental suicide should always be a concern; however, as a result of cuts that go too deep or wounds that are dangerous (Levenkron, 2006). Allen (1995) explained "self-harm is a problem with an unparalleled ability to evoke rage, terror, punitive feelings, and disagreement… perhaps because it is seen as both dangerous and willful" (p. 248). Self-injury can induce strong reactions in others, but Allen reminds us that "self-harm is not primarily intended to 'manipulate' or upset others. The self injury can be viewed as part of a struggle to cope with conflicts within the self. Austin and Kortum's (2004) research supported the idea that self-injury is not intentionally manipulative because the behavior itself is so shameful and hidden to those doing it. Self-injury is usually kept hidden from others, not displayed or shown off. The authors expressed that self-injury is not intended to attract attention from others, although self-injury may feel circuitous to those who observe it.

Reasons Students May Self-Injure

Strong (1998) explained that people who do not cut or self-injure may see the behavior as self-destructive, masochistic, or irrational. However, self-injury has meaning for the person who self-injures. Self-injury fulfills something in an individual that other actions or behaviors cannot, and to an emotionally fragile adolescent self-injury can be very consequential. Research consistently indicates that self-injury is a maladaptive means of coping performed by an individual with poor problem solving skills; it is a temporary way of managing overwhelming emotions and an attempt to heal oneself (Favazza, 2006; Levenkron, 2006; Strong, 1998).

Alderman (1997) suggested that by self-inflicting pain and injury, an individual may be trying to nurture and heal. An external, visible wound is easier to attend than a non-specific, intangible hurt, and even though hurting oneself seems contradictory, she states "by nurturing and taking care of … physical wounds, [the student] is actually caring for internal scars. As odd as it may sound, [self-injury] may actually be a way for [one] to physically and psychologically take care of [oneself]" (p. 45).

Deiter, Nicholls, & Pearlman (2000) examined the relationship between self-injury, childhood abuse, and self-capacities in adults, and found that self-injuring individuals had greater than average weaknesses in their self-capacities, which include the abilities to deal with strong emotions, have a sense of self-worth, and connect with other people. Individuals who do not have adequate self-capacities most likely have poor relationships with others and low communication and coping skills, and may turn to self-injury as a strategy to maintain emotional equilibrium.

Other researchers put more weight on relationships, or lack thereof, with parental figures, and the communication within these relationships. Coy and Simpson (2002) explained "…the common quality (in individuals who self-injure) is the literal or symbolic loss or disruption of a significant relationship" (p. 18). This loss or disruption leads an individual to believe the only option to communicate emotional distress is self-injury.

Strong (1998) wrote that in most incidents of self-injury behaviors are generated by fear of being abandoned, whether or not the abandonment is real or just perceived by the individual. These feelings of "tension, anger, rage, fear, anxiety, panic" (Strong, 1998, p. 55) build up until they are overwhelming and the individual feels he cannot maintain control. Because self-injuring individuals do not know how to regulate these strong emotions by communicating in a healthy way, they must be dealt with by an equally strong action.

In a study of children and teenagers hospitalized for self-mutilation, Strong (1998) described what self-injury can mean to those who do it:

> …the researchers viewed self-injury as serving a variety of purposes for these abused kids: a cry for help, an outlet for pent-up rage, a means of self-punishment, a controllable method for reducing emotional trauma, a form of 'body stimulation' for children who had

> become inured to pain as a result of physical and sexual trauma, and a way of feeling something other than despair (p. 52).

Alderman (1997) explained that self-injury is "actually a method of sustaining life and coping during an emotionally difficult time… helps some people feel better by giving them a way to physically express and release their tension and emotional pain" (p.7). She suggested that self-inflicted violence is one way of exerting power over one's body and asserting a sense of independence, which is an important factor for adolescents and school-aged individuals.

Alderman says the following about adolescents and their need for independence:

> "One of the new things adolescents must learn to deal with is increased need for autonomy and control that accompanies adolescence. Adolescence is the time in life when you start to achieve a real sense of yourself as an independent and autonomous person, capable of making your own choices and decisions…When you injure yourself, you are demonstrating (if only to yourself) that you are in complete control of your own body, and in that respect you have autonomy" (p. 17).

Adolescence is a time of "finding oneself," and often teenagers feel like they do not fit in anywhere or with anyone. Strong (1998) reiterated this by saying that adolescence is a difficult time for individuals who have poor coping or communication skills. She explains that adolescence is marked by coming to terms with the person's sexuality and all the anxieties and responsibilities of becoming an adult.

Alderman (1997) explained that one widely recognized factor in the study of self-injury is the individual's need for an immediate endorphin rush. These hormones, released by the body in times of stress, pain, or anxiety, result in a pleasurable sensation and often block out the physical pain caused by self-injury. The behavior becomes a way of self-medicating that can become habit-forming or even addictive. Eells (2006) supported the theory of endorphins by explaining that endorphins provide a numbing or high feeling which may temporarily relieve the emotional pain. Self-injury then becomes part of a cycle in which the individual does-not learn how to appropriately recover from emotional states without the act of self-harm.

Self-injury can be a form of self-punishment, typically as a result of abuse suffered in the past. Abuse in one's past can cause individuals to reenact the abuse or physical pain in order to gain a sense of control that was taken from them in the original case of abuse, or even as a flashback of post-traumatic stress (Alderman, 1997). When an individual feels out of control, self-injury might give a sense of structure, or a sense of being in control. In much the same way, negative thoughts can also be controlled through self-injury. "By changing [one's] behaviors, emotions, or physical sensations, [one] can also affect [one's] thoughts…. Therefore, [one] may hurt [one's self] in order to control intrusive, obsessive, or otherwise unwanted thoughts" (p. 51).

Strong (1998) wrote:

> Whatever the source, the child is left feeling emotionally abandoned, [the child's] unmet needs and unsoothed fears create an overwhelming level of anxiety. Later in life, cutting or burning becomes [the child's] primary strategy for regulating … emotions and avoiding further mental deterioration. It is a means of self-soothing and in that sense can be viewed as a flawed attempt at self-mothering (p. 48).

Development and Possible Causes

Conterio, Lader and Bloom (1998) explained self-injurers can have a varied background and history. While some may grow up in homes with healthy families, others may suffer abuse or neglect. Some may be children of alcoholics, addicts, or parents with mental illness. Some might have been on the receiving end of constant criticism, or maybe they were punished and ridiculed for displays of emotions. Other self-injurers might have struggled with families that offered no guidance for appropriate communication. The authors explain that the first time an individual self-injures the injuries are most likely accidental. Somehow the resulting wound or

bleeding turned out to be cathartic and the individual realized that this behavior made him feel immediately better. Allen (1995) cited three reasons people learn that self-injury is beneficial: 1) they learn they can manage their moods or feelings, 2) they learn to punish themselves in response to negative beliefs about themselves or perceived wrongdoings, and 3) they learn they can manage interactions with other people: their self-injury causes reactions in others and then their emotional needs are indirectly met.

To further explain how self-injury can manage moods or feelings, research by Austin and Kortum (2004) said "most students self-injure themselves because they are unable to handle intense feelings, and so they turn to self-injury as a way to express their feelings and emotions" (p. 518). Favazza (2006) and Levenkron (2006) further explained why self-injury might be in response to negative beliefs about oneself. An individual who has been abused might use physical pain to diminish emotional pain, which is harder to typify. Thoughts and emotions, which are intangible, are harder to understand than something that is physical, which can be seen and felt. Physical expression of emotional pain allows the individual to have concrete evidence of that which seems intangible, amorphous, or indefinable (Alderman, 1997). Self-injury may also be a learned act of anger turned towards oneself because to direct it at another person might be physically impossible (towards a past abuser), or emotionally risky (towards a parent) (Levenkron, 2006).

Managing interactions with other people is often a result of families frequently avoiding or sometimes punishing direct communication (Eells, 2006). An individual's attempts at healthy communication of needs and feelings were not supported and self-injury is the only way one feels one can express individual gains self-expression. The self-injury becomes a learned behavior because other attempts at communication or expression fail (Allen, 1995; Eells, 2006).

Best Practices for School Counselors

School counselors must balance providing guidance for students with a teenager's need for autonomy. As we all know, teenagers can be an enigma without adding the issues of self injury. If self-harm is connected with low self-esteem, lack of self-confidence and high levels of anxiety, schools need to ask themselves what they can do to promote a healthy self-concept and equip young people with the confidence and skills necessary to handle problematic situations without experiencing overwhelming levels of anxiety (Best, 2006).

The American School Counselor Association (ASCA) Ethical Standards for School Counselors (2008) specifies the school counselor's primary obligation is to the student, and the counselor should be "concerned with the educational, academic, career, personal and social needs and (should) encourage the maximum development of every student". Working with a student who self-injures, the school counselor can help by listening; encouraging support and, if necessary, intervention; encouraging the student to advocate for himself; and making referrals to appropriate community resources.

Austin and Kortum (2004) wrote

> …it seems that through …body language, self-injuring children and teenagers can communicate much more directly and forcefully than they can speak in words. Because of this same inability to communicate, many of them cannot or do not like to go to professionals with their problems…. The professional must initiate the first step of communication (with students suspected of self-injury) and yet at the same time give the teenager power to communicate back" (p. 521).

Alderman (1997) supported this by reminding us that self-injury can be a means of communicating that an individual is deeply hurting or suffering psychologically. If a student tells a trusted teacher or counselor about his injuries, he may be trying to talk or start a conversation about his struggles.

Best's (2005) research with school staff showed that a few students had occasionally engaged in self-injury, including cutting, while at school. He reported that while many teachers did not seem to

know what self-injury was, or understand it, teachers are in the best position to see and report self-injury in their students. The school counselor's role is that of providing training and educational opportunities for the entire school on student self-injury.

In support of what school counselors can do for students who self-injure, Coy and Simpson (2002) maintained that the intervention limitations placed on school counselors through local policies and state guidance plans prevents school counselors from providing more than crisis intervention with these students. They suggest working with local "experts" in the field and using these professionals to train counselors and school staff for the extended support that these students may need. A counselor who is educated and understands self-injury is better able to connect with and provide services for students who self-injure. The student is likely to need continued support during times when school is not in session. Therefore, a school counselor should see themselves as a support person for the primary care mental health worker, who can provide on-going care.

