The Journal of the Pennsylvania Counseling Association

Janet L. Muse-Burke, Editor
Richard Joseph Behun, Associate Editor

Volume 13, Number 1 Fall, 2014

Editorial Review Board

Manuscript: See inside Back Cover for Guidelines for Authors and email for manuscript submission. Manuscripts are welcomed from students, practitioners, and educators in the field of counseling.

Advertising: For information, contact Richard Joseph Behun. Advertising will be accepted for its value, interest, or professional application for PCA members. The publication of any advertisement by PCA is an endorsement neither of the advertiser nor of the products or services advertised. PCA is not responsible for any claims made in an advertisement. Advertisers may not, without prior consent, incorporate in a subsequent advertisement the fact that a product or service has been advertised in a PCA publication.

Subscriptions: Membership in the Pennsylvania Counseling Association, Inc. includes a subscription to the *Journal.*

.

Cover Design and Graphics: Kurt L. Kraus, Assistant Professor, Shippensburg University, Shippensburg, PA. Special thanks to Johanna Jones for the typeset.

Fall 2014 *Volume 13, Number 1*

The Journal of the Pennsylvania Counseling Association

Contents

Letter from the editor…

This edition of the Journal of the Pennsylvania Counseling Association largely focuses on the theme of the 45th Annual PCA Conference (2013), entitled "Efficacy and Advocacy: Advancing the Profession of Counseling in Pennsylvania." Dr. Brian Wlazelek, 2013-2014 PCA President, carefully and thoughtfully selected this theme. Professional counselors, researchers, educators, students, and other helping professionals were invited to submit innovative proposals addressing diverse areas of counseling and counselor education. Both clinical and research-based presentations were offered, and presenters were encouraged to submit their papers for inclusion in this special Conference Edition of the Journal. Innovative approaches to counseling and counselor training will be addressed in this volume, highlighting important areas in which the counseling profession might advance in Pennsylvania.

Many individuals across Pennsylvania have been involved in developing this latest edition of the Journal, and I am truly appreciative of their contributions. First, I would like to offer gratitude to Dr. Richard Joseph Behun for his assistance with final edits and assembly as Associate Editor. Likewise, Micalena Sallavanti, my Graduate Assistant at Marywood University, was immensely helpful as reviewer and "final editor" of several documents. Nine other counselor educators and doctoral students served as reviewers for the submissions to the Journal. Their feedback and suggestions improved the quality and relevance of the articles, and I am thankful of their time, energy, and expertise. The Journal would not be possible without the generous availability and knowledge provided by these volunteer members of PCA.

For the four years that I have served the Journal, I worked with Mr. Ray Burd, Director of Mailing and Printing Services at the University of Scranton, to publish, print and distribute the Journal. Sadly, Mr. Burd died in an accident earlier this year. Mr. Burd was a kind, professional, and experienced Director; he was a willing and helpful collaborator in developing the final version of the Journal for many years. I was fortunate to have the opportunity to work with him, and his long-standing service to the Journal will continue to be appreciated.

As Editor of the Journal, I am honored by this opportunity to serve PCA and the professional counselors and educators throughout Pennsylvania. It was exciting to assemble this interesting and eclectic collection of articles to help advance our profession. I hope you find these articles to be informative and meaningful; may you find inspiration to expand your own counseling practice, approach to training, or pursuit of scholarship.

Sincerely,

Janet L. Muse-Burke, Ph.D.
JPCA Editor

Letter to the Editor: Response to Coppock, McCrudy, and Gleason (2012)

Sherry W. Goodill, Ellen Schelly Hill, & Elizabeth McNamara

March 10, 2013

Editors
Journal of the Pennsylvania Counseling Association

Dear Editors,

We are writing in response to the article "Professional Counselors in Pennsylvania: Thirteen Years After Enactment of the ACT 136 of 1998" by Coppock, McCurdy and Gleason, published in the Spring 2012 issue of this journal. The article contains incomplete information with regards to the specialty area of dance/movement therapy (DMT), and we seek to rectify that herein. We write as PA LPCs in good standing and as educators/supervisors of creative arts therapists in a large graduate program in Pennsylvania. In addition, we hold state or national leadership roles in the American Dance Therapy Association (ADTA), which has afforded us the interdisciplinary exchange and perspectives on which we draw in this letter.

The article incorrectly identifies the dance/movement therapy specialty credential as ADTR. In fact, in 2009 the advanced DMT credential was changed to board certification, the BC-DMT (Board Certified Dance/Movement Therapist). This credential is conferred by the Dance/Movement Therapy Certification Board, which is affiliated with, but corporately separate from the American Dance Therapy Association. The examination for the BC-DMT is by portfolio review, an assessment that is increasingly valued among credentialing experts (Institute for Credentialing Excellence [ICE], n.d.). A second point to clarify is in regards to the licensure exam: since the enactment of Act 136, dance/movement therapists have taken the NCE and submitted scores from that exam.

A third clarification is on Table 2, the comparison of professional training standards for counseling and related fields. The table incorrectly presents that ADTA does not require training in group work, professional orientation, appraisal, or research. However, a review of the ADTA Standards for Dance/Movement Therapy Master's Programs (ADTA, 2010) shows that all four are included, although not in the exact language named in Act 136. Group work is required under Section F. 5. as "theoretical information and practical application relating to groups…knowledge of group processes" (p. 3). Appraisal is required under F.4. and F.9. as "methods for observation, analysis and assessment" and "knowledge of psychopathology and diagnosis" (p. 3). Research is required under D.3. (Competency) as "skills in research design and methodology" and F.2. (Program content) as "research in human behavior" (p. 2-3). Knowledge of professional and ethical practice is also required in these standards.

The authors correctly note that there is no other licensing of dance/movement therapists in the Commonwealth. We concur with Coppock et al. that it is redundant and

possibly confusing for the state to license individuals under more than one licensing board. Therefore, we support the recommendation that the PA Social Worker, Marriage and Family Therapy and Professional Counselor Board move to limit its licensure of those disciplines that are not also regulated by another of the Commonwealth's professional licensure boards.

Licensing exists to protect the public from incompetent practitioners. Dance/movement therapists are good licensees. A review of disciplinary reports by the State Board of Social Workers, Marriage and Family Therapists and Professional Counselors from 2010 to 2012 shows no actions or citations of any sort against any of the dance/movement therapy specialists who are licensed in PA.

Coppock et al. argue that more than one professional identity leads to identity diffusion that is ethically problematic. We suggest that this position has less to do with protecting the public and more to do with the Vision 20/20 priorities advanced at the national level in the last several years. We are well aware of the recent voices against inclusive licensing and for a homogenous counseling identity. We are also aware that not all national leaders in the counseling field are in agreement with the criticisms of inclusive licensing laws. Recently in fact, in the March 2013 issue of Counseling Today, ACA President Dr. Bradley Erford published the following statement:

> A larger question is how we develop and maintain an appropriate professional identity (boundary) while still benefiting from the input and strength of our interprofessional colleagues (permeability). After all, we share the same literature, have similar training standards and often receive similar supervision. But will we, as a counseling profession, mirror the mistakes of other mental health professions that seek to create impermeable barriers between professional groups? That seek to restrict counselor practice through legislation and regulations? (p. 83)

It distorts the purpose of licensing to use it as the venue for clarifying professional identity.

Evidence of the relevance of the arts and creative arts therapies to the field of counseling abounds, especially in the formation of the Association for Creativity in Counseling (ACC), a division of ACA that has grown to well over 1,000 members in a few short years. The ACC journal, the Journal of Creative in Mental Health, includes several creative arts therapists on its editorial review board, and articles published in that journal frequently cite the large body of research, theoretical, and clinical literature from the creative arts therapies, including dance/movement therapy. That this integration and development is happening in the ACA, while at the same time there are efforts to constrict counseling licensing, is an alarming inconsistency. This too indicates the need for more dialogue and mutual learning, not regulatory actions.

To that end, we recommend that here in Pennsylvania, the committee to steward the licensing bill be reconfigured from its current composition as a PCA-only committee, and reformed as a group that represents all of the disciplines licensed under the act. This would solve the problem and very real challenge of individuals having to communicate with state legislature on matters about which they are minimally conversant. A more diverse committee will be much more effective and will mirror the wisdom of the original state coalition.

As mentioned above, we are personally involved in education and training, specifically in the graduate programs for the creative arts therapies (CAT) at Drexel University (DU). Our programs provide all of the required content areas for LPC eligibility in the core curriculum, with specialty material covered in each of the CAT areas. The Professional Orientation and Ethics course in the DU curriculum reviews ethics codes of the art therapy, music therapy, and dance/movement therapy professional associations as well as the American Counseling Association. Our students are well able to manage their multiple professional identities and find that a professional counseling identity and philosophy as described by Remley and Herlihy (2009) and represented in the 2010 American Counseling Association definition is very compatible with their creative arts therapist identities. Among our faculty are those with LPCs and those with doctoral degrees in counseling education. Much of this information was also presented in a PACES panel at the 2010 PCA conference.

We urge our colleagues in the PCA to join us in dialogue and exchange, ideally in face-to-face discussions that consider all aspects of the important issues raised herein and in the Coppock et al. article, and we look forward to your response.

Sincerely,

Sherry W. Goodill, Ph.D., BC-DMT, NCC, LPC
Clinical Professor and Chairperson
Department of Creative Arts Therapies
Drexel University, Philadelphia
and President, American Dance Therapy Association

Ellen Schelly Hill, MMT, BC-DMT, NCC, LPC
Director, Dance/Movement Therapy M.A. Program
Department of Creative Arts Therapies
Drexel University
and Standards and Ethics Chair, American Dance Therapy Association

Elizabeth McNamara, MA, BC-DMT, NCC, LPC
Government Affairs Chairperson, Pennsylvania Chapter, ADTA

References

American Dance Therapy Association. (2009, April). *ADTA standards for dance/movement therapy master's programs.* Retrieved from http://www.adta.org

Coppock T. E., McCurdy K. G., & Gleason A. (2012). Professional counselors in Pennsylvania: Thirteen years after enactment of the Act 136 of 1998. *Journal of the Pennsylvania Counseling Association, 12,* 19-32.