Crawford, Geraghty, Street, and Simonoff (2003) advocated training for all staff within the school and community who will be working with youth that self-injure, including counselors, teachers, coaches, administration, and health care providers. They suggest that if education can identify "evidence-based, effective treatments" then staff will feel more comfortable working with self-injury. The school counselor's role is to locate the appropriate training and to schedule the training through the school's route of in-service provision.

White-Kress et al. (2004) suggested that the school counselor's main goal to be to maintain a safe and trusting environment at school for self-injuring students to talk if necessary, with an emphasis on "structure, consistency, and predictability" (p. 17), until community counseling can begin. The counselor working with other school personnel and behavioral committees, would initiate the school personnel to identify a safety plan that details what the student feels his or her triggers are so the student can try to avoid them, what has been previously effective in reducing the behavior, who are safe people and where are safe places the student can trust and contact in times of need, and avoidance of tools used previously for self-injury. The safety plan would stress the importance of not having tools on campus, both for personal safety and adherence to school policy.

McAllister (2003) encouraged the school counselor to listen attentively to the student and the student's reasons for self-harm rather than making cause and effect assumptions about the behavior. By remaining open to the student's interpretation of the events, the school counselor can reframe the self-injury as a coping skill rather than a harmful act upon oneself. Seeing the behavior as purposeful and necessary for the student's personal concept of well being, and not just as a symptom of a bigger problem, can help school counselors clarify the behavior to the faculty and help to create a less stressful environment for both the school and the student. Societal attitudes towards mental health and well-being definitely impact the reactions of faculty, staff, and students to students, who are purposefully harming themselves. The school counselor can better serve this population of students by providing education and awareness of the behavior through in-service and guidance activities. Through gaining a better insight into the behavior, the self-harming students can better be served, as well as the community at large in creating an enlightened environment for understanding and removing the alarm that many people feel with the discovery of the behavior (Best, 2006). Although there are no clear guidelines or ethical standards for dealing with students who self-injure, Alderman (1997) suggested that counselors follow this principle regarding reporting the behavior or not: "…do the risks of our actions surpass the benefits that may derive from these actions?" (p. 202). Alderman also suggested that school counselors remain aware of the shameful feelings self-injury brings for the individual, and maintain appropriate boundaries when working with these students.

Malikow (2006) cautioned against focusing too much attention on the self-injury behaviors. He says that a relationship between student and school staff that is built on the self-injury reinforce and encourage the behavior. The school counselor's role is to help school faculty and staff to realize that asking about the behavior or talking about it to the student is not appropriate, as this attention may exacerbate the behavior. The

faculty and staff can be encouraged to provide the student with attention in areas that are not related to the self -injury, i.e., perfect attendance, prepared lessons, participation in sports and school functions.

When working with a self-injuring student, Conterio et al. (1998) encouraged counselors to believe self-injury is not an attempt at gaining attention. They feel that statements made to that effect will only "belittle" the distress an individual feels. The authors offer three guidelines for school counselors NOT to try with clients who self-injure. They suggest discouraging individuals who want to show or describe their wounds or incidents of self-injury. Focusing on the marks instead of the underlying issues is not what is best for the student. They also discourage encouraging alternate behaviors, like snapping a rubber band on the wrist or drawing "cut" marks. Destructive acts should not be encouraged in any way. Lastly, they discourage any physical anger or release, saying … "these methods tend to reinforce the erroneous belief that feelings of anger must inevitably bring about an expression of violence…" (p. 189). The authors firmly believe that the "fully functioning, healthy adult" (p. 189) expresses emotions and anger verbally and appropriately, and encouraging or supporting other methods will not cease self-injurious behavior. School counselors participating in the building wide treatment plans will want to be cognizant of these guidelines in the development of the individual plan for the student who self injures.

Allen (1995) supported this belief by saying that "… it is vital that healthy and appropriately assertive expression of negative feelings is encouraged and rewarded" (p. 248). If self-harm is a way of expressing and communicating distress or anger, then these individuals may have to learn appropriate releases. The school counselor will need to work with the primary mental health worker to help develop a strategy that will reinforce the learning in appropriate emotional expression. This step in the intervention requires that the school counselor and the building based intervention committee work closely with all the mental health providers to create a consistent and supportive environment for the student.

Notifying parents of the self-injury may pose some special problems and considerations for the school counselor. School counselors must keep in mind the best interest of the student before contacting the parents. Strong (1998) said "…when the scars are uncovered and … their children's pain is revealed, some parents respond with anger and annoyance rather than sympathy and understanding. They overreact …, only driving their symptoms further underground. Other parents under react, dismissing the cuts, bruises, and broken bones as melodrama" (preface, p. 19). The school counselor who is prepared with educational information, referrals, and an understanding of the student's family life will be more likely to approach the parents in a way that they can understand and be helpful to the student. The parent needs to be informed of the school's role in any interventions and how the school counselor intends to help provide a supportive environment for the student. Parents do have the right to deny services for minor children; therefore, the school counselor may have to call upon his or her skills of persuasion to illicit the cooperation of the parent in helping the student.

Froeschle and Moyer (2004) cautioned school counselors working with students who do not want to share information with their parents. Consulting with other counselors, being familiar with state law, and keeping appropriate records are just a few of the guidelines to follow, but knowing your school and district policy regarding disclosing information to parents is the first place to start (Froeschle & Moyer, 2004). White-Kress et al. (2004) encouraged school (I am guessing that the author means 2006 because that is what is in the reference section) counselors to always contact parents in cases of self-injury, even without threat of suicide or serious harm. If there is concern over disclosing to parents, they suggest consulting school administration and the school district attorney. Because self-injury involves the possibility of accidental death, school counselors must carefully consider referring the student to mental health for an evaluation if the student is clearly a danger to himself or herself. One should always consult and refer to school protocol when available (ASCA, 2008) and include the parents when possible.

Roberts-Dobie and Donatelle (2007) encouraged school counselors to take on a dual role, of coordinator and liaison, to help students who self-injure. School counselors can coordinate education of faculty and staff in position to recognize and report self-injury. In addition to school personnel, school counselors should educate students and families. Students can be taught the signs of self-injury within an existing health curriculum and

how to refer a friend to a trusted adult. Educating families informs parents of school policies regarding student self-injury, plus it teaches parents to recognize warning signs in their own children. Some ways to provide assistance to families is to have links on a counseling website to many concerns of adolescent and child mental health problems, including self-injury. The school counselor needs to maintain a local file of referrals that are knowledgeable in the various areas of mental health concerns of youth. Being a liaison links the school counselor between school and community systems, including possible free and low cost resources for families within the community to select among for services. School counselors want to remember that referrals to sources outside of the school can result in the school district being required to contract and pay for student services received. Referrals of this nature are best posed and discussed through the committees that are part of the normal referral system within each school district, and used only when the school district cannot provide adequate services.

According to Roberts-Dobie (2004), the school counselor can help maintain students' well-being and ensure a successful academic environment for them by providing a safe outlet in case students needs to talk or need to be alone, or by addressing concerns to the student's teachers or parents. In addition, the student may need a Section 504 Plan, or a health care plan to further his safety while in school.

All schools should develop and implement plans for working with students who self-injure. Eells (2006) urged that the plans should line out specific protocol and roles of everyone involved, from administrators to staff members. Ideally the plans would include education about self-injury and training for all staff members.

White-Kress et al. (2004) encouraged school counselors to become part of a policy making system within their schools. The author stresses school policies that address the following questions: when and to whom teachers and other staff report student self-injury; what is the role of administration, the school counselor, and the school nurse; and what is the policy on parental notification and other involvement. Having an established policy helps protect students, counselors, and the school itself. Onacki (2005) suggested school policy be developed using the nurse, counselor, and administration as facilitators of the plan. She encourages a policy that involves educating students and encouraging healthy communication, educating staff members on how and when to report, and working collaboratively with parents and the community.

Summary

In conclusion, school counselors have obligations to their students, their school and district, and themselves. Self-injury is a serious and dangerous phenomenon, and to provide the best services possible to our students we need to become educated about self-injury, aware of our own reactions to it and the limitations we have in working with self-injuring clients, and we must become active in developing a response to students in need. Our roles as school counselors are multi-faceted, and providing appropriate services for students in their educational setting remains our main goal.

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Obtaining Counseling Licensure in Alabama

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Abstract

This article describes the historical development of counseling licensure and explains the process for obtaining the Licensed Professional Counselor credential in the state of Alabama. The process of obtaining counseling licensure involves fulfilling an academic requirement, submitting an application, obtaining supervised experience, passing an examination, and some other miscellaneous requirements.

Many counselors-in-training find themselves confused about the process of obtaining the Licensed Professional Counselor (LPC) designation in the state of Alabama. This article seeks to reduce such confusion by presenting a concise description of the process required by the Alabama Board of Examiners in Counseling (ABEC). Because the intention for this article is to be brief, what follows is a general description of the requirements for licensure. Exceptions and caveats exist and the interested reader is encouraged to explore the state code of Alabama and the administrative code related to counseling, which can be found at www.abec.alabama.gov. In addition to an overview of the licensure process, the historical development of licensure will also be reviewed.

Historical Development of Licensure

Licensure is a state authorized process of regulating the title and practice of a particular profession (Forster, 1977; Fretz & Mills, 1980; Gross, 1978). Counselor licensure was a milestone for the counseling profession because it led to a stronger counselor identity (Geisler, 1995) and offered credibility to the profession (Davis, Witmer, & Navin, 1990). Professionals with licensure are seen as having more experience and knowledge by the consumers they serve (Davis, 1981). As Forster (1978) stated, “Licensure seems to have become the focal point of the profession’s search for additional credibility, which is the purpose of credentialing” (p. 596). In addition to bringing recognition to the field of counseling, one of the original arguments for licensure was to protect the public from incompetent practitioners (Fretz & Mills, 1980).

In 1975, the American Personnel and Guidance Association (APGA), now the American Counseling Association (ACA), established a Licensure Commission (Cottingham & Warner, 1978). Multiple events led to the development of the licensure commission. Counselors were being sued by practitioners in other fields, such as psychology, for infringing on their profession and, by their standards and definitions, practicing psychology without licensure (Cottingham & Warner; Warner, Brooks, & Thompson, 1980).

In 1967, the American Psychological Association (APA) committee on legislation proposed more precise language in psychology licensure laws (Bradley, 1995). These changes in licensure laws led to multiple court cases in the late 1970s focused on the practice of allowing those outside the field of psychology to become licensed. Court cases were brought as a result of the definition of the practice of psychology which included many elements of the practice of counseling. Psychology was a licensed profession while counseling was not and because of this, counselors had no legal rights to engage in psychological practices (Cottingham & Warner, 1978).

As a result of these court battles, three major events occurred. First, many states began to deny those not trained specifically in psychology the opportunity to sit for the licensing exam (Cottingham & Warner; Fretz & Mills, 1980). Second, in 1973, the southern division of the Association for Counselor Education and Supervision (ACES) created the first committee on counselor licensure (Bradley). Third, in July of 1974, the APGA encouraged members in all states to begin lobbying for state licensure (Warner et al., 1980).

Many rationales were given for counselor licensure laws, all of which had growing the profession at their core. First, for counselors to be recognized nationally, a registry was needed to signify that members of the profession had a distinct set of skills apart from those in other related fields (Cottingham & Warner, 1978). Second, licensure laws were intended to reflect the professional standards established by the APGA. The relationship between licensure requirements and professional standards helps to further define the field (Arbuckle, 1977).

As a result of internal and external pressures, counselors began calling for state licensure laws. It was understood by practitioners at the time that it would be difficult to have licensure laws established (Cottingham & Swanson, 1976). Legislators were reluctant to establish laws for fear of restricting consumer choice. In addition, psychology and social work organizations lobbied against counselor licensure laws to protect their own professional interests (Brooks & Gerstein, 1990). Despite these hurdles, Virginia passed the first counselor licensure law in 1976 (Cottingham & Warner, 1978; Warner, Brooks, & Thompson, 1980). In 1979, Alabama became one of the first states in the country to adopt counseling licensure laws (Ala. CODE §34-8A-1, 1979). Currently, the ABEC webpage lists 1581 LPCs (ABEC, n. d. b) and 285 Associate Licensed Counselors (ABEC, n. d. a).

Steps Toward Obtaining Licensure

In order to obtain the LPC designation, several steps must be completed by the applicant. These steps include (a) fulfilling the academic requirement, (b) submitting an application, (c) obtaining supervised counseling experience, (d) passing an examination, and (e) completing some final miscellaneous steps.

Fulfilling the Academic Requirement

Any person wishing to obtain the LPC designation in Alabama must first fulfill the academic requirement. Persons must hold a master's degree from a regionally accredited university in a 48-hour counseling or closely related program. Counseling programs must adhere to nationally recognized training standards, such as those set forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or the Commission on Rehabilitation and Education (CORE). If the applicant's master's degree is not CACREP or CORE accredited, he or she must be able to show that the program's content is equivalent to programs that are accredited (Ala. CODE §34-8A-7, 1979; ABEC, 2006a).

Submitting an Application

After graduating from an approved master's degree program, persons seeking licensure are eligible to submit an application to the Alabama Board of Examiners in Counseling ("the board") (Ala. CODE §34-8A-8, 1979; ABEC, 2006b). A complete application consists of: the (1) main application, (2) course worksheet, (3) plan of supervision and (4) letters of recommendation. The Plan of Supervision may be sent at a later time if the applicant has not obtained a supervisor at the time of application. However, the application is not complete without it. Before the applicant can perform any counseling duties, the application must be approved by the board, the licensure fee must be paid by the applicant, and the license certificate must be issued by the board (Ala. CODE §34-8A-8).

Once a person has received approval from the board, that person becomes an Associate Licensed Counselor (ALC) and can begin counseling-related activities under the direct supervision of the board-approved supervisor (Ala. CODE §34-8A-8, 1979). The board currently approves ALC applications for a period of two years. At the end of this time, ALCs must submit proof of 20 hours of continuing education, 3 hours of which must

be focused on ethics, and a renewal fee for the renewal of the ALC designation (ABEC, 2006e).

Obtaining Supervised Counseling Experience

Two criteria exist regarding supervision and counseling experience hours. ALCs must spend a minimum of 100 hours in supervision annually. Of the 100 hours, 50 hours must be spent in individual face-to-face meetings with the supervisor (ABEC, 2006b). In addition to the supervision hours required, ALCs must obtain a minimum of 3,000 hours of supervised clinical practice (Ala. CODE §34-8A-7, 1979). Of the 3,000 hours, 2250 hours must be hours spent directly counseling individuals, couples, families, or groups. The remainder of the 3,000 hours can be indirect hours related to documentation, consultation, and referral development. The board allows ALCs to subtract 1,000 hours by completing 15 post-masters graduate hours in counseling. ALCs can subtract a total of 2,000 by completing 30 post-masters graduate hours in counseling. However, ALCs must complete a minimum of 1,000 hours of supervised practice, including 750 hours of direct service and 250 hours of indirect service (ABEC, 2006a).

Passing an Examination

All licensure applicants must show competence by passing an examination (Ala. CODE §34-8A-7, 1979; ABEC, 2006a; ABEC, 2006b). The current examination used by ABEC to establish counseling competency is the National Counselor Examination (NCE). Applicants are eligible to take the exam immediately following the completion of the academic requirement (ABEC). Taking the examination soon after graduation may be beneficial to the applicant because many universities require a similar exam for graduation and this material will still be fresh in the applicant's mind if the NCE is taken soon after graduation.

Miscellaneous Requirements

Several requirements fall into the miscellaneous category. Licensure applicants must (a) show that they are at least 19 years old (Ala. CODE §34-8A-7, 1979), (b) be of good character (Ala. CODE §34-8A-7), (c) submit an official academic transcript (ABEC, 2006c), and (d) not be in violation of any part of the state code of Alabama related to counselors (Ala. CODE §34-8A-7). Applicants must show character and professional integrity by furnishing a minimum of three references and endorsements specifically related to the applicant's clinical work, rather than character references, to the board (ABEC, 2006a; ABEC, 2006d). Upon successful completion of all the requirements, the board will meet to vote on approving the applicant for licensure.

Conclusion

While the process of becoming licensed may be time consuming, it does not have to be confusing. Licensure has elevated the field of counseling to a profession. Licensure has increased professional identity and defined what counseling is (Bloom et al., 1990). Davis (1981) articulated the recognition of licensure when he stated that "licensing marks the evolution of counseling from an occupation, a varied collective of practitioners with many common interests and skills, to a profession" (p. 83).

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Individual and Family Resilience: Definitions, Research, and Frameworks Relevant for All Counselors

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Abstract

The author provides a brief review of the clinical and research literature on individual and family resilience. The review includes resilience-focused frameworks that may have relevance to counselors working in varied contexts who provide strength-based counseling. School, family, and mental health counselors are encouraged to consider the potential utility of infusing the construct of resilience in future research and helping intervention and treatment efforts.

Introduction

Considerable research has been devoted to the study of resilience in order to better understand individuals and systems that display adaptation in spite of earlier risks. Researchers have long been intrigued by what contributes to positive adaptation and associated outcomes in the face of adversity (Luthar & Zigler, 1991; Rutter, 1987, 1990, 1999; Garmezy, 1999; McCubbin & McCubbin, 1988; Walsh, 2003; Werner & Smith, 1982). The concept of resilience, as originally conceptualized by developmental psychologists and psychiatrists, grew out of concern for identifying and ameliorating risk factors that could negatively affect children's development and well-being. These early explorations of risk factors were primarily viewed from a deficit framework. That is, researchers explored outcomes from a psychopathology perspective in search of risk factors that would predict specific negative outcomes related to adverse events and environments.

However, this early deficit framework soon gave way to a strength framework, when researchers discovered that some children did well and grew into healthy, adjusted adults despite living in poor environments during childhood (Werner, 1993; Wolin & Wolin, 1993). Thus resilience is germane and applicable to adults as well. More recently, some researchers and theoreticians (Luthar & Brown, 2007; Walsh, 2007) have suggested that resilience is evidenced *because of* the challenging environment, not *in spite of* it. Psychologists, counselors, and other human helpers have now recognized that even in the worst conditions and environments, positive outcomes can be experienced. Indeed, some scholars have reported that resilience is more the rule than the exception (Waller, 2001).

This article describes the construct of resilience and reviews various conceptual frameworks that emphasize strengths rather than deficits among persons who experience varying degrees of adversity, trauma, and stress. Such a review is important for several reasons. First, it summarizes the theoretical and empirical foundation for exploring adversity from a strength-based, wellness perspective. This approach shows how a different trajectory may be experienced after childhood adversity. Second, this review considers both individual and environmental factors. As Fraser, Richman, & Galinsky (1999) stated, "individual attributes that produce resilience under one set of environmental conditions may not produce resilience under another set of environmental conditions" (p. 10). Third, the frameworks described in this review will help researchers and practitioners reconceptualize negative outcomes associated with childhood adversity. Finally, a strength-based framework may reveal or elucidate different aftereffects previously overlooked or unexamined, thereby guiding research efforts and ultimately creating and facilitating wellness-focused interventions and

treatments when needed (Myers & Sweeney, 2008).

Guiding Principle of Resilience

Psychologists' and counselors' view of human suffering is often grounded in existential theory and philosophy. Resilience, closely aligned with posttraumatic growth, is guided by the existential principle that individuals and families can find meaning in the midst of struggle and hardship (Frankl, 1963).