Erford, B.T. (2013, March). Who are you? Who, who, who, who?. *Counseling Today, 83,* 5. Institute for Credentialing Excellence. (n.d.). Retrieved from http://www.credentialingexcellence.org/

Remley, T., & Herlihy, B. (2009). *Ethical, legal, and professional issues in counseling* (3rd ed.). Saddle River, NJ: Pearson Education, Inc.

Letter to the Editor: Response to Goodill, Schelly, & McNamara (2013)

Timothy E. Coppock & Kenneth G. McCurdy
Gannon University

December 18, 2013

Editors
Journal of the Pennsylvania Counseling Association

Dear Editors,

First, we express our appreciation to the editors for the invitation to reply to the March 2013 letter submitted by Goodill, Hill, and McNamara. Our response that follows is in recognition of our common interest in the counseling profession and specifically in support of Professional Counselor Licensure in Pennsylvania.

We acknowledge that our article, "Professional Counselors in Pennsylvania: Thirteen Years after Enactment of the Act 136 in 1998," was the result of several years of data collection and archive review that began in 2008. While we made every attempt to update our information about the various organizations that collaborated to successfully pass Act 136, we acknowledge that the changes that occurred within the Dance/Movement Therapy discipline were not updated with the changes that Goodill, Hill, and McNamara note, and hence, not included in our manuscript.

Goodill, Hill, and McNamara suggest that we were incorrect in our identification of licensure exams, specifically that we did not recognize that dance/movement therapists take the National Counselor Examination (NCE) and submit scores from that exam for licensure. Our manuscript stated correctly that Act 136 does not specifically identify an exam for applicants who have degrees in dance/movement therapy, psychiatry, social work, marriage and family therapy, drama therapy, or human services. Eligibility for Pennsylvania Licensure Exam Registration for the NCE is determined by the National Board for Certified Counselors (NBCC). The application minimally requires that an official transcript of a master's degree in counseling or a related field be submitted.

We further acknowledge and are encouraged to recognize that the American Dance Therapy Association (ADTA) has included equivalent competency requirements in the common content areas of group work, appraisal, and research. However, we would point out that, although the authors suggest that knowledge of professional and ethical practice are included in the ADTA standards, there is no evidence of adherence to the ACA Code of Ethics, history of the profession of counseling, and professional counseling organizations, such as the American Counseling Association.

We are also encouraged that Goodill, Hill, and McNamara concur with our recommendation that the PA state licensure board move to limit its licensure to those disciplines that are not also regulated by another PA state licensure board, specifically: psychologists, psychiatrists, social workers, marriage and family therapists, and drug/alcohol counselors.

We do take exception to Goodill, Hill, and McNamara's inference that a focus on a more unified counselor identity in training and licensure does not contribute to protecting the public. Our article was intended to bring attention to the lack of clarity in the requirements for professional orientation in the training standards articulated in the law and administrative code. Title 49, Paragraph 49.2.8 specifically defines professional orientation to include "studies that provide an understanding of all aspects of professional functioning, including history, roles, organizational structures, ethics, standards and credentialing." Our position is that a common "Professional Counselor" identity should be required of all counselor preparation programs in Pennsylvania and therefore assure that content areas that examine the practice, history, and roles of professional counselors are included in all professional counselor training programs. In addition, we would advocate for training to include clear understanding of professional identity and ethical practice as promoted by the professional counseling organizational structure and codes of ethical practice of the American Counseling Association as well as the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). The ACA and CACREP are the only two professional organizations whose primary focus is on the counseling profession, either through advocacy for clinicians and clients or through specific counselor training standards.

None of the professional accrediting bodies represented in the "related fields" identified in the law and code require a professional counseling orientation and this oversight has resulted in a fragmented professional identity. Hence, we believe that a unified professional orientation training requirement that emphasizes specific professional counseling functions, as well as ethical practice and standards, is in the best interest of protecting the public. Furthermore, we support the interdisciplinary provision of services for clients seeking treatment for mental and emotional disorders and conditions. Interdisciplinary treatment teams comprised of professional counselors and other related professionals are vital to provide the best practice of holistic care in today's healthcare environment. However, interdisciplinary practice to meet the public's needs depends on strong training and licensure requirements as a precursor for practice in each discipline.

We acknowledge that licensure alone does not clarify professional identity, nor should it. We emphasize that the training standards used to prepare licensees must foster and develop professional identity. Licensure provides the minimal level of preparation required of a specific professional to practice within a given scope and within legal parameters to protect the public from unqualified practitioners. The current LPC training standards required for licensure in PA do not promote a "professional counseling orientation."

In conclusion, we concur with Goodhill, Hill, and McNamara that further dialogue and exchange is needed, both within the PCA and as well with colleagues across the spectrum of disciplines currently identified as "related fields" in the PA licensure law and code.

Sincerely,

Timothy E. Coppock, PhD, LPC, NCC
Associate Professor and Director
Clinical Mental Health Counseling Program
Department of Psychology and Counseling
Gannon University
Erie, PA

Kenneth G. McCurdy, PhD, LPC, NCC
Associate Professor and Outcomes Coordinator
Clinical Mental Health Counseling Program
Department of Psychology and Counseling
Gannon University
Erie, PA

Licensed Professional Counselors and Collaborative Care

Michael T. Morrow
Arcadia University

Jessica A. Cuttic
KidsPeace

Elizabeth R. Cretekos
Valley Youth House

Jan Lineberger
LCI-Lineberger Construction, Inc.

Author Note

We would like to thank Eleonora Bartoli for her guidance in developing our summary of LPC coursework and training. We also appreciate the health professionals who took time to make this study possible. No financial relationships exist between the authors and the training programs noted in this paper. The first author can be contacted at morrowm@arcadia.edu.

Abstract

This study examines the current state of behavioral services in collaborative care, along with health professionals' perceptions of Licensed Professional Counselors (LPCs) as behavioral providers in collaborative settings. Data were gathered from 68 professionals from a range of collaborative programs via an online survey that assessed multiple aspects of their programs as well as their training for collaborative care. Participants also rated LPCs' qualifications to provide behavioral services (assessment, treatment planning, and intervention) in collaborative programs. Overall, participants rated LPCs as moderately qualified for collaborative care and offered multiple reasons why LPCs are and are not suited for these programs. Findings are discussed with regard to the training needed to prepare LPCs for careers in collaborative care.

Licensed Professional Counselors and Collaborative Care

Throughout the United States, behavioral health services tend to be limited in availability, difficult to access, and underutilized when they are obtainable (Office of the Surgeon General, 1999). With the recent passage of the Affordable Care Act (U.S. Department of Health and Human Services, 2013) and newfound federal commitment to increasing behavioral coverage (The White House Blog, 2013), the U.S. stands at a critical juncture for the expansion of behavioral healthcare. As one step toward this reform, collaborative care (CC), a healthcare model integrating medical and behavioral care (Blount & Bayona, 1994), has been debated (World Health Organization, 2008). To move toward

this integration, it is necessary to identify and train behavioral professionals to effectively incorporate and operate within CC programs (O'Donohue, Cummings, & Cummings, 2008).

CC is rooted in the biopsychosocial model, in which biological, psychological, and social factors are considered simultaneously, along with their potential interactions, in the treatment of physical and behavioral illness (Blount & Bayona, 1994). Many CC programs are guided by a social ecological framework targeting individual, interpersonal, and broader environmental factors (e.g., community, organizational, and societal); this model also emphasizes disease prevention and health promotion (McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokols, 2000). CC programs are housed across multiple settings (e.g., hospitals, primary care clinics, community health centers, and mental health agencies), include a diverse array of professionals (e.g., medical providers, behavioral providers, and administrators), and offer a broad spectrum of common and specialty healthcare services (Cummings & O'Donohue, 2011). CC sites may also serve general patient populations or target very specific groups of patients (e.g., patients with diabetes, cardiac conditions, or substance use disorders; Blount, 2003).

Although CC programs vary in numerous ways, they typically include at least one of the following components: (a) patient information is regularly exchanged across medical and behavioral agencies for patients treated in both settings, (b) medical and behavioral services are located in the same physical space, (c) there is an established process for referring patients from medical to behavioral care, and (d) a multidisciplinary team of providers develops unified treatment plans for patients, including medical and behavioral components (Blount & Bayona, 1994). Moreover, three specific models of collaboration have been distinguished: coordinated, co-located, and integrated (Collins, Hewson, Munger, & Wade, 2010).

Coordinated care is the least collaborative arrangement and is simply marked by a referral relationship between separate agencies or providers. Often, medical professionals will recognize the need for behavioral services during a routine visit and then refer to a connected or familiar behavioral provider. Co-located care includes the delivery of behavioral and medical services within the same setting, with a similar referral process as coordinated care. The highest level of assimilation is integrated care, which involves medical and behavioral providers collaborating within a single agency to develop and implement a unified treatment plan that incorporates both medical and behavioral interventions (Blount, 2003; Collins et al., 2010). Integrated care is also thought to capture the administrative and organizational processes that facilitate the delivery of collaborative healthcare services (Oss, 2013).

A growing body of research has revealed numerous benefits of CC. Patients tend to be more satisfied with the medical and behavioral services received in CC settings (Kates, Crustolo, Farrar, & Nikolaou, 2001). Patients' initial show rates for behavioral services also tend to be higher in CC compared to non-collaborative programs (Reynolds, Chesney, & Capobianco, 2006), and observations from the field suggest that show rates are even higher when medical providers facilitate warm handoffs, by introducing patients to behavioral providers in person during medical visits (Horevitz, 2011). In general, CC appears to offer increased access to behavioral services, typically in familiar settings with trusted providers.