The construct of resilience and the resilience literature have supplemented and guided many studies focused on trauma, adverse events, natural disasters, traumatic childhoods, and problematic adulthoods. For example, in Walsh's (1998) definition of individual resilience, the individual exhibits resilience because of adversity, not in spite of adversity. Thus, one can hypothesize from a resilience-based framework that one may experience resilience in adulthood because of maltreatment, not in spite of maltreatment. Moreover, while an examination of individual-related outcomes is critical, familial experiences (e.g., context, culture, family values and beliefs, spirituality, and birth order) play a significant role in the individual's trajectory. In short, it is impossible to separate the implications of the family system or context from the outcomes experienced at the individual level, which may be related to childhood adversity. Therefore, both individual and family resilience will be reviewed.

Individual Resilience

While many researchers disagree on the exact definition of resilience (Luthar, 1991; Rutter, 1990; Wolin & Wolin, 1993), most researchers agree that one must have, at minimum, experienced hardship to experience resilience. Many definitions also include the idea of "bouncing back" and returning to pre-crisis functioning (Wolin & Wolin, 1993). Important to counselors and a counseling framework, and implicit in a resilience perspective or framework, is the emphasis on resources, wellness, and positive outcomes.

Individual resilience is demonstrated by "individuals who adapt to extraordinary circumstances achieving positive and unexpected outcomes in the face of adversity" (Fraser et al., 1999, p. 136). Wolin and Wolin's (1993) definition of resilience is the ability to negotiate significant challenges to development and consistently bounce back in order to complete the developmental tasks that facilitate movement into and during adulthood.

The study of individual resilience has been explored with emphases on different factors. For example, some researchers have placed particular emphasis on the risk and protective factors that may lead to or interrupt resilience in the individual (Garmezy, 1991; Luthar, Cicchetti, & Becker, 2000; Rutter, 1990). Others have focused on the internal or biological factors and/or external or environmental factors related to resilience (Luthar & Zigler, 1991). Still others have used an integration of a damage and challenge model to clarify how resilience is realized by some but not by others (Wolin & Wolin, 1993). With regard to counseling populations and research participants, resilience has long been considered in both children and adults.

Werner and Smith (1982) were early investigators who clarified the construct of resilience and considered the possibility of resilience in adulthood in relation to children's exposure to high-risk scenarios. In their research, Werner and Smith identified four factors that differentiate between at-risk children who successfully adapt and those who do not: (a) active problem solving, (b) an ability to perceive difficult or painful things in a constructive way, (c) an ability to foster positive interaction with others, and (d) an ability to take in and make meaning of events through the use of faith. The resilience-associated outcomes evidenced in adulthood are personal satisfaction; success with work, family, and social life characteristics; no history with the legal system; and the presence of supportive adults.

Resilience is very similar to posttraumatic growth (Hooper, 2007), which describes positive life changes following a stressful experience (Cordova, Cunningham, Carlson, & Andrykowski, 2001). Tedeschi, Park, and Calhoun (1998) point to research carried out with children during the Great Depression. Elder (1974), the principal investigator of the study, reported these children, some of whom adopted a "parentified-like" role, experienced both positive and negative effects as a result of a confluence of individual, family, and societal fac-

tors. Elder argued that the outcomes in his study were directly related to the participants' family socioeconomic status. That is, children from middle-class families in that study tended to demonstrate resilience at greater rates than children from poor families. Among specific resilient characteristics hypothesized to be related to familial hardship in this study are responsible and achievement-oriented. Importantly, these characteristics were carried into adulthood. Many of these children reported, as adults, that "they were stronger now because of their early childhood experiences."

Other theorists have argued that a study of resilience must consider both environmental and biological factors. For example, Mandleco and Peery (2000) proposed a model that explores internal and external factors that may contribute to or prevent resilience at the individual level and implicitly at the family level. Internal (i.e., genetic) factors can be described as biological and psychological in nature; they are intrinsic and generated within an individual. In regard to internal factors, resilient children tend to be healthy, experiencing few medical illnesses and having regular sleeping and eating habits. Conversely, external (i.e., environmental) factors are generated outside of an individual and often reflect the quality of relationships with either family members or persons outside the family. Factors within the family include but are not limited to parents, parenting style, siblings, and culture. Factors outside the family that may play a role in resilience include relationships and resources in and with the community, adults, peers, school, and church. This framework has guided research and interventions with children and adults (Hawley, 2000; Mandleco & Peery, 2000).

Resilience is often delineated in terms of risk and protective factors for the child and, later, the adult. Risk factors are defined as factors that usually increase the likelihood that the individual will encounter challenges in childhood and/or across the lifespan (Hawley, 2000). For example, Hawley identified parental divorce, poverty, and physical and mental illness as common risk factors. In contrast, protective factors help individuals avoid or buffer the negative effects of adversity. Examples cited in the literature include temperament, hardiness, social support, and the presence of an adult who takes an interest in or mentors a child (Garmezy, 1985; Luthar, 1991). The importance of having a significant meaningful relationship with an adult when a trauma or stress has been experienced in childhood cannot be overstated.

Walsh (1998) and Wolin and Wolin (1993) argue that a child's responses to stress, adversity, or trauma are greatly mediated by the child's having one caring parent or at least one caring adult in his or her life. To this end, in Werner and Smith's (1982) seminal study, all the adults who had experienced trauma or stress in childhood and individual resilience in adulthood identified at least one significant adult who cared for and accepted them regardless of their temperament, intelligence, or self-esteem. Hawley (2000) contends that resilience is most likely to be found when risk factors are or have been minimized and when protective factors are or have been present. Rutter (1990) asserts that risk and protective factors are ever-changing and that, at different times, risk factors can be protective factors, and protective factors can be risk factors. Nascent research has also focused on self-righting tendencies that enable children to experience normal development under adverse or traumatic events (Gold, 2001; Hooper, Marotta, & DePuy, 2009; Mandleco & Peery, 2000).

Clinical research conducted from this aforementioned perspective has focused heavily on factors that contribute to symptom development and its contribution to childhood and adult disorders (Garmezy, 1991; Luthar, Cicchetti, & Becker, 2000; Notter, MacTavish, Shamah, 2008; Rutter, 1990; Werner & Smith, 1982). These investigations have greatly contributed to uncovering protective and risk factors that may contribute to resilience and psychopathology. Further, these studies have concentrated on how some children have successfully overcome the odds in spite of adverse conditions such as child abuse, neglect, substance abuse, ineffective parenting, emotionally ill parents, and dysfunctional families.

Wolin and Wolin's (1993) challenge model delineates the characteristics often seen in adults after trauma or stress has been present in the family of origin. This model is grounded in the premise that positive outcomes after childhood trauma are feasible and should be investigated by researchers and clinicians. Hardship, as Wolin and Wolin see it, is the component that engenders strength and positive outcomes.

In their argument for their challenge model, Wolin and Wolin first described the disadvantages of the hitherto

prevailing approach, which Wolin and Wolin termed the damage model. Unlike the challenge model, the damage model focuses on disease, maladjustment, psychopathology, and dysfunction. Thus, clinical work and research with adults that use this damage model emphasize the negative symptoms that result from the exposure to harmful events and environments experienced early in life. The damage model suggests that children are vulnerable and helpless in the context of dysfunctional or suboptimal families given their age-appropriate dependence on the parental and family system, whereby the problem (i.e., parents) is often the solution. Thus, this problematic system may and likely will contribute to the problems of the individual over his or her lifespan. Furthermore, the individual is highly likely to repeat the same damaging behaviors that were enacted upon him or her. Wolin and Wolin (1993) asserted that this focus on the transmission of psychopathology does little to elucidate cases of exception—that is, individuals' strengths and resiliencies. Consequently, when researchers operate from the damage model, they accept as a given that problems and sickness will result from the accumulative effects of family dysfunction.

Wolin and Wolin argued that the damage model is one-sided, fails to help clients live well in the present, and fails to promote or put forward research or clinical work about the potential for resilience irrespective of childhood history. In contrast, the challenge model considers both the damage and the challenge:

The troubled family is seen as a danger to the child as it is in the damage model and also as an opportunity. Adults are vulnerable to their parents' toxic influence, and they are also challenged to rebound from harm by experimenting, branching out, and acting on their own behalf. As a result of the interplay between damage and challenge, the survivor is left with pathologies that do not disappear completely and resiliencies that limit their damage and promote their growth and well being. (Wolin & Wolin, 1993, p. 16)

Unlike the damage model, the challenge model does not assume the transmission of dysfunctional patterns across generations. Rather, the model deliberately elucidates resiliencies and strengths within the individual who has experienced dysfunction in his or her family of origin. Importantly, Wolin and Wolin acknowledge that their described model does not suggest or deny the veracity of negative outcomes associated with adversity, stress, and trauma. What they do assert, however, is that many different aftereffects may be experienced in adulthood among those who have been involved in traumatic events and environments.

Because resilience fosters competency and coping in the face of adversity, resilience may play a role in buffering the effects of adversity among other stressors (e.g., hurricanes, maltreatment, terrorist attacks) (Burnham & Hooper, 2008; Chase, 1999; Hooper, Marotta, & Lanthier, 2008; Jurkovic, 1998).

Family Resilience

Barnard (1994) argued that the importance of family characteristics in fostering individual resilience cannot be overstated and that the absence of parent-child role reversals (i.e., the presence of appropriate parent and child roles) is just one of many family-related characteristics that may lead to individual resilience. Therefore, the family is usually viewed as and assumed to be a protective factor. However, the family in which child maltreatment takes place may or may not serve as a protective factor. Some people who experience trauma may have a self-righting capacity and thus may experience resilience in the face of a possibly ineffective family and parenting system (Gold, 2001; Hooper, 2008). Moreover, the family system may be a risk factor for a member during childhood and a protective factor later in adulthood for the same individual.

Whether studying individual or family resilience, one must understand and recognize the importance of context. Fraser et al. (1999) stated that "resilience emerges from a heterogeneity of the individual and environmental influences that conspire to produce exceptional performance in the face of significant threats" (p. 138). Individual resilience has been studied for a long time; however, the research and clinical literature has just recently begun to explore family resilience (Walsh, 1996, 1998). Moreover, resilience in general is often considered at the individual level in the context of a dysfunctional unit or family; thus, in the past, family resilience was often overlooked.

Family resilience, or a systemic view of resilience, is defined for the purposes of this review as interaction processes that over time strengthen both the family and individual hardiness. Characteristics often associated with families who report resilience are not often associated with families where adversity or trauma is evinced (McCubbin & Patterson, 1982; Patterson, 2002). For example, family warmth, family affection, family emotional support, and structure and limits are all elements that may or may not be absent from the family system where child maltreatment takes place. However, Walsh (1998) contended that "if parents are unable to provide this climate, relationships with other family members, such as older siblings, grandparents, and extended kin can serve this function" (p. 265). As previously discussed, research has shown that resilient children from troubled families often actively seek out others and form important secure attachments with other adult figures that influence their healthy development (Walsh, 1996).

Family resilience can add to the study and treatment of parentification (a type of maltreatment) because, in the context of family resilience, parentification may in fact be an appropriate temporary solution for the family in reaction to conflict and stress that ultimately engenders both family and individual resilience (Gold, 2001; Hooper, 2007; Jurkovic, 1997; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Walsh, 1996, 1998). Important to this review—and for those counselors considering resilience in their clinical and research efforts—is the idea that even troubled, ineffective, or dysfunctional families can be a source of resilience (Gold, 2001). As Walsh (1996) states, "Emphasis on family resilience affords researchers and practitioners the ability to identify and encourage behaviors that enable families to cope more effectively and emerge hardier from crises, trauma, or persistent stresses experienced in the family" (p. 263).

Family resilience also enables researchers to understand the moderating influence of family processes in dealing with trauma, crises, or adverse events. It encourages researchers to view families as having universal qualities, at the same time acknowledging idiosyncratic and different strengths and weaknesses, as well as different trajectories and solutions to similar problems. Thus, the construct of family resilience poses this question: How can each family, when faced with adversity or crises, cope in a way that is healthy and functional for that specific family, given its culture and lifecycle stage and accounting for political and community factors?

Conclusion

If counselors infuse and promote a resilience framework into their helping orientation strategies, counselors will likely consider and uncover the possibility for a wide-range of both functional and dysfunctional behaviors and environments (Masten & Coatsworth, 1998) among the individuals and families with whom they work. Numerous pathways may foster resilience and positive outcomes among individuals and families who experience adversity and trauma; however, if resilience is left unexplored, counselors and other providers may miss out on uncovering these varied pathways (Hooper, 2008; Notter et al., 2008).

Similarly, researchers may consider exploring alternate pathways and conceptual links between individual and family resilience and other factors, such as community resilience (Walsh, 2007) and posttraumatic growth. Posttraumatic growth is both similar to and different from resilience and may add to and extend our understanding of resilience. While resilience considers how individuals and families may return to their prior level of functioning before the adversity, trauma, or stress, posttraumatic growth considers how individuals and families thrive after trauma or adversity and in many cases are "better for it." Initial investigations into posttraumatic growth have been spearheaded by Tedeschi and Calhoun (1995). Additional empirical studies on posttraumatic growth may complement what we know and don't know about fostering resilience among individuals and families. A new line of inquiry related to the expansion of the posttraumatic growth model to the family system (Berger & Weiss, in press) could yield important transportable findings related to family growth for researchers and counselors alike. According to Luthar and Brown (2007) resilience-focused "researchers' central mission is to illuminate processes that significantly mitigate the ill effects of various adverse life conditions…" (p. 931). Luthar and Brown exhorted the importance of translating resiliency-focused science to practice cannot be overstated.

Resilience appears to be an important construct and framework for counselors to consider when working with children and adults alike. Myers and Sweeney (2008) stated, "professional counselors seek to encourage well-

ness, a positive state of well-being, through developmental, preventive, and wellness enhancing interventions" (p. 482). A resilience framework is congruent with a counseling framework and lends support to the notion that individuals who experience adverse events or trauma (e.g., child maltreatment) are not necessarily fated to psychopathology, poor relationships, and difficulties in adult functioning. Because "opportunities for resilience can occur at various points throughout [the] life course" (Notter et al., 2008, p. 622), resilience ought to be considered and, when appropriate, fostered during individual and family counseling with both children and adults.

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The Production of Professional School Counselors in Alabama: Graduation Rates of CACREP and Non-CACREP Programs

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Abstract

Today's professional school counselors have many roles and tasks within the schools. As more children de pend on the services of school counselors, well-trained counselors are needed to meet the demands. Data pre sented in this paper provide support for the production of professional school counselors in Alabama and the immediate southeastern area of the United States. We compared the number of graduates from universities that are accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) and those that are not accredited by CACREP.

The Production of Professional School Counselors in Alabama

In today's world, the work of Professional School Counselors is crucial because the needs of our school-age children are vast and diverse. Parents and other stakeholders must be made aware of the roles and tasks that Professional School Counselors perform so that their services are utilized to the fullest to meet the needs of 21st century students. Accordingly, it is imperative that Professional School Counselors are trained to the utmost extent so they are capable of working to help resolve the needs of today's students. To this end, the American School Counseling Association (ASCA) developed the National Standards for School Counseling Programs (Campbell & Dahir, 1997) to ensure training matches the demands of 21st century students. Additionally, the ASCA National Model (ASCA, 2003, 2005) was developed as a model framework to provide K-12 school counselors the structure needed to guide their comprehensive programs. The Transforming School Counseling Initiative (TSCI) (Education Trust, 2003) preceded these ASCA developments and was "the impetus for seeking and developing the fundamental changes needed to bring the work of school counselors into alignment with the mission of schools for the 21st century" (Martin, 2002, p. 148).

Vaughn, Bynum, and Hooten (2007) reported the need for counselor education programs to prepare school counselors who are able to assume the roles as proposed by ASCA. Adherence to the State Plan for Alabama Higher Education 2003-04 to 2008-09 is also an important aspect to consider for training school counselors in the state of Alabama as it articulates the framework for higher education (Alabama Commission on Higher Education (ACHE), 2008).

Connecting ASCA and Other Initiatives for School Counselor Education

A key factor connecting the ASCA initiatives as well as TSCI is the educational focus that joins school counseling programs to the total school program. As an integral part of the school, Professional School Counselors work as team members collaborating to fulfill the No Child Left Behind (U. S. Department of Education (USDOE), 2001) legislation. As part of the educational team of their school, Professional School Counselors are also involved in the national standards-based movement as well as being accountable for providing comprehensive,

developmental programs (ASCA, 2003, 2005; Cobia & Henderson, 2007; Curry & Lambie, 2007; Dimmitt, Carey, & Hatch, 2007). Vaughn et al. (2007) found the majority of their study's participants prefer to promote academic achievement through appropriate academic, career, and personal/social school activities. However, the study indicated several areas of concern. Specifically participants identified the necessity to reduce clerical tasks. Also recognized were the needs to improve parental involvement and to increase the role of school counselors as leaders in the school and advocates for student needs. The needs identified by Vaughn et al. are considered necessary to meet the multiple demands of school children in the 21st century. Becoming advocates for social justice (Bailey, Getch, & Chen-Hayes, 2007; House & Martin, 1999; Phillips, Sears, Snow, & Jackson, 2005), helping to bridge the gap with the education of low income children (Amatea & West-Olantunji, 2007), developing diversity training for school personnel (McFarland & Dupuis, 2001), and using and understanding data that effectively demonstrate changes in student behavior and in academics (Cobia & Henderson, 2007; Dimmitt, et al., 2007; Stone & Dahir, 2007) are education requirements for school counseling graduates if they are to effectively meet these current demands.

School counseling programs are involved with many systems within the school including students, parents or caregivers, faculty and administration, community, and other stakeholders. They are expected to develop and evaluate a comprehensive program that meets many demands but particularly those of their students in the areas of academic achievement, career preparedness, and social/emotional development. With all that Professional School Counselors are expected to do and are accountable for within in the school, system, and state, the need for strong counselor education training programs is essential.

CACREP Accreditation versus non-CACREP Accreditation

CACREP is the largest and most prestigious accrediting body in the nation for counseling programs. CACREP was created to: 1) present guidelines reflecting the expectations of the profession, 2) endorse professional quality programs, and 3) strengthen the credibility of counseling (Accredited Counselor Education Programs, 1982; Bobby & Kandor, 1992). As a voluntary accreditation body CACREP promotes the standardization of the counselor's scope of practice by established curriculum guidelines (Paisley & Borders, 1995; Smaby & D'Andrea, 1995). Loesch and Vacc (1988; 1994) reported that the CACREP standard for the core curriculum is reflected by the National Counselor Examination (NCE) as administered by the National Board for Certified Counselors (2008). Programs that are not accredited establish their own curriculum. Faculty members use their past counseling experiences, state mandates, and professional preferences to guide them in their planning. This in no way suggests that non-accredited programs have standards that are substandard or produce faulty graduates, however because the curriculum is not reflected by the NCE, there is no external evaluation to compare the quality of the curriculum (Bobby & Kandor, 1992; Smaby & D'Andrea, 1995).

Research on CACREP Accreditation versus non-CACREP Accreditation

There is a dearth of literature related to graduates of programs accredited by the Council for Counseling and Related Educational Programs (CACREP) versus non-CACREP accredited programs and much of it is outdated. Bobby and Kandor (1992) investigated hindrances programs identified that kept them from seeking CACREP accreditation. Their findings included barriers of the 600 clock-hour internship and the student-to-faculty ratios set by CACREP. Other identified concerns were the 48 semester hour program or 72 quarter hour, the requirement of a minimum of 2 full-time faculty members (currently 3 full-time faculty members) in an individual program, and the 20-1 now 10-1 advisor/advisee ratio. Faculty in few accredited programs found any major difficulty meeting the above standards, however sometimes financial and faculty support are not easy to acquire.

Akos and Scarborough (2004) examined internships for preservice counselors, which CACREP considers, along with practicums, to be the most critical experiences of a program. Both CACREP accredited and non-CACREP programs were investigated. Using a qualitative analysis of internship program syllabi, Akos and Scarborough found vast disparities in expectations for students during these clinical experiences, yet within

CACREP, programs handle these experiences in individual manners that adhere to the standards.