The behavioral services offered within CC programs also appear quite promising, especially for certain conditions. Multiple studies have documented support for the feasibility and acceptability of collaborative behavioral interventions for internalizing and externalizing disorders (e.g., Berge, Law, Johnson, & Gawain Wells, 2010; Craske et al., 2002; Richardson, McCauley, & Katon, 2009). A substantial line of research also provides

robust support for the effectiveness of behavioral treatment for depression in CC, including depressive disorders in adults and adolescents (Gilbody, Bower, Fletcher, Richards, & Sutton, 2006; Richardson et al., 2009). Collaborative behavioral services have also been linked to patient gains in adaptive functioning (e.g., increased compliance with medical regimens and decreased absences at work) as well as improved quality of life (Wang et al., 2007; Woltmann, Grogan-Kaylor, Perron, Georges, Kilbourne, & Bauer, 2012). Finally, research suggests that certain collaborative behavioral services are more cost effective than usual care or offset the cost of medical services (Blount et al., 2007; Chiles, Lambert, & Hatch, 1999).

Before initiating this study, we spoke to multiple professionals working in CC to learn about the behavioral providers working in these settings. Per these conversations, we discovered that Psychologists, Social Workers, and Nurses provide a majority of their behavioral services, while LPCs are largely absent from their programs. LPCs are relative newcomers to the healthcare field. The first professional counselor licensure law was passed in 1976 with mental health counseling accreditation standards emerging in 1988 (Gerig, 2007). State licensure for professional counselors was only recently established in all 50 states in 2009 (Shallcross, 2009). Despite their professional status, LPCs have experienced a history of exclusion from access to funding, reimbursement, and several employment settings (Gerig, 2007). Moreover, LPCs continue to be discredited by certain sects of the healthcare field (Barstow, 2012).

In the U.S., each state sets its own requirements for LPC licensure; thus, the exact specifications vary from state to state, as do the precise services that can be offered by an LPC (Gerig, 2007). Nonetheless, all states require a master's degree that typically includes extensive coursework, clinical training, and the successful completion of a comprehensive exam (e.g., The National Counselor Examination). Although curricula vary across programs, Table 1 provides a general description of a possible curriculum with potential concentrations (*What Professional Counselors Can Do for You*, 2013). Moreover, it highlights several guiding principles inherent in LPCs' training and professional identity: evidence-based practice, multicultural competence, strength-based approaches, and client wellness (ACA, 2005; Gerig, 2007).

In the current study, we surveyed behavioral, medical, and administrative professionals currently working in CC programs. Depending on participants' positions (see Method section), they were asked to provide information about their programs (setting, patients, and behavioral services), their training for CC, and their perceptions of LPCs' qualifications for CC. Our primary goals in collecting these data were to examine LPCs' current potential to contribute to CC and shed light on possible steps toward preparing LPCs for careers in CC.

Method

CC professionals were contacted by email or listserv announcements to complete an anonymous online survey. Prior to recruitment, we completed a scan of CC programs in our local and surrounding areas. We contacted site Directors by email asking them to forward a request for participation to the professionals working in their programs. We also posted requests for participation on two listservs for professional CC organizations: the Collaborative Family Healthcare Association (CFHA listserv) and the SAMHSA-HRSA Center for Integrated Health Solutions (PC-BH-Integration listserv). Snowball sampling was employed by including requests to forward our contact emails and listserv announcements to other professionals working in CC.

Before starting the survey, individuals were asked to read a brief description of CC (Blount & Bayona, 1994) to confirm that they worked in a CC program. All those who reported currently working in CC were asked to complete an online survey via a secure link to Survey Monkey. The survey contained a mix of open-ended, forced-choice, checklist, and rating-scale items. Participants were first asked to classify their position (Behavioral, Medical, Administrative, or Other), which determined the specific survey questions they received.

Behavioral professionals were asked about their training for CC. Behavioral and Medical professionals were surveyed about their programs' settings, patients, and behavioral services. We decided to report the findings for Behavioral (but not Medical) professionals regarding settings, patients, and services because a majority of these questions focused on behavioral aspects of CC (e.g., behavioral conditions, therapeutic interventions, and theoretical orientations). Upon review, we concluded that many Medical professionals may lack the knowledge needed to accurately report on these aspects of their programs. Finally, all three groups of professionals rated LPCs' qualifications to administer behavioral services in CC. Before offering their ratings, participants were asked to read a description of LPCs' academic and clinical training (Table 1) that we developed by consulting Dr. Eleonora Bartoli, Director of Arcadia University's Graduate Program in Counseling, and drawing from a recently developed educational brochure (*What Professional Counselors Can Do for You*, 2013).

Although nonbehavioral (Medical and Administrative) professionals might lack prior knowledge about LPCs, we chose to assess their impressions of LPCs' qualifications for CC for several reasons. First, nonbehavioral professionals often play key roles in hiring behavioral providers and overseeing multidisciplinary teams; thus, their perceptions may heavily influence LPCs' access to and experience in CC positions. Furthermore, by examining nonbehavioral professionals' views of LPCs, it may be possible to identify gaps and misperceptions about LPCs' qualifications that could be limiting their entry into CC.

The final sample included 68 participants who reported their positions as follows: 37 (54.41%) Behavioral, 13 (19.12%) Medical, and 16 (23.53%) Administrative. Two participants (2.94%) reported their position as Other. All participants were then prompted to offer open-ended descriptions of their roles, which were coded. We coded professionals as Directors if they reported directing, managing, coordinating or leading programs, clinics, or projects. Participants were coded as Consultants if they provided training to CC professionals (but not direct care), as Supervisors if they offered supervision to CC providers (but not direct care), and as Trainees if they provided healthcare services as part of their clinical training (e.g., as externs or interns).

The 37 Behavioral professionals were coded into the following positions: 8 Directors, 8 Nurses, 7 Counselors or Therapists, 6 Psychologists, 3 Consultants, 2 Supervisors, 2 Trainees, and 1 Social Worker. The 13 Medical professionals were coded as follows: 10 Nurses, 1 Director, 1 Physician, and 1 Psychiatrist. All 16 Administrative professionals listed their positions as administrators; one participant reported serving as an Administrator and healthcare navigator. Of those who chose Other professional, one reported dual roles as both a Medical and Behavioral Nurse; the other reported working as a Medical Nurse and Administrator.

Results

We conducted descriptive and inferential analyses of the quantitative data collected, along with content analyses of the qualitative data. A four-step process was used to analyze the qualitative data. For each open-ended item, two coauthors reviewed responses

separately and generated lists of recurring categories/themes. They then met to compare lists, resolve differences, and consolidate categories/themes into one final list. Next, the other two coauthors used these lists to independently code open-ended responses; they then met to compare coded data, settle discrepancies, and create final tallies of codes. Two coauthors generated categories/themes for the first half of items and coded the second half, while the other two generated categories/themes for the second half of items and coded the first half.

CC Programs: Settings, Patients, and Services

Behavioral and Medical professionals were asked to provide open-ended descriptions of their CC programs; however, as explained earlier, we decided to report data for only Behavioral professionals; 36 offered descriptions of their settings, from which we coded seven different settings: 11 (28.94%) primary care clinics, 10 (26.32%) community health centers, 6 hospitals (15.79%), 4 (10.53%) community mental health clinics, 3 (7.89%) specialty care centers, 3 (7.89%) private practices, and 1 nursing home (2.63%). Notably, two respondents reported working in multiple sites, both within hospitals and satellite health clinics.

On a forced-choice item, 15 (40.54%) Behavioral professionals indicated their programs serve targeted patient populations, 13 (35.13%) reported their programs serve general populations, and 9 (24.32%) noted their programs serve general and targeted populations. Participants also provided open-ended descriptions of their targeted patient populations; responses included patients from multiple backgrounds (e.g., military, LGBTQ, and homeless) and with a variety of medical conditions (e.g., cancer, HIV/AIDS, diabetes, cardiac conditions, epilepsy, cystic fibrosis, multiple sclerosis, traumatic brain injury, chronic pain, hypertension, obesity, and sleep disorders) and substance-related disorders. Participants also completed a checklist to indicate all age groups their CC programs serve: 7 (18.92%) serve infants, 16 (43.24%) serve children, 20 (54.05%) serve adolescents, 29 (78.38%) serve young adults, 32 (86.49%) serve middle-age adults, and 31 (83.78%) serve elderly adults.

Table 2 depicts Behavioral professionals' reports of whether their CC programs assess and/or treat multiple behavioral conditions. The three conditions *assessed* most frequently include depression or other mood disorders, suicidal thinking or behavior, and anxiety or obsessions and compulsions; the four conditions *treated* most frequently include depression or other mood disorders, anxiety or obsessions and compulsions, interpersonal problems, and coping with medical problems or treatment. Participants also provided open-ended descriptions of conditions their programs assess and/or treat; two issues mentioned that were not included in our list are challenges with sexual orientation and gender identity.

Behavioral professionals also reported whether their CC programs provide specific services (Table 3). In terms of assessment, roughly 95 percent indicated their sites provide mental health screening, and roughly half revealed their sites offer comprehensive psychological evaluations. With regard to interventions, individual therapy was reported by more participants than all other formats (family, couple, and group therapies). Moreover, short-term therapy (1-20 sessions) was reported most frequently, followed by brief consultation (1-2 sessions), and then long-term therapy (more than 20 sessions). For other services, behavioral care for medical concerns was reported most frequently, while all other services (case management, risk assessment, crisis management, support or educational groups, preventive behavioral care) were endorsed by roughly 50 to 65 percent of participants.

Participants were then asked to select three psychological orientations most fre-

quently utilized at their CC sites. The cognitive-behavior orientation was endorsed by 34 (91.89%) of the Behavioral professionals; the motivational orientation and behavioral orientations were both endorsed by 19 (51.35%). Other orientations were reported by fewer participants: mindfulness (37.84%), family systems (27.03%), acceptance and commitment (24.32%), dialectical (21.62%), interpersonal (18.92%), psychodynamic (16.22%), and attachment-based (16.22%).

Participants also completed a five-point (1 = *Very Rarely*, 2 = *Rarely*, 3 = *Sometimes*, 4 = *Often*, 5 = *Almost Always*) rating scale to assess the extent to which their CC sites adhere to four principles: evidence-based practice, multicultural competence, strength-based approaches, and holistic care. On average, participants reported that their sites often incorporate each principle: evidence-based practice (M = 4.30, SD = .88), multicultural competence (M = 4.14, SD = .82), strength-based approaches (M = 4.57, SD = .69), and holistic care (M = 4.51, SD = .65).