More recently, Adams (2006) studied the effect CACREP accreditation had on student knowledge in the core counseling areas as assessed by the NCE. The study examined the scores on the NCE over a 5-year period to differentiate between CACREP and non-CACREP scores. Scores on the NCE were significantly higher overall on the NCE by CACREP program graduates, as well as in the core knowledge areas as compared to graduates of non-CACREP accredited programs. Adams concluded that graduates of non-CACREP programs may not have profited from the energy and quality of curricula that is set in CACREP accredited programs. No investigations were located specifically addressing the number of school counseling graduates from CACREP versus non-CACREP accredited programs.

Training Standards for the Counseling Profession

Training standards within the counseling profession have been outlined by CACREP since 1981 and are often revised to meet current needs of clients and students (CACREP, n.d.). CACREP accreditation provides program graduates with training that meets or exceeds national standards (CACREP, 2006). With the national standards for school counseling programs, the ASCA National Model (2003, 2005), credentialing through various boards including the National Board for Certified Counselors (2008) and the National Board for Professional Teaching Standards (2008) it might seem that school counselor candidates are trained with the same knowledge, skills, and strategies for their future careers. Yet can one logically question whether all Professional School Counselors are trained in a like manner with equal skills and educated with the same curriculum. Additionally, one might wonder if all Professional School Counselors perform the same tasks at their sites in the same manner. Answers to these queries should be negligible, but without the same standards and similar curricula this may not be so. The importance of graduating well-trained Professional School Counselors is further heightened when one looks at the large number of school counselors needed in the nation's schools today (Snow, Boes, Chibbaro, & Sebera, 2008).

School Counselor Shortages

There is an increased need for well-trained school counselors in our schools to meet the needs of students who are faced with increasingly challenging issues (Schwab, 2001; Portman, 2002). According to Top Colleges (n.d.) there is a widespread need for more Professional School Counselors across the nation. There are not enough well trained Professional School Counselors Who give college advise to our high school students. In January, 2008, House Joint Memorial Bill 3 was introduced for legislation in New Mexico. This bill titled "Study School Staff Shortage Issues" predicts there will be several shortages of school personnel including nurses, instructional support staff, and school counselors. These shortages are expected in public and charter schools (House Joint, 2008).

Shifting populations and an increased number of school-aged children are contributing to the predicament. Smith-Adcock, Daniels, Lee, Villalba and Indelicato (2006) reported on a shortage of Spanish speaking school counselors in the state of Florida. Additionally, they noted the population of school-age Hispanic children in Hillsborough County, Florida alone was estimated to be 51,000. Iowa also lists special needs staff shortages which are calculated on the number of conditional licenses which are issued, the number and frequency of job postings at their Department of Education website and the number of projected graduates in the various disciplines (n.d.). California (Pytel, 2006) and Michigan (Hobson, Fox, & Swickert, 2000), have reported shortages that continue to be problematic. While these reports only represent a cross section of Professional School Counselor shortages from individual states, The National Association of School Psychologists (NASP, 2006) announced shortages across the nation in pupil service personnel which includes counselors who are equipped to help students more effectively.

While there had been a slight increase in school counselors during the 1990's, the increase did not keep up with the increased number of school-aged children enrolled in our nation's schools. The ratio of students to counselors has remained approximately the same as it was prior to the increased hires of school counselors in the 1990's (American Counseling Association [ACA], 2007).

School Counselor Programs and Counselor Ratios in Alabama and Georgia

Alabama has15 universities with programs training school counselors and 6 of the15 are accredited by CACREP (2008). CACREP has set the standard for the training of school counselors in the United States and many programs desire this status. Most programs in Alabama graduate 25 or less students per year according to the reports to American Association of Colleges for Teacher Education (AACTE) (1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002). In keeping enrollments low, it appears programs in Alabama approximate one of the CACREP requirements of reasonably small instructor/student ratios. In the neighboring state of Georgia program graduates were higher per year (AACTE, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002). However, the Board of Regents (BOR) for the University System of Georgia decreed that all school counseling programs in the state be accredited by CACREP which may possibly affect the number of program graduates per year in the future. In the *Regents' Principles and Actions for the Preparation of Educators for* t*he Schools* (BOR, 2004) section IIB (10) all programs are to "seek and maintain national accreditation for school counseling programs through the Council for the Accreditation of Counseling and Related Educational Programs (CACREP)" (p. 7).

Many school counseling programs desire CACREP accreditation but not all are supported at the state level as in Georgia. The National Center for Education Statistics (USDOE, 2007) presents student-to-counselor ratios for the United States. In the data presented the state of Alabama educated 741, 758 students with 1,814 counselors for a student-to-counselor ratio of 409:1. Data from the neighboring state of Georgia demonstrate that in 2007 approximately 1,598,461 students were educated. The number of counselors was approximated at 3,536 for a student-to-counselor ratio of 452:1. The recommended student-to-counselor ratio by ACA (2007) is 250:1, the ratio determined to demonstrate students receive adequate access to counseling services. The current U.S. average student-to-counselor ratio is 476:1. Neither Alabama nor Georgia is near the 250:1 recommended ratio. Both have better ratios than the national average. If shortages as predicted by NASP (2006) and other states (Hobson, et al., 2000; Pytel, 2006; Smith-Adcock et al., 2006) occur in Alabama and Georgia, both states may need more well-trained counselors. These predictions along with the changing needs of school -aged children seem to suggest more counselors who are trained in appropriate skills to better counsel our children.

Because graduation rates of training programs are a determining factor addressing potential shortages the present study focused on the number of school counseling graduates being produced by the various institutions in the state of Alabama. The study also compared the sum of school counseling graduates in Alabama to Georgia and other training programs in the southern area of the United States. The data was reviewed for all school counseling programs whether the program was accredited by CACREP at the time. Current CACREP status is also noted for the school counseling programs.

Method

Data Collection

The collection of data for this study was based on a review, analysis, and compilation of information found in various directories of members from 1995 to 2002 published by the American Association of Colleges for Teacher Education (AACTE). Part of each AACTE directory is an analysis of the productivity at member institutions. These member universities and colleges submit an annual report through the AACTE/NCATE Professional Education Data System and information is presented for teachers, administrators, and school counselors. The data are approximately 2 years old when published in each directory, so information found in the

2002 directory is actually reporting data from 2000, the 2001 directory from data for 1999 and so forth. After the 2002 directory, however information for counseling is not identified specifically but is grouped under "advanced" programs. Thus, information about school counseling graduates or completers the term used by AACTE, was available only through the 2002 directory.

The data collected by AACTE is considerable in length and is specified for each member institution. AACTE (2002) describes itself as follows:

AACTE and its predecessors reflect educator preparation's evolution from normal schools to colleges to comprehensive universities. The Association's approximately 760 member institutions include private, state, and, municipal colleges and universities – large and small- located in every state, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam. Together, they graduate more than 90% of new school personnel entering the profession each year in the United States. In addition, AACTE has a growing number of affiliate members, including state departments of education, community colleges, educational laboratories and centers, and foreign institutions and organizations (p. 1).

Data Analysis

Using this database from AACTE, the authors identified every college or university reporting school counseling graduates. The authors then identified the accreditation status by CACREP of each reporting institution. Those that were accredited by CACREP were identified with the year accreditation was granted. In the analysis of data, only graduates who completed the school counseling program during or after the year accredited were considered CACREP graduates. Thus, an institution may have both graduates from a CACREP program and graduates from a non-CACREP program.

The authors are unaware of any databases that even approximate the information about school counselors as that collected by AACTE. Clawson, Henderson, Schweiger, and Collins (2004) along with predecessors, Hollis and Dodson, (2000), Hollis (1997), Hollis and Wantz (1990, 1994) have gathered considerable information about counselor education programs in the United States. While these authors have delineated helpful information including some data relative to admission and graduation rates, most of the numbers seem to be estimates and, of course, these works have not been published yearly with specific data for each year.
Results

Fifteen universities have school counseling programs in the state of Alabama. Six universities currently have CACREP accreditation, while others may be in the application process (CACREP, 2008) (see Table 1). The number of school counseling graduates from each of the 15 universities is depicted in Table 2.

Alabama and Selected Georgia School Counseling Programs

The University of Alabama was the first program to acquire CACREP status in 1982 and Auburn University became CACREP accredited in 1986. It was not until 1999 that the University of Troy at Phoenix City acquired CACREP status, followed by the University of Montevallo in 2003. More recently, the University of Troy acquired CACREP accreditation in 2005, followed by the University of Troy at Montgomery in 2006 (CACREP, 2008). Those programs not yet achieving CACREP accreditation status in Alabama include Alabama A & M University, Alabama State University, Auburn University at Montgomery, Jacksonville State University, Troy State University at Dothan, the University of Alabama at Birmingham, the University of North Alabama, the University of South Alabama, and the University of West Alabama.
The University of West Alabama data was first reported in this series of years as Livingston University. In 1995 Livingston University gained regional status (Wikipedia, 2008). Data is incorporated in Table 2 under its current name The University of West Alabama.

The total number of graduates of school counseling programs in the state of Alabama approximates 1,095 for the years 1995-2002 (AACTE, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002). Individual program numbers for these reporting years range from 35 graduates at Alabama A & M, a non-CACREP program and Auburn University, a CACREP accredited program to a high of 148 graduates from Alabama State University, also not a CACREP accredited program (see Table 2).

Top Ten Graduating Programs in the Southern ACES Region

Of further comparison, by examining the Southern Association of Counselor Education and Supervision (SACES) region for the top 10 producing universities with school counseling graduates from both CACREP accredited programs and programs that are not CACREP accredited for the years 1995-2000, no university program in Alabama is represented. The top 10 producing programs in the southeast include: Western Kentucky University (non-CACREP), the University of West Georgia (CACREP), University of South Carolina (CACREP), Prairie View A& M University (non-CACREP), Eastern Kentucky University (CACREP), Georgia Southern University (non-CACREP), University of Georgia (CACREP), University of South Florida (non-CACREP), Morehead State University (non-CACREP), and Georgia State University (CACREP) (see Table 3 for numbers of graduates). Five of these top producers have attained CACREP status (CACREP, 2008) while the other five programs are not accredited. Forty percent of the 10 programs are in the state of Georgia, which is notable and three of these programs are CACREP accredited. Thirty percent of the programs are in Kentucky, with one in Florida, South Carolina, and Texas (see Table 3).