Training for CC: Received and Requested

Behavioral professionals were asked to describe the training they received for CC. Overall, 33 Behavioral professionals provided open-ended responses, and three broad categories were identified. Fourteen professionals (42.42%) reported receiving specific training in CC practices (e.g., coursework, clinical training, continuing education, conferences, colloquiums, certificate programs, and consultation). Eighteen professionals (54.54%) reported receiving on-the-job training, and one (3.03%) reported receiving no training. Of the 18 professionals who received on-the-job training, 10 (55.56%) received no specific training in CC practices.

Behavioral professionals also described training that would help them work more effectively in CC; 28 participants provided responses, and four categories were identified. Eight professionals (28.57%) requested training in collaborating with different providers, 4 (14.29%) requested training in administrative policies for CC, 8 (28.57%) requested training in best practices for populations seen in CC, and 6 (21.43%) requested no training. For the first category, many responses reflected the need to communicate more effectively with physicians (i.e., learning to *speak physician*). For the second category, participants expressed desire to learn more about the specific services that different health providers are able to offer and claim for reimbursement. For the third category, participants requested training in treatment options for youth, as well as substance abuse, anxiety, chronic pain, and cognitive impairments.

Perceptions of LPCs' Qualifications for CC

All participants (Behavioral, Medical and Administrative) were asked to complete a five-point (1 = *Not at All*, 2 = *Slightly*, 3 = *Moderately*, 4 = *Very*, 5 = *Extremely*) rating scale of LPCs' qualifications to provide CC services; 7 Behavioral professionals skipped these items, and those who identified as Other professional were excluded from these analyses, leaving 59 respondents. Collectively, CC professionals rated LPCs as moderately qualified and as most qualified to provide assessment, followed by intervention and collaborative treatment planning (Table 4). Behavioral professionals' ratings followed the pattern just described. In contrast, Medical professionals rated LPCs as most qualified for treatment, then assessment, and finally treatment planning. Administrative professionals rated LPCs as most qualified for assessment, then treatment planning, and lastly treatment.

Due to the small samples of Medical and Administrative professionals, we performed Kruskal-Wallis tests of differences in the ratings of the three groups. This test is a nonparametric counterpart to one-way ANOVA and does not assume normality of residuals or homogeneity of variances (Kruskal, 1952). With small samples, it is difficult to evalu-

ate assumptions of ANOVA; thus, without making assumptions of normality or homogeneity, the Kruskal-Wallis test is an appropriate alternative (Lix, Keselman, & Keselman, 1996). Results indicated no significant group differences in any ratings, $\chi^2(2) = 1.69 - 3.79, p = .15 - .43$.

For each item on this scale, participants were asked to provide open-ended explanations (Table 5). Those who provided ratings of 1 or 2 (*Not at All* or *Slightly*) were asked to explain why LPCs are *not* qualified for CC. They reported challenges with billing and reimbursement as their top concern, along with limitations on LPCs' privileges to diagnose psychiatric disorders and restrictions on prescribing and managing psychotropic medication. Participants who provided ratings of 3 to 5 (*Moderately*, *Very*, or *Extremely*) were asked to explain why LPCs *are* qualified for CC. Overall, they reported general academic and clinical training most frequently. Several participants also referred to LPCs' specific training in evidence-based and multicultural practices, along with their orientations toward patient strengths and wellness. A few responses also referred to LPCs' qualifications to provide complementary services under the supervision of higher-level providers, while others suggested LPCs are qualified to offer the full range of services and have already demonstrated proficiency in CC.

Discussion

The present study provides a broad picture of CC, along with data regarding behavioral services in CC programs. Despite the small sample of professionals surveyed, the findings highlight rich variation and consistent trends among CC programs. This study also offers a glimpse into CC professionals' views of LPCs' qualifications to work in CC programs. Collectively, these findings lend helpful information to evaluate LPCs' current potential to contribute to CC, as well as guide the Counselor educators in preparing LPCs for careers in CC.

A Snapshot of CC and the Behavioral Services Offered

The current results suggest that CC is quite prevalent within primary care clinics, community health centers, and hospitals. The findings also reveal that CC programs are more likely to serve adults than youth and target specific populations of patients, particularly those with certain medical and behavioral conditions. CC programs also appear to play an important role in offering behavioral screening and assessment services for a wide range of mental health conditions yet focus their behavioral treatment services on a narrower set of conditions.

The behavioral health issues most frequently assessed or treated by these programs include mood, anxiety, suicidality, and challenges coping with physical conditions or medical treatment. Across sites, individual therapy was reported as the predominant treatment format, while therapy services appear generally flexible in duration, from brief consultation to long-term care. Cognitive-behavior therapy was reported as the dominant approach, while motivational and behavioral methods also appeared with some frequency. Several additional psychosocial services were also reported across sites (e.g., case management, risk assessment, crisis management, support or educational groups, and preventive behavioral care).

A Glimpse of CC Professionals' Perceptions of LPCs

Overall, the professionals surveyed rated LPCs as moderately qualified to provide behavioral services in CC, including behavioral assessment, collaborative treatment planning, and behavioral intervention. On average, LPCs were perceived to be most qualified

for assessment, followed by intervention, and then treatment planning. However, there was some variability among participants, with some rating LPCs as *extremely* qualified and others rating them as *not at all* qualified.

Participants who did not view LPCs as qualified for CC referred to challenges with billing and reimbursement (primarily via Medicare) as their main concern, followed by limitations in LPCs' privileges to diagnose psychiatric disorders and restrictions on prescribing and managing psychotropic medication. Several professionals indicated that LPCs do not receive adequate clinical experience for CC, whereas others pointed toward specific educational gaps that might limit LPCs' contribution to CC (e.g., gaps in program development and evaluation, health psychology, and specific populations seen in CC settings).

Participants who considered LPCs qualified for CC largely attributed their ratings to LPCs' general academic and clinical training, suggesting that some professionals view the typical LPC training model as adequate preparation for CC. While several participants suggested that LPCs are qualified to provide the full range of services offered in CC, others carefully noted that LPCs are better suited to provide complementary services under the direction of higher-level providers. Thus, even among those who view LPCs as qualified for CC, there is some disagreement about their competence to provide the full array of behavioral services. Several professionals also referred to LPCs' orientations toward evidence-based practice, multiculturalism, strength-based approaches, and patient wellness. While these doctrines are fundamental to LPCs' professional identity (ACA, 2005; Gerig, 2007), they also appear to be common features of the services offered in CC. Thus, LPCs appear to operate within a framework that is largely consistent with the values and priorities of many CC programs.

Notably, we were surprised to learn from our participants that so few received specific training in CC (e.g., coursework, colloquiums, and certification), other than informal, on-the-job training. This finding speaks to the larger need to ensure that behavioral health providers receive adequate preparation for CC. Participants reported specific training needs in several key areas, such as collaborating with other health providers (e.g., learning to speak physician), administrative policies in CC, and best practices for targeted patient populations.

Limitations of Current Study

Before proceeding, several weaknesses of this study should be recognized. First, there are clear limitations regarding the representativeness of our sample. With only 68 participants, we captured a very small portion of CC professionals. Moreover, we directly contacted several local agencies to participate in this study; thus, our results may reflect specific trends in CC within this particular geographic area that may not extend to other regions. Our small sample size also limited the statistical power of our analysis of professionals' perceptions of LPCs' readiness for CC. With a larger sample, we might have detected significant variation in how behavioral, medical, and administrative professionals view LPCs' qualifications.

It is also critical to note weaknesses in our coding of participants' positions, beyond their own reports as Behavioral, Medical, or Administrative professionals. Some of the categories that we developed likely overlapped, such as Directors and Administrators; it is possible that some of the participants who simply described their positions as administrators may serve as directors. Moreover, we failed gather enough information to distinguish certain positions (e.g., Behavioral and Medical Nurses). Finally, we neglected to assess how many of the Counselors or Therapists were LPCs. Given these weakness, the current findings should be interpreted cautiously.

Training Opportunities for LPCs Interested in CC

Although our findings are tentative, they reveal that additional training is likely needed to prepare LPCs for CC. Currently, there are several degree and certification programs available, most of which focus on preparation for collaborative primary care settings. For instance, Arizona State University (ASU) offers a Doctorate of Behavioral Health (DBH) that includes a curriculum covering multiple dimensions of CC, such as: physical illnesses encountered in CC, evidence-based brief therapies, consultation on multidisciplinary teams, healthcare economics and policy, and business entrepreneurship (ASU, 2013). However, degree programs may not be feasible for LPCs who are currently practicing or do not wish to complete another degree. Fortunately, certificate programs are available and offered by the University of Massachusetts (UMASS), Farleigh Dickinson University (FDU), and the University of Michigan (UofM).

Each program emphasizes an understanding of CC culture, specifically, how to consult with medical professionals and knowledge of behavioral care for chronic illnesses. Other overlapping areas are specialization in brief evidence-based psychotherapies, understanding common psychotropic medications, and culturally competent practices. UMASS's program incorporates specific training in working with families in primary care, as well as integrating care for individuals with serious and persistent mental health challenges (UMASS, 2013). Farleigh Dickinson's curriculum offers training in billing, record keeping, and ethical issues (FDU, 2013). UofM's program incorporates a capstone project, in which students design and implement a project to move their current workplace toward integration (UofM, 2013).

A Possible CC Concentration for LPCs

It may also be possible to integrate CC training into LPCs' curricula. For example, a CC concentration could be developed that includes elective coursework and clinical training. Based on our results, we strongly recommend that this coursework covers four areas of knowledge: (a) common physical conditions and medical treatments, (b) medical models and healthcare policies, (c) health psychology, and (d) program development and evaluation. It is feasible that several topics could be integrated into a single course or infused across multiple classes. To further specialize, students could be encouraged to direct their assigned course work (e.g., literature reviews) and professional development requirements (e.g., conferences, workshops, and webinars) toward the patient populations and health conditions associated with CC.

As part of a CC concentration, we also recommend training in three skill areas: (a) brief screening and assessment (e.g., mood, anxiety, and suicidality), (b) conceptualization of relations between physical and behavioral conditions, and (c) evidence-based interventions (e.g., CBT, BT, and MI). This skills training could occur within courses or even as labs connected to classes. As an additional requirement, students could be required to complete internship at a CC site. Given the current limitations associated with billing and reimbursement for LPCs, the last expectation may not be feasible at this time. Nevertheless, at least one Counseling program has successfully established a CC training clinic (see Curtis & Christian, 2012).

The Importance of Advocacy

In tandem with developing training programs, it will be necessary to advocate for change in healthcare policy, especially with billing and reimbursement through Medicare and Medicaid. Notably, advocacy efforts are currently underway by the American Counseling Association (Barstow, 2012). As part of this process, we believe that it is vital to educate the larger healthcare field, including medical providers, administrators, and

even behavioral providers about LPCs. To facilitate this process, an informational pamphlet was recently developed (*What Professional Counselors Can Do For You*, 2013), and is available for distribution by contacting the first author. Finally, it is essential that LPCs and Counselor educators unite as a professional body to build the critical mass needed to establish LPCs' place in CC.

References

American Counseling Association. (2005). *ACA Code of Ethics*. Alexandria, VA: Author.

Arizona State University. (2013). *Doctor of Behavioral Health*. Retrieved from http://asuonline.asu.edu/dbh

Barstow, S. (2012, January). *Counselors, the patient protection and affordable care. act, and more*. Presentation at the Conference of the American Association of State Counseling Boards Conference in Charleston, SC.

Berge, J. M., Law, D. D., Johnson, J., & Gawain Wells, M. (2010). Effectiveness of a psychoeducational parenting group on child, parent, and family behavior. *Families, Systems, & Health*, *28*, 224–235. doi: 10.1037/a0020907

Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health, 21*, 121-134. doi: 10.1037/1091-7527.21.2.121

Blount, A., & Bayona, J. (1994). Toward a system of integrated primary care. *Family Systems Medicine*, *12*, 171-182. doi: 10.1037/h0089151

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B., Thomas, M., O'Donohue, W., & Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. *Professional Psychology: Research and Practice, 38*, 290-297. doi: 10.1037/0735-7028.38.3.290

Collins, C., Hewson, D., Munger, R., & Wade, T. (2010). *Evolving models of behavioral health integration in primary care*. New York: Millbank Memorial Fund. doi: 10.1599/EvolvingCare2010

Chiles, J., Lambert, M., & Hatch, A. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology: Science and Practice, 6*, 204-220. doi: 10.1093/clipsy.6.2.204

Craske, M. G., Roy-Byrne, P., Stein, M. B., Donald-Sherbourne, C., Bystritsky, A., Katon, W., & Sullivan, G. (2002). Treating panic disorder in primary care: A collaborative care intervention. *General Hospital Psychiatry, 24*, 148-155. doi: 10.1016/S0163-8343(02)00174-3

Cummings, N. A., & O'Donohue, W. T. (2011). *Understanding the behavioral healthcare crisis*. New York: Routledge.

Curtis, R., & Christian, E. (2012). *Integrated care: Applying theory to practice*. New York: Routledge.

Kates, N., Crustolo, A., Farrar, S., & Nikolaou, L. (2001). Integrating mental health services into primary care: Lessons learnt. *Families, Systems, & Health, 19*, 5-12. doi: 10.1037/h0089457

Kruskal, W. H. (1952). A nonparametric test for the several sample problem. *Th Annals of Mathematical Statistics, 23*, 525-540. doi: 10.1214/aoms/1177729332

Farleigh Dickinson University. (2013, November 24). *Certificate Program in Integrated Primary Care*. Retrieved from http://integratedcare.fdu.edu/

Gerig, M. S. (2007). *Foundations for mental health and community counseling: An Introduction to the profession*. Columbus, OH: Pearson.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for

depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine, 166*, 2314-2321. doi: 10.1001/archinte.166.21.2314

Horevitz, E. (2011, December 22). Integrate this: Evidence-based practice in integrated primary care. Retrieved from http://www.cfha.net/blogpost/689173/CFHA-Blog

Lix, L. M., Keselman, J. C., & Keselman, H. J. (1996). Consequences of assumption violations revisited: A quantitative review of alternatives to the one-way analysis of variance F test. *Review of Educational Research, 66*, 579-619.

McLeroy, K. R., Steckler, A., & Bibeau, D. (1988). The social ecology of health promotion interventions. *Health Education Quarterly, 15*, 351-377. doi:10.1177/109019818801500401

O'Donohue, W. T., Cummings, N. A., & Cummings, J. L. (2009). The unmet educational agenda in integrated care. *Journal of Clinical Psychology in Medical Settings, 16*, 94-100. doi: 10.1007/s10880-008-9138-3

Office of the Surgeon General, Center for Mental Health Services, & National Institute of Mental Health. (1999). *Mental Health: A Report of the Surgeon General*. Retrieved from http:// www.surgeongeneral.gov/library/reports/

Oss, M. E. (2013). *What's in a word? A lot, if that word is "integrated."* Retrieved from http://www.openminds.com/

Reynolds, K., Chesney, B., & Capobianco, J. (2006). A collaborative model for integrated mental and physical health care for the individual who is seriously and persistently mentally ill. *Families, Systems, & Health, 24*, 19-27. doi: 10.1037/1091-7527.24.1.19

Richardson, L., McCauley, E., & Katon, W. (2009). Collaborative care for adolescents: A pilot study. *General Hospital Psychiatry, 31*, 36-45. doi: 10.1016/j.genhosppsych. 2008.09.019

Shallcross, L. (2009). Counseling profession reaches the big 5-0. Retrieved from http://ct. counseling.org/2009/12/counseling-profession-reaches-the-big-5-0/

Stokols, D. (2000). Social ecology and behavioral medicine: Implications for training, practice, and policy. *Behavioral Medicine, 26*, 129-138. doi: 10.1080/08964280009595760

The White House Blog. (2013, November 24). *The Affordable Care Act and Expanding Mental Health Coverage*. Retrieved from http://www.whitehouse.gov/blog/2013/

University of Michigan. (2013, November 24). *Web-Based Certificate in Integrated Behavioral Health and Primary Care*. Retrieved from http://ssw.umich.edu/

University of Massachusetts. (2013, November 24). *The Center for Integrated Primary Care*. Retrieved from http://www.umassmed.edu/cipc/index.aspx

Wang, P. S., Simon, G. E., Avorn J., Azocar, F., Ludman, E. J., McCulloch, J., Petukhova, M. Z., & Kessler, R. C. (2007). Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized controlled trial. *Journal of the American Medical Association, 298*, 1401-1411. doi:10.1001/jama.298.12.1401

What Professional Counselors Can Do for You. (2013). Glenside, PA: Arcadia University.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A., & Bauer, M. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis. *American Journal of Psychiatry, 169*, 790-804. doi: 10.1176/appi.ajp.2012.11111616

World Health Organization. (2008). Integrated health services: What and why? *Technical Brief, 1*, 1-10.

Table 1

Summary of Licensed Professional Counselors' Training and Practice

Overview of LPC Training and Practice
Licensed Professional Counselors (LPCs) provide direct counseling services to patients with diverse and co-occurring psychosocial needs. LPCs are trained to assess and promote behavioral change, wellness, and resilience by utilizing a variety of counseling practices that are multiculturally sensitive and evidence-based. Prior to licensure, LPCs complete 60 credits of graduate coursework, along with 3,000 supervised hours of clinical training. In contrast with most other masters-level clinicians, LPCs' curriculum is more focused on learning to provide direct counseling services. LPCs' training is also distinct in its emphasis on patient-centered and strength-based approaches aimed to empower patients to make significant positive changes in their lives. With this training, LPCs are suited to work across a wide range of settings and also in partnership with other health providers to coordinate holistic approaches to patient care. Although state policies vary, a majority of services provided by LPCs are billable. Please see below for additional information on LPCs' coursework and clinical training.
Representative Coursework and Clinical Skills Training
Human growth and development Social and cultural foundations of development Psychopathology and wellness models Screening and some types of assessment Psychoeducation Theories and techniques of counseling Multiple treatment modalities Individual and group therapy Couples and family therapy Evidence-based practice Multicultural competence Research methods and program evaluation Career & lifestyle development Professional issues and ethical practice Supervised clinical practicum and internship Opportunities to specialize in areas, such as: Community mental health Child & family therapy Substance abuse counseling Treatment of trauma-related symptoms

Note. LPC = Licensed Professional Counselor. Participants were asked to review it before completing their ratings of LPCs' potential contribution to collaborative care programs.

Table 2

Behavioral Conditions Assessed and Treated at Behavioral Professionals' Collaborative Care Sites (N = 37)

Attention Problems	Hyperactive or Impulsive Behavior	Oppositional Behavior or Conduct Problems	Early Childhood Problems	Developmental Delays
A: 67.57% T: 67.57%	A: 72.97% T: 72.97%	A: 48.65% T: 45.95%	A: 32.43% T: 18.92%	A: 29.73% T: 16.22%
Autism Spectrum Symptoms	Mental Retardation	Other Cognitive Impairments	Learning Disorders	PTSD or Trauma Symptoms
A: 32.43% T: 24.32%	A: 27.03% T: 16.22%	A: 59.46% T: 43.24%	A: 21.62% T: 8.11%	A: 83.78% T: 78.38%
Abuse or Neglect	Substance Abuse or Addictive Behavior	Depression or other Mood Disorders	Anxiety or Obsessions and Compulsions	Eating Disorders
A: 67.57% T: 54.05%	A: 86.49% T: 72.97%	A: 97.30% T: 94.59%	A: 94.59% T: 94.59%	A: 64.86% T: 48.65%
Personality Disorders	Suicidal Thinking or Behavior	Non-Suicidal Self-Injurious Behavior	Unsafe Sexual Behavior	Problems with Parenting or Discipline
A: 72.97% T: 62.16%	A: 94.59% T: 81.08%	A: 72.97% T: 64.86%	A: 62.16% T: 56.76%	A: 54.05% T: 45.95%
Interpersonal Problems	Grief or Bereavement	Problems with Medical Adherence	Poor Nutrition or Sedentary Lifestyle	Coping with Medical Problems or Treatment
A: 86.49% T: 83.78%	A: 81.08% T: 81.08%	A: 86.49% T: 78.38%	A: 81.08% T: 67.57%	A: 89.19% T: 83.78%

Note. A = Assess. T = Treat. Percentage values indicate the percentage of sites that assess or treat each condition.