During the time of the AACTE reported data, The SACES region included 58 university programs with CACREP status and 115 programs that were not CACREP status. The total count of PSC graduates in the SACES region from CACREP accredited programs for the time period for the study was 8,741 while the non-accredited programs reported 11,679 graduates. The graduates from non-accredited programs surpassed the number of graduates from CACREP accredited programs. Fifty seven percent of graduates for the 1997-2002 timeframe were from non-CACREP accredited programs as compared to 43% of school counseling graduates from CACREP accredited programs. Programs with CACREP accreditation status generally graduate fewer students overall.

Discussion

It appears evident that program size and graduation rates vary between CACREP accredited and non-CACREP accredited programs in the SACES region. While CACREP (2001) reports programs with accreditation status typically graduate lower rates of Professional School Counselors, this was not always true for the programs in Alabama. Alabama A & M reported only 35 graduates and Auburn University at Montgomery reported 36 graduates for the timeframe of the study which is the same as the reported graduates for Auburn University which has acquired CACREP status.

The population of Alabama as estimated by the U.S. Census Bureau (2000a) for mid census 2006 under Quickfacts, is reported at a total population of 4,599, 030. Of this populationthere is an estimated 6.5% of children under the age of 5 and 24.2% of children reported as less than 18 years of age. This leads one to ponder whether the number of graduates of school counseling programs from the 15 university programs are adequate to facilitate the needs of the future school population. In Georgia, Quickfacts (U.S. Census Bureau, 2000b) estimates the total population for 2006 to be 9,363,941 persons with 7.5% of those persons being under 5 years of age and 26.2% of these persons being under the age of 18.

Interestingly, the number of school-age children is somewhat similar according to the percentages provided by Quickfacts (2000a, b), yet the number of Professional School Counselors produced in Georgia, with fewer school counseling programs, for the reporting period by AACTE (1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002) was more than double the production number of Professional School Counselors in Alabama. There are 15 school counseling programs in Alabama supplying over 1,000 school counselors for the reporting years.

There are only 10 school counseling programs in Georgia producing more than double the number of Profesional School Counselors for the same reporting years (Snow et al., 2008). Obviously, school counseling programs in Georgia tend to be larger than those in Alabama. With such growing populations, more Professional School Counselors may be needed in Alabama and Georgia.

It is interesting to note that the various items Bobby and Kandor (1992) noted as keeping programs from seeking CACREP accreditation are those that make programs outstanding and graduates capable of developing exceptional comprehensive guidance programs that are connected to academic achievement, career preparedness, and social/emotional development. The 600 clock-hour internship plus a 100 hour Practicum gives graduates a minimum of 700 hours of work in a school counseling program under the direct supervision of a site supervisor.

This two semesters or longer of clinical experience was considered the most critical experience of counseliprograms (Akos & Scarborough, 2004) and it is understandable that programs throughout a state with similar curricula will be graduating stronger Professional School Counselors. The student-to-faculty ratios, advisor/advisee ratio along with the minimum of three full-time faculty works to keep classes smaller and offers the opportunity to get student needs met while in the program. While accredited programs found little difficulty meeting CACREP standards, programs that are not accredited do not realize the impact these standards set. The number of school counseling graduates may lessen as more programs aim for CACREP accreditation.

Summary and Recommendations

With 15 school counseling programs at institutions in the state of Alabama, six with CACREP accreditation, school counselor production currently appears to cover P-12 counseling needs. Adherence to CACREP standards and licensure guidelines, which often follow CACREP guidelines, benefits P-12 students in the state of Alabama because similar curricula will ensure school counselors throughout the state develop similar comprehensive programs. Thus, the areas of academic achievement, career preparedness, and social emotional are mandated by ASCA to meet the counseling needs of P-12 students throughout the nation. Similarities in curriculum such as depicted in accreditation standards allow school counselors to develop similar comprehensive programs that help students in the areas of academic achievement, career preparedness, and social/emotional development. While accreditation was not the primary focus of the study, generally school counseling programs which have acquired CACREP accreditation graduate fewer professional school counselors and the assumption can be made they have a culture that enhances student and professor relationships because of the required ratios (Snow et al., 2008). Limitations of this study include the obvious that AACTE's data is no longer published relative to school counselor program graduates. School counseling graduates are subsumed under "advanced programs."

Recommendations

Additional studies are needed to investigate the quality of school counseling programs that are accredited and those that are not accredited by CACREP. Predictive shortages of school counselors in the nation may challenge CACREP accredited programs due to the lower graduation rates. Thus it is important to continue this research. While Adams (2006) found there is a difference on NCE scores from accredited and non-accredited programs there is still a need for more empirical research to determine quality of training programs.

In general it appears enrollments in school counseling programs in Alabama are kept relatively low, which approximates the CACREP (2001) requirement for reasonably small instructor and student ratios. A logical question might be whether all programs in the state of Alabama might be CACREP accredited if the appropri ate support would be available. Without knowing the curriculum, faculty resources, student to faculty ratios, and other quality indicators at institutions not currently accredited by CACREP, it does appear realistic, how ever, that many or most could achieve accreditation if the appropriate support was available. The mandate by

The Board of Regents (2004) in the state of Georgia has moved more school counseling programs toward CACREP accreditation status. Such a mandate might make it possible for more programs in Alabama to attain this status. However, without such a mandate, one recommendation might be that accreditation status become a practical advocacy theme for counselor educators within the state. As counselor educators it is also important to advocate for issues of the profession, should we deem the appropriateness of such actions.

Table 1

Alabama School Counseling Programs and Year of Initial CACREP Accreditations.

University Name	CACREP accreditation year
Alabama A & M University	N/A
Alabama State University	N/A
Auburn University	1986
Auburn University at Montgomery	N/A
Jacksonville State University	N/A
University of Alabama	1982
University of Alabama at Birmingham	N/A
University of Montevallo	2003
University of North Alabama	N/A
University of South Alabama	N/A
University of Troy at Dothan	N/A
University of Troy at Montgomery	2006
University of Troy at Phoenix City	1999
University of Troy	2006
University of West Alabama	N/A

Note. The year indicated is the initial year of CACREP accreditation. N/A indicates CACREP status is not applicable at this time.

Table 2

Production of School Counselors by Programs in Alabama

University	2002	2001	2000	1999	1998	1997	1996	1995	Total
Alabama A & M	-	8	4	5	-	5	8	5	35
Alabama State	27	18	16	12	6	5	41	23	148
Auburn University	9	8	5	2	3	7	-	1	35
AU at Montgomery	5	13	-	-	-	-	9	9	36
Jacksonville State31	72	-	-	8	1	3	10	125	
U. of Alabama	19	17	10	16	23	10	9	11	115
UA at Birmingham	11	10	9	10	8	7	8	2	65
U. of Montevallo	4	-	7	5	11	6	12	15	60
North Alabama	14	-	3	7	10	3	9	8	54
South Alabama	8	14	9	7	5	7	4	10	64
Troy at Dothan	9	13	6	14	18	6	9	16	91
Troy at Montgomery									
Troy at Phoenix C.	23	27	-	20	28	30	0	0	128
Troy at Troy									
West Alabama	13	8	7	4	5	87	8	7	139
Subtotal	173	208	76	102	125	174	120	117	1095

Note. These numbers represent the totals as reported to AACTE in a given year. They may not reflect actual numbers for each year as a university may collapse data and report numbers at different timeframes. The reader is reminded that Livingston University became the University of West Alabama in 1997. Troy University and Troy University at Montgomery did not report as single units, thus there no data is presented.

Table 3

Numbers and Means of School Counseling Graduates of SACES Top Producing Programs

from 1995-2002

		N	$\overline{X}$
Western Kentucky University	(N/A)	931	116
University of West Georgia	(2001)	620	78
University of South Carolina	(1984)	602	75
Prairie View A&M University	(N/A)	517	65
Eastern Kentucky University	(2003)	449	56
Georgia Southern University	(N/A)	427	53
University of Georgia	(1987)	401	50
University of South Florida	(N/A)	375	47
Morehead State University	(N/A)	367	48
Georgia State University	(1980)	349	44

Note. These numbers represent the totals as reported to AACTE in a given year. They may not reflect actual numbers for each year as a university may collapse data and report numbers at different timeframes. Dates indicate the year first accredited by CACREP. N/A indicates CACREP status is not applicable at this time.

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Deinstitutionalization: Its Impact on Community Mental Health Centers and the Seriously Mentally Ill

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Abstract

Deinstitutionalization has had a significant impact on the mental health system, including the client, the agency, and the counselor. For clients with serious mental illness, learning to live in a community setting poses challenges that are often difficult to overcome. Community mental health agencies must respond to these specific needs, thus requiring a shift in how services are delivered and how mental health counselors need to be trained. The focus of this article is to explore the dynamics and challenges specific to deinstitutionalization, discuss implications for counselors, and identify solutions to respond to the identified challenges and resulting needs.

State run psychiatric hospitals have traditionally been the primary component in the treatment of people with severe and persistent mental illness. For many years, individuals with severe mental illness (SMI) were kept out of the community setting. This isolation occurred for many reasons: a) the attitude of the public about people with mental illness, b) a belief that the mentally ill could only be helped in such settings, and c) a lack of resources at the community level (Patrick, Smith, Schleifer, Morris & McClennon, 2006). However, the institutional approach was not without its problems. A primary problem was the absence of hope and expectation that patients would recover (Patrick, et al., 2006). In short, institutions seemed to become warehouses where mentally ill were kept for long periods of time with little expectation of improvement.

In 1963, the Kennedy administration addressed the institutionalization of the severely mentally ill and the condition of state mental hospitals. The result was the passage of the 1963 Community Mental Health Centers Act (CMHCA). The CMHCA had a tremendous impact on the mental health system in the United States and upon the profession of mental health counseling. This act not only restructured how services were provided but also who performed those services. No longer was treatment restricted to the medical professionals. Therapeutic services to the SMI were now relegated to a host of non-medical professionals.