Table 3

Behavioral Services Provided at Behavioral Professionals' Collaborative Care Sites (N = 37)

Assessment Services	%	Intervention Services	%	Other Services	%
Developmental Screening	21.62%	Individual Therapy	89.19%	Case Management	59.46%
Mental Health Screening	94.59%	Couple Therapy	62.16%	Risk Assessment	56.76%
Cognitive Testing	37.84%	Family Therapy	75.68%	Crisis Management	56.76%
Academic Testing	8.11%	Group Therapy	51.35%	Support or Educational Groups	64.86%
Comp. Developmental Evaluation	13.51%	Brief Consultation	62.16%	Preventive Behavioral Care	51.35%
Comp. Psychological Evaluation	54.05%	Short-term therapy	81.08%	Behavioral Care for Medical Concerns	86.49%
Comp. Neuropsychological Evaluation	18.92%	Long-term therapy	48.65%		

Note. Percentage values indicate the percentage of sites that provide each service. Comp. = Comprehensive. Within the survey, Brief Consultation was described as *1-2 sessions*, Short-term Therapy was described as *1-20 sessions*, and Long-term therapy was described as *More than 20 sessions*.

Table 4

Perceptions of LPCs' Qualifications for Collaborative Care (N = 59)

	Behavioral Professionals	Medical Professionals	Administrative Professionals	All Professionals
Areas of Contribution	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)	*M* (*SD*)
Assessment	3.62 (1.15)	4.15 (1.07)	3.93 (1.21)	3.86 (1.15)
Treatment Planning	3.50 (1.25)	4.11 (.93)	3.75 (1.07)	3.70 (1.15)
Behavioral Treatment	3.60 (1.19)	4.40 (.70)	3.73 (1.22)	3.77 (1.17)
Overall Contribution	3.47 (1.22)	4.33 (.71)	3.80 (1.15)	3.73 (1.15)

Note. LPC = Licensed Professional Counselor. Means correspond to a 5-point scale (1 = *Not at All*, 2 = *Slightly*, 3 = *Moderately*, 4 = *Very*, 5 = *Extremely*). Behavioral (n = 30); Medical (n = 13); Administrative (n = 16). There were no significant differences in any of the ratings across the three groups.

Table 5

Themes Regarding Licensed Professional Counselors' Qualifications for Collaborative Care

Why are LPCs qualified for CC?
General academic training (coursework and course content)
General clinical training (supervised clinical experiences)
General orientation matches mission of CC
Specific training in evidence-based practices
Specific training in multicultural practices
Specific orientation toward patient wellness, holistic health, and growth
Specific orientation toward patient strengths, resources, barriers, and developmental needs
Clinical skills would complement those of other providers on multidisciplinary team
Equally competent to other types of behavioral providers working in CC
Already working in CC and have demonstrated proficiency
Adequately trained to provide supportive services to higher-level behavioral providers
More cost effective than many other types of behavioral providers working in CC
Why are LPCs not qualified for CC?
Challenges with billing and reimbursement from Medicare for services provided by LPCs
Limitations in LPCs' training and privileges to diagnose psychiatric disorders
Not trained or privileged to prescribe or manage psychotropic medication
Limited general clinical training (supervised clinical experiences)
Lack of training in research methods, statistics, and integrating new research findings into practice
Lack of training in program development and evaluation
Lack of training in medical models, medical health conditions, and health psychology
Lack of training in understanding, assessing, and conceptualizing interactions among medical and behavioral issues
Lack of academic and clinical training in CC practices
Limited experience in medical settings relative to other types of behavioral providers
Lack of specialized training with specific populations seen in CC

Note. LPC = Licensed Professional Counselor. CC = Collaborative Care

Creating Effective Counselors: Integrated Multicultural and Evidence-Based Curricula in Counselor Education Programs

Eleonora Bartoli & Michael Morrow
Arcadia University

Christian Gaskin Dozier
The Center for Growth

Alexandra Mamolou
NHS Human Services

Angela R. Gillem
Arcadia University

Author Note

Eleonora Bartoli, Angela R. Gillem, and Michael Morrow, Psychology Department, Arcadia University. Christian Gaskin Dozier, The Center for Growth. Alexandra Mamolou, NHS Human Services. Correspondence for this article should be addressed to Eleonora Bartoli, Arcadia University, Psychology Department, 450 S. Easton Rd., Glenside, PA 19038. E-mail: bartolie@arcadia.edu.

Abstract

Traditionally, counselor education programs offer a single multicultural (MC) course addressing the concerns of all diverse populations, and a single research course providing students with tools to evaluate scientific evidence. Inclusion of MC and evidence-based (EB) practice information across the curriculum is potentially an effective method of addressing the shortcomings of the "one course" system; however, the amount of inclusion across courses can vary widely depending on the faculty, the course itself, and administrators' ability to coordinate curricula. The authors describe a curriculum that both infuses and integrates MC and EB practice perspectives in a comprehensive way in a counselor education program without requiring additional credits. Examples of how to prepare students to think scientifically and sensitively about their work with clients are also presented.

Keywords: multiculturalism, evidence-based practice, curriculum, counselor education training

Creating Effective Counselors: Integrated Multicultural and Evidence-Based Curricula in Counselor Education Programs

Traditionally and most commonly, counselor education programs have offered a single multicultural course (Curtis-Boles & Bourg, 2010; Malott & Paone, 2012) to pre-

pare students to work with a variety of cultural groups, and a single research course to train students to analyze scientific evidence. This "single course" model is inadequate to train counselors to be culturally sensitive to the range of diversity that they will encounter in their work and to become skilled consumers of evidence-based practices (Fouad, 2006; Leffler, Jackson, West, McCarty, & Atkins, 2013; Hunsley, 2007; Sheu & Lent, 2007). It has been argued that infusion of multicultural (MC), and by extrapolation evidence-based (EB), content across the curriculum ensures that both areas are covered broadly and with more depth (see Forman, Fagley, Steiner, & Schneider, 2009; Lee, 2007; Malott & Paone, 2012). In fact, some programs attempt to do just that by encouraging faculty to address both topics in all of their courses (Lee, 2007).

The "infusion" model, however, leads to inconsistent coverage of the material both across courses and over time, due to the fact that faculty may be more or less trained, committed to, or experienced in MC and EB concepts and practices (Prieto, 2012; Sehgal et al., 2011). Further, most programs have courses taught by a mix of full-time and part-time faculty, with some of the latter teaching only sporadically in the program. In this context, coordinating the exact content covered in each course, and ensuring that the curriculum is in fact delivered, is a difficult proposition for program administrators. Another solution suggested by Malott and Paone (2012) is to require more than one multicultural course; however, additional courses imply an increased credit load (and cost) for students.

In this paper, we will describe an integrated MC and EB curriculum that addresses these shortcomings by combining the single course model with the infusion model, producing a curriculum that can be consistently delivered across courses and faculty. The proposed curriculum does not require additional courses or credits. We will review the relevance of MC and EB concepts to the work of counselors, especially as these concepts are promoted by the American Counseling Association (ACA) Code of Ethics (ACA, 2005). We will briefly address potential systemic resistance to integrating MC and EB content into counselor education programs and how to overcome it. We will also highlight the inextricable connection between MC and EB practices and make an argument for their integration (and not simply infusion) within the curriculum. Finally, we will describe the structure and content of an integrated MC and EB curriculum implemented in our counselor education program and reflect on how the curriculum impacts some of the students.

Multicultural and Evidence-Based Practice in Counselor Education Programs

Ethical Considerations and Concerns in Multicultural and Evidence-Based Training

Multicultural content is incorporated in a number of places in the ACA Code of Ethics (ACA, 2005), including sections on client rights, assessment, supervision, and research. Multicultural competence is called upon in the most central way in the section relevant to counselor education, where the ACA Code of Ethics calls for counselor educators to "infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors" (ACA, 2005, p. 15) and to "actively train students to gain awareness, knowledge, and skills in the competencies of multicultural practice" (p. 16). Without an adequate structure within which to do so, counselor education programs cannot meet the multicultural mandates of the ethics code.

In addition to the logistical difficulties involved in delivering a coordinated MC curriculum, as described earlier, a department's culture can also enable or undermine efforts in this direction (Alvarez, Blume, Cervantes, & Thomas, 2009; Fouad, 2006; Pieterse, Carter, Evans, & Walter, 2010; Tummala-Narra, 2009). For instance, the depart-

ment that housed the counselor education program described in this paper, voted more than 10 years ago to 'multiculturalize' its graduate program. However, at the time, there was a single faculty member with specialty in this area; the program lacked a critical mass of multiculturalists in order to craft and deliver a more comprehensive program. It was not until a second multiculturalist was hired into a leadership position that the original intent was re-engaged and ultimately operationalized.

EB practice is also strongly emphasized in the ACA Code of Ethics, starting with the Preamble, which describes a resolute commitment to the application of science in the counseling profession (ACA, 2005). EB practice appears repeatedly throughout the Code, most notably in the Scientific Bases for Treatment Modalities section, in which counselors are called to "use techniques/procedures/modalities that are grounded in theory and/or have an empirical or scientific foundation" (pp. 10-11). Counselors are also obliged to discuss with clients the potential risks and ethical implications of utilizing interventions that lack adequate empirical support.

Despite this ethical mandate, the EB practice movement has encountered opposition within the mental health field (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, in press). It is likely that much of this resistance stems from the narrow view that EB practice only involves utilizing empirically supported treatments. In recent years, advocates of EB practice have moved toward a broader model that envisions EB practice as an overarching framework for science-based clinical decisions across multiple dimensions of counseling (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Additional resistance to EB practice originates from concerns regarding manualized treatments (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009), insofar as they may detract from the creativity, flexibility, and humanity of counselors' work with clients. Nonetheless, a majority of manuals emphasize the common elements of counseling, and many promote individualizing interventions to meet clients' unique needs (Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Lilienfeld et al., 2013). Regardless of whether this resistance is present in a specific academic program or mental health agency, it is essential to prepare students to handle the opposition to, and confusion about, EB practice that they are likely to encounter in their counseling careers.

Integration of Multicultural and Evidence-Based Practices

EB and MC practice are inextricably linked. EB practice relies on accurate assessment and conceptualization, as well as on implementing interventions appropriate to each population (La Greca, Silverman, & Lochman, 2009; Lee, 2007). The successful application of techniques, in turn, requires the development of a strong therapeutic alliance (Vasquez, 2007). At each step, MC considerations are key (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009).

For instance, the literature (e.g., Helwick, 2012) describes the tendency to over-diagnose paranoid symptoms in clients of color, as clinicians at times underestimate clients' experiences with racism. Such misinterpretations lead to incorrect diagnoses and, consequently, inappropriate treatment. MC variables are also central to conceptualization. If a mother of a young child feels intense guilt or anxiety when she leaves her child in daycare or a father feels dejected for being out of work, simply classifying such symptoms as irrational thoughts misses the influence of gender and cultural norms on their development. Without such gender/cultural analysis, interventions that exclusively target the irrational thoughts risk "blaming the victim" and may be more harmful than healing.

Cultural adaptations of EB interventions are essential in preventing harm as well. For instance, some parenting programs were found to be effective with White populations, but led to a decrease in the desired behaviors in Latino and African American

populations (Maríñez-Lora & Atkins, 2012). We cannot simply ask ourselves whether a treatment is EB, we must also ask to whom the evidence applies. Finally, the presence of a safe and strong therapeutic alliance is essential not only to the appropriate delivery of interventions, but also, and perhaps most importantly, to counselors' ability to engage clients in treatment to begin with. Multicultural insensitivity creates fertile ground for therapeutic ruptures. Minority populations tend to seek treatment much less readily and drop out of treatment more frequently than mainstream populations (e.g., Owen, Imel, Adelson, & Rodolfa, 2012; Thompson, Bazile, & Akbar, 2004). In sum, despite the widespread practice of discussing MC and EB separately both in training programs and in the field, their separation is problematic; there is no evidence-based practice without multicultural practice, as accurate implementation of the former requires a degree of sophistication in the latter.

The Curricula

Evidence-Based Practice Curriculum

We have adopted a view of EB practice as a broad model for clinical decision making that includes not only the selection and implementation of empirically supported interventions, but also decisions regarding other important aspects of the counseling process: assessment, conceptualization, progress monitoring, treatment planning, evaluation, and adaptation. In this framework, clinical decisions are based on two dimensions: science and the situation. That is, decisions are always guided by scientific theory, empirical research, and basic scientific principles (e.g., hypothesis testing, establishing a baseline, and repeated measurement). At the same time, clinical decisions must account for unique facets of the counseling situation, including clients' background (e.g., beliefs, preferences, and values) and features of the treatment context (e.g., characteristics of the community where treatment is offered, aspects of the treatment setting, potential managed care restrictions). The ultimate goal of this model is to integrate information from both dimensions.

This expanded perspective of EB practice involves training students to learn multiple skills: choosing reliable and valid assessment and monitoring tools, integrating scientific theories into case conceptualizations, evaluating and selecting specific interventions, monitoring clients' progress, providing psychoeducation, practicing empirically supported skills, and utilizing EB treatment manuals with both fidelity and flexibility. In our counselor education program, we also emphasize that EB processes can be adapted to account for obstacles encountered in the "real world" by assisting students in recognizing challenges to EB practice (e.g., limits on the number of sessions) and identifying strategies to overcome these barriers, while staying true to an EB approach.

EB concepts and skills apply to several counseling areas and should be reinforced across courses; in that process, it is extremely helpful to use a common language. In refining our curriculum, we have discovered that our instructors often utilize different terminology for similar EB concepts. For instance, in some cases, treatment "mediators" might be called "mechanisms," "active ingredients," or "process variables" (see Sprenkle, Davis, & Lebow, 2009). This divergent terminology tends to confuse students, who might then be less able to apply these concepts across courses and contexts. Thus, it is critical for faculty to agree on a common EB vernacular and help students recognize the overlap among similar terms.

In our program, students take a research course in their first year that is designed to lay a foundation of skills that carries into other courses. Specific skills include thinking scientifically, hypothesis testing, critiquing research studies, evaluating meta-analyses,

interpreting moderators and mediators, and utilizing established criteria to judge the level of empirical support for interventions (Chambless & Hollon, 1998; Nathan & Gorman, 2007) and their potential for harm (Lilienfeld, 2007). Students develop these skills by repeatedly critiquing research. While randomized controlled trials are featured heavily, alternate research designs (observational studies, case studies, and meta-analyses) are also included, and their implications for counseling are discussed. As students develop these skills, they are consistently asked to judge whether a study and its findings are persuasive enough to influence their counseling decisions (e.g., to select a specific treatment or integrate a finding into a case conceptualization).

Through this course, students also learn to weigh different treatment options in cases where several empirically supported interventions are available for and applicable to a given client (e.g., cognitive-behavior therapy and interpersonal psychotherapy for adolescent depression; David-Ferdon & Kaslow, 2008). These scenarios offer an excellent opportunity for students to incorporate not only science, but also the unique variables embedded in the clinical situation. Students are also taught to consider the clinical implications of moderators (will an empirically supported treatment benefit specific clients and in certain contexts?) and mediators (which techniques or processes should be targeted during counseling?) in research (Rose, Holmbeck, Coakley, & Franks, 2004). Throughout this process, we make a concerted effort to highlight the notion that EB interventions are not only essential to ensuring adequate treatment progress and accountability in counseling, but also to avoid harming clients, directly or indirectly (see Lilienfeld, 2007), a reality that the mental health field often ignores.

Students are guided to develop a balanced view of research by recognizing its limitations and the gaps in the literature. As there are many questions research has yet to answer, students are invited to think about how to follow an EB framework when there is very limited empirical work to guide the process (e.g., by evaluating related research and incorporating basic scientific practices into treatment). Our goal is to help students develop a resilient orientation toward EB practice that is malleable to the constraints and demands of "real" counseling with "real" clients in "real" settings. Furthermore, we prepare them to address potential resistance to EB practice by discussing and role-playing various scenarios (e.g., how to respond if a supervisor asks them to use a potentially harmful treatment or how to reply to a colleague who describes a treatment as "well-established" when in fact the intervention does not meet criteria). Students are invited to practice articulating arguments and providing corrective information in professional and respectful ways.

Students then carry their foundational EB skills into other courses. For instance, some courses require students to select appropriate assessment tools by evaluating the reliability and validity of the measure, while other courses ask them to develop avenues for tracking progress throughout treatment in ways that are both scientifically-grounded and feasible for clients. Many courses challenge students to review, evaluate, and integrate developmental theory and research in case conceptualization, while in others, students repeatedly practice the process of identifying and weighing empirically supported interventions to craft treatment plans.

In addition to EB decision making, most courses provide students the opportunity to practice empirically supported techniques and interventions. We typically do so through structured role plays with mock clients (usually another student in the program), synchronously in class or in formal training rooms with a two-way mirror, or asynchronously through videotapes. Several courses include role-play assignments in which students practice delivering psychoeducation on psychological theories and research findings

related to clients' specific presenting concerns in a manner that is engaging and easily understandable (e.g., using stories, metaphors, visual aids, and activities).

Many courses provide students with opportunities to practice the basic counseling techniques that recur across a range of empirically supported therapeutic modalities and specific interventions (e.g., positive regard, congruence, appropriate empathy, validation, interpretation, reframing, and cultivating detachment; Lebow, 2005; Sprenkle et al., 2009). After developing these essential skills, students are then asked to practice larger interventions (e.g., Parent Management Training, Cognitive-Behavior Therapy, and Exposure and Response Prevention). To facilitate this, several courses incorporate evidence-based treatment manuals (e.g., Cohen, Mannarino, & Deblinger, 2006; Kazdin, 2005; Kendall & Hedtke, 2006; March & Mulle, 1998) while keeping in mind that recommended treatment protocols may change with advances in research. Additional skills-based training in EB approaches (e.g., Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Motivational Interviewing, Interpersonal Psychotherapy, and Multi-Dimensional Family Therapy) could also be offered through workshops outside of class, where students might be required to complete a certain number of trainings prior to graduation.

MC considerations are also incorporated throughout the aforementioned EB curriculum in numerous ways. For instance, students are invited to think about whether given assessment instruments are appropriate for different cultural groups. We also challenge students to examine research on risk and resilience across different cultures and reflect on the impact of these differences on case conceptualization and treatment planning. Additionally, students review the emerging literature on culturally adapted treatments (Bernal et al., 2009; Maríñez-Lora & Atkins, 2012), consider when to integrate these adaptations into their treatment plans, and practice implementing the skills needed to execute them. In sum, the success of EB training depends on its integration with MC training, as well as its *systematic* infusion throughout the program.

Multicultural Curriculum

MC training is often based on a model encompassing three components: knowledge, skills, and self-awareness (Sue & Sue, 2003). Traditionally, MC training has focused primarily on self-awareness and knowledge, as core MC skills are less readily identifiable and their practice require more time and pedagogical resources. Therefore, our aim in revising our MC curriculum was twofold: create a clearly defined skills curriculum and expand the training in the areas of self-awareness and knowledge. We developed a model that didn't add credits or cost to students' program plans, but allowed us to hire faculty to deliver the additional training. We did so by creating MC labs associated with core courses that carried zero credits for the student, but one credit for the faculty teaching them.

The proposed MC Curriculum consists of 4 nine-hour MC labs (two self-awareness labs and two knowledge labs), that are connected to four separate courses; each of these four courses is a pre-requisite for the one that follows: an introductory psychopathology course, an introductory theories and techniques course, and two sequential internship courses. The two self-awareness labs are attached to the first two courses, while knowledge labs are attached to the internship courses. Combined, the four labs are equivalent to almost one full additional course. We continue offering the traditional multicultural course, which also addresses MC self-awareness and knowledge. Finally, we developed a clearly defined skills curriculum, which is delivered developmentally in three sequential courses: the introductory psychopathology and theories and techniques courses mentioned above, as well as an advanced counseling techniques course.