Previous to the CMHCA, mental health counselors were primarily working with people who were struggling with issues such as marital conflict or developmental issues, but who were essentially healthy (Browers, 2005). Individuals with SMI, especially if it were persistent, were placed in hospitals and dealt with at the institutional level. However, the development of the first antipsychotic medication in 1954 opened the door for community-based treatment rather than lifelong institutionalization (Stubbs, 1998). The CMHCA legislation brought people into the community who exhibited more significant symptoms of mental illness, thus creating new challenges for the mental health system at the community level, as well as for mental health counselors.

Social, Cultural, and Political Context of the Deinstitutionalization

It should not be surprising that such a dramatic shift in approach for treating individuals with SMI should emerge from the culture of the 1960's. The culture was distinct from the conservative lifestyle of the fifties and there was a revolution of thought and a radical shift in the framework of American life. This was a time

when the rights of individuals became highly valued, with both the civil rights movement and the feminist movement attacking beliefs and values that oppressed and limited populations (Goodwin, 2005). Goodwin suggested this was also a time dominated by youth, with the baby boomer generation moving into its teen years and young adulthood. This generation was shaped by powerful events including the war in Vietnam, the Civil Rights movement, women's liberation, the hippie movement, a newly emerging environmental movement, and even the space race (Dixon & Goldman, 2003; Goodwin, 2005). It seems a logical conclusion in the midst of this rush toward positive social change that the plight of the mentally ill should get some attention and that an institutional approach to treatment should be challenged (Feldman, 2003).

It should be noted that this era was also a time when, at the political level, a great deal of change was occurring. John F. Kennedy was a charismatic leader who created much hope in America (Goodwin, 2005). President Kennedy seemed prepared to involve the government in social change. The CMHCA was a reflection of the political climate present during the days of the Kennedy administration (Dixon & Goldman, 2003; Feldman, 2003). The change occurring in mental health at the political level had actually begun during World War II, but culminated with the Joint Commission on Mental Health and Illness. After eight years of examination, the Commission submitted a report which indicated that the nation needed to become less dependent upon hospitals and more dependent on non-traditional caregivers such as case workers, clergy and educators. This perspective was a significant factor leading to the CMHCA three years later (Feldman, 2003).

Challenges of Deinstitutionalization

The benefits of deinstitutionalization have been noted in the professional literature. These benefits have been identified as independence and a better quality of life outside of institutions (Forrester-Jones et al., 2002), reduction in psychotropic medication needs (Hobbs, Newton, Tennant, Rosen & Tribe, 2002), and increased socialization and adaptability to change (Priebe, Hoffman, Isermann, & Kaiser, 2002). However, Iodice and Wodarski (1987) contended that while in theory it may have been a good idea, it may not have worked as well as intended. The individuals who were to receive the benefits of deinstitutionalization were often homeless, isolated, and victimized. Some individuals with SMI who were released from institutions deteriorated, were reinstitutionalized, and some lost their lives (Honkonen, Henriksson, Kovisto, Stengard, & Salokangas, 2004; Iodice & Wodarski, 1987; Kelly & McKenna, 2004; Sealy & Whitehead, 2004).

Kelly and McKenna (2004) suggested that the community at large is frequently afraid of people with mental illness, believing them to be dangerous. This belief often caused rejection, stigmatization, victimization, and harassment (French, 1987). Mentally ill clients thus become unsupported and at high risk for self harm. Instead of being integrated into the community, people with mental illness traded the isolation of the hospital for the isolation of the house or apartment (Kelly & McKenna, 2004). In a recent study, it was concluded that individuals with SMI were victims of violent crime at a rate 11 times higher than that of the general population (Teplin, 2005). An additional challenge that resulted from deinstitutionalization was the incarceration of individuals with SMI. A study investigating the relationship between deinstitutionalization and homelessness and crime found a statistically significant correlation between deinstitutionalization and homelessness, and a more pronounced correlation between homelessness and criminal activity (Markowitz, 2006). Of the state and federal prison populations, as well as county jails, roughly 15-22% of individuals incarcerated have psychotic disorders, compared to 3.1% of the general population (James & Geize, 2006). In as much as 66% of these cases, these individuals have served prior sentences. Further, only one in three of these inmates report receiving mental health treatment while incarcerated. These statistics indicate a different setting for a similar institutionalization. When not incarcerated, these individuals are twice as likely to be homeless (James & Geize, 2006). It seems, then, that deinstitutionalization, while providing freedom, has not solved the problem of providing needed mental health services.

Implications for Mental Health Counseling

Clearly the CMHCA necessitated the movement of care from a state institution into the community. This means that communities are being asked to absorb individuals with SMI into the community setting, a reality that has many implications. This move necessitates not only the development of appropriate housing, but also the development of psychiatric, therapeutic, case-management, health and educational services to provide the wrap-around care needed by this population (Hobbs, et al., 2001; Patrick, et. al, 2006; Pruett, Davidson, McMahon, Ward & Griffith, 2000; Werner & Tyler, 1993). The major challenge for community mental health centers is limited funding to support mental health professionals that provide more specific and in-depth services to the SMI population. As indicated in a recent article in Clinical Psychiatry News (Johnson, 2006), community mental health centers are currently understaffed and face increased understaffing.

All of the discussion regarding whether the CMHCA was positive or negative may well depend upon whether one believes the goal is to keep clients stable in the community (i.e., maintenance) or whether it is to help the clients learn and grow (i.e., recovery). The National Institute of Mental Health in England (NIMHE, 2005) focuses on recovery as a process of returning to a state of wellness. The goal is to help individuals with SMI discover optimum quality and satisfaction with life. It is a personal process of overcoming the negative impact of diagnosed mental illness/distress despite its continued presence. In order to facilitate recovery, NIMHE focuses on nine essential components including a) clinical care, b) family support, c) peer support, d) work and meaningful activity, e) personal power and control, d) community involvement, education, e) access to resources that promote recovery (e.g., such as technologies), and f) the minimization of stigma attached to mental illness. Most of these components require an intervention from a community based setting. The CMHCA clearly creates impetus for the adoption of a recovery model.

With a shift in treatment setting and paradigm, it has become important to develop treatment programs that are effective for the SMI in the community setting. As indicated above, certain key elements have been identified as being important and new evidence-based practices have emerged (Dixon & Goldman, 2003; Rogers, 2003). It should be noted that many of the evidence-based practices related to working with people who have SMI in the community require multi-disciplinary approaches and people with various levels of training (Feldman, 2003; Forrester-Jones, et. al., 2002; Iodice & Wodarski, 1987). This has increased the need for counselors and possibly has contributed to the expansion of the role of providers with master's degrees. It is simply impossible to adequately provide therapy to the SMI population with the limited numbers of psychiatrists and psychologists available.

There has been some initial research related to various approaches that are effective when working with people having SMI in the community setting. One of the most successful of these approaches is Assertive Community Treatment, in which a multidisciplinary team works with clients who have SMI in their natural setting (e.g., home, work; ACTA, 2007; Marsh, 2006). This model has demonstrated effectiveness as a meta-analysis found that in randomized trials those subjects with whom assertive community treatment was used were less likely to become homeless and had improvement in symptom severity compared with those who were part of more standard treatment protocols (i.e., standard case management). Peer-support models (i.e., peer support counseling) have also been found to be effective (Davidson, 2006; Hardiman & Segal, 2003; Shahar, Kidd, Styron, & Davidson, 2006). In addition, supportive employment models are noted to provide benefit to the SMI population in that not only are the services effective but those providing the services gain a sense of intrinsic reward and satisfaction for their efforts. From a practical perspective, it was found that the cost of providing mental health care is reduced for those who receive supported employment. Further, the number of hours of mental health services provided per month for these same individuals was almost cut in half (Becker, Drake & Naughton, 2005; Perkins, Born, & Raines, 2005).

In addition, the movement of care into the community setting resulted in a need for many professionals working at the community level to receive additional training, including specific skills for working with the SMI population. Thus, continuing education and master's level counselor training was needed to teach skills that enable counselors to work with this population (Feldman, 2003). However, in a review of counselor training program plans of study, as specified on program homepages, no courses were provided specific to the SMI

population. Thus, it can be assumed that many counselor training programs address the SMI population is abnormal behavior or diagnosis and assessment coursework only.
The Campaign for Mental Health Reform (CMHR) is supported by 16 organizations, including National Alliance for the Mentally Ill, the National Mental Health Association, and others (CMHR, n.d.). This reform recommends increased federal and state funding for a) Community Mental Health Centers, b) programs for prevention, early intervention, and rehabilitation services for SMI, and c) discharge planning and links to mental health services upon release from jail or prison. Further, increased funding is needed to meet the requirements of the Mentally Ill Offender and Treatment Crime Reduction Act of 2004 (P.L. 108-414), which supports provision of services within the criminal justice and mental health systems. I am not quite sure what to make of this, especially the parentheses. My best guess is that a citation and reference are missing? The CMHR provides a response to the challenges outlined above and would allow for the full intentions of deinstitutionalization and CMHCA to be realized.

Conclusion

Deinstitutionalization and the CMHCA initiated in 1963 has had a profound effect upon the counseling profession. While it has encouraged the development of the profession, it has also provided the profession with new challenges. Counselors have been forced to respond to the need to gain new competencies and encourage collaborative relationships with other mental health providers. The biggest challenge remains with the funding of programs to support the continued deinstitutionalization of those with SMI, although from the institution of imprisonment rather than psychiatric hospitalization. Mental health services for those individuals with SMIs who are incarcerated need to be improved, including an aftercare component once released from jail or prison.

Any failures related to deinstitutionalization are not the result of philosophical errors but rather the implementation of models designed to support individuals with SMI (Talbott, 2004). Specifically, the lack of funding limits the efficacy of such models. Increased funding can provide new and established services to further support deinstitutionalization. Additionally, increased funding can provide more employment opportunities for counselors to work with the SMI population, thus allowing for more manageable numbers of SMI clients on caseloads. Thus, through adequate funding existing services can be improved, training specific to working with the SMI population can be provided, and the opportunity for new and more effective programs can be offered.

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