Specific curricula were developed for all three content areas (knowledge, self-awareness, and skills). Thus, faculty teaching a given course is responsible for delivering

specific sections of the curriculum, and faculty teaching subsequent courses can rely on students having acquired that prior information. For instance, in the knowledge area, the psychopathology course covers concepts related to assessment and diagnosis. Here, students learn to accurately assess symptoms to avoid over or under-diagnosing. The multicultural course covers material related to the history and primary concerns of given populations; for instance, there may be a unit describing the concerns affecting LBGT clients, African American clients, religious and spiritual clients, and so forth. The knowledge labs offer us an additional six units to cover this material as well.

The MC self-awareness curriculum is delivered both in the labs attached to the psychopathology and introductory theories and techniques courses, as well as in the multicultural course. The self-awareness curriculum invites students to understand and explore their sociopolitical identities; to track their biases and multicultural countertransference; to learn how to remain engaged in difficult or culturally charged dialogues without shutting down due to guilt or defensiveness; to become adept at analyzing both their mainstream (or privileged) and marginal identities, realizing the impact these might have on others; and to identify their need for additional training, allies, and accountability for ongoing self-work.

The MC skills curriculum is delivered in the psychopathology course, and in both the introductory and advanced counseling techniques courses. In the psychopathology course, MC skills apply to both assessment and diagnosis. Here students are taught the cultural influences on diagnoses, with particular emphasis on understanding whether given behavioral markers are symptoms of psychiatric concerns or culturally accepted/appropriate behaviors. For example, within given cultural or religious contexts, contact with a deceased ancestor may not be the sign of a thought disorder. This course also trains students on how to ask cultural questions during an initial assessment. In this context, students are taught to think of culture in all of its richness, and not simply as a potential liability. For instance, being a woman may imply experiencing some form of sexism, but there is much to womanhood that falls outside of that experience and that is enriching. Therefore, the strength and wellness based approach characteristic of counseling is at the foundation of this training.

In the introductory counseling techniques course, MC skills focus on building a strong therapeutic alliance and infusing multicultural considerations into case conceptualization. One of the key skills students learn in this course is how to repair ruptures in the therapeutic alliance, avoiding potential defensive reactions, and remaining truly empathetic with their clients' experience of the counseling process (focusing on the impact of one's actions, rather than on the actions' intent). Students also learn to raise questions of a MC nature while investigating the familial, communal, and cultural influences impacting clients' symptomatology, as well as to invite and address questions of a MC nature related to differences in background or experience between client and therapist. Written assignments and role-plays require students to weave MC considerations into their case conceptualizations; in that process, we emphasize that any conceptualization formulated without MC information will inevitably contain a number of potentially unfounded and therefore potentially harmful assumptions.

The advanced counseling techniques course continues to focus on students' ability to monitor the impact of their countertransference on MC conversations while it begins to integrate MC interventions and adaptations. This could mean simply changing the language or metaphor used when implementing an EB technique; or it could mean adapting a technique to the specific cultural background of the client by modifying certain aspects of it (e.g., developing a relationship with a client's community before implementing an individual intervention, or incorporating religious and spiritual beliefs into

a given treatment process); or it could mean delivering an altogether different protocol (e.g., one that might engage a family member to support behavioral change with a client, or crafting a collaborative version of an intervention).

The MC curriculum is described as somewhat compartmentalized in its delivery, while in practice it is highly interconnected—even when the curriculum focuses on one area the others are engaged and referred to. This overlap not only provides opportunities for further infusion of the curriculum throughout the program, but it also allows students to learn and practice similar concepts across multiple times. Further, we are in the process of assessing the effectiveness of our MC curriculum with a new performance-based test that we administer to our students at the beginning and end of the program to compare outcomes before and after the implementation of this new MC curriculum.

Students' Experience of the Curriculum

In reflecting on their experience of the program, two students (a current intern and a recent graduate—here on forth referred to as "the students") have identified a number of significant outcomes of our curriculum for both their learning process and counseling practices. This last section of the paper offers these students' reflections on their experiences in the program. They address their experience of some of the positive outcomes of an integrated curriculum as well as some of the challenges they have observed while in the program. Their reflections might be helpful for faculty and administrators who wish to gain further insight into, and potentially better assess, students' experience of innovative MC and EB curricula.

While researching graduate counseling programs, some students may find that while multiculturalism is a popular emphasis of programs' *missions*, the integration of MC and EB *practices* does not appear to be promoted to the same extent. Learning how to incorporate EB and MC practices has several advantages in the field, including developing the ability to identify EB resources for, or to adapt EB treatments to, diverse clients, and realizing that not all EB treatments work for all clients who present with a similar diagnosis. The emphasis on an integrated curriculum, therefore, may be both somewhat unique and instrumental in increasing students' ability to meet the needs of their clients.

The students also noticed that some programs are committed to teaching techniques derived from a specific theoretical orientation and others encourage students to develop their own well defined theoretical approach. As the students entered the field (either through internship or upon graduation), they remarked on the relevance of using skills derived from EB and MC principles within *any* theoretical orientation. This training focus has allowed them to implement multiple treatment approaches, as applicable to the clients or agencies they served, and access core counseling processes (common to various theoretical orientations) to build effective therapeutic relationships. Therefore, the students have found the overarching focus on EB and MC practices, rather than a specific theoretical orientation, both practical and effective.

On a related note, given the program's emphasis on *skills* training, the students have found it helpful when faculty structured their courses by first explaining a given skill, then modeling it (via faculty-led demonstrations and counseling videos), and finally having students practice it themselves. When the students were offered the opportunity to review and critique professors' and other counseling professionals' work (through live demonstrations or training videos), they felt less anxious in conducting role-plays and accessing both faculty and peer feedback.

The students have experienced MC training as difficult to navigate at times due to the fact that during such training they are presented with difficult conversations that highlight some of their own biases and prejudices. This has caused some students to

feel uncomfortable discussing cultural issues in the classroom due to fears of judgment, repercussions, rejection by peers, or guilt. In this context, however, the students report being able to remain engaged in difficult dialogues by allowing themselves to be vulnerable and to sit with the uncomfortable feelings (as they had the opportunity to practice in the MC and EB experiential exercises infused throughout the curriculum), and by being supportive of each other in the process (for which both faculty modeling and the practice of constructively critiquing each other's work across the curriculum provides further foundation), thus creating a sense of safety. Some minority students have found it helpful to identify allies among White students who were open to understand their experiences and curious to learn from their perspectives. Allies can thus facilitate growth in minority students by providing them with a sense of belonging and safety in otherwise potentially isolating and marginalizing conversations.

The students also found it useful at the beginning of MC or EB focused classes when faculty predicted that students might find certain concepts challenging, painful, or scary. In these cases, students were invited to share their experience of the curriculum in journals, which faculty then reviewed and commented upon, at times providing clarifying information, but more often offering questions for reflection (e.g., "Is this evidence-based?") or simply encouraging a student to seek their own answers by remaining with the struggle (e.g., "You're moving in the right direction; what does your feeling/reaction tell you about your work with a client?"). This process invited the students to develop critical thinking skills while also learning not to avoid painful feelings or conversations, as these are useful skills in a number of clinical situations (e.g., in discussing MC issues with a client or EB practice concerns with a colleague).

The students have appreciated faculty availability to share their own process in developing MC awareness or EB competencies, as well as their willingness to model how to navigate the inevitable struggles that this learning process entails. Faculty often encouraged all students to meet with them to discuss these issues and, depending on the professor's own identity and background, they were able to mirror different experiences for the students. Faculty collaborated with each other in complementary ways so that each student had the best chance to receive individualized support. This is certainly another strong argument for counselor education programs to hire a diverse faculty.

EB and MC training seem to be effective when it becomes part of the culture of a program and of ongoing conversations, rather than being addressed only in specific assignments or courses. Because of the integration and infusion of MC and EB concepts throughout the curriculum, the students observed that the dialogue often continued outside of the classroom. These conversations allowed for scaffolding and ongoing peer support in the learning process, and normalized some of the practical difficulties in integrating MC and EB concepts into the real world. At times, these conversations have had the added benefit of inspiring independent research projects.

Developing an Integrated Curriculum in Your Program: Social Justice in Action

Developing effective EB and MC curricula seems to rely on both their *integration* and *infusion* of these concepts throughout a program, which can be a daunting proposition. In this paper, we offered counselor education programs a potential model to implement such a curriculum and some of the specific steps necessary to develop it. Perhaps not surprisingly, the process must start with a clear intention on the part of the program's leaders, core faculty, and administrators. Further, the curriculum described above was not developed or implemented all at once. An analysis of both students' and faculty's feedback can easily lead to the identification of one or two of the most salient changes that could be made in specific courses or at the program level. Ongoing assessment and

evaluation of such changes, coupled with a clear intention and explicit conversations among faculty, administrators, *and* students, allows for these initial efforts to build upon each other and develop into an increasingly cohesive and comprehensive structure.

Just like we ask students to trust the developmental nature of training and learning, shifting a program's curriculum also involves trust from faculty and administrators that individual and sequential steps over time will yield results. The point is not to aim for perfection at the start, but rather to create avenues for consistent communication among all interested parties (i.e., faculty, administrators, and students) so that the process can take place. As counselors, our inspiration and commitment to stay the course is, as always, realizing that the quality of training we provide our students will have a direct impact on the well-being of the clients they will serve, and consequently on the society in which we live. Creating effective EB and MC curricula is therefore not simply an academic exercise, but an ethical imperative.

References

Alvarez, A. N., Blume, A. W., Cervantes, J. M., & Thomas, L. (2009). Tapping the wisdom tradition: Essential elements to mentoring students of color. *Professional Psychology: Research and Practice, 40*(2), 181-188. doi:10.1037/a0012256

American Counseling Association. (2005). *ACA Code of Ethics*. Alexandria, VA: Author.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361-368. doi:10.1037/a0016401

Borntrager, C. F., Chorpita, B. F., Higa-McMillan, C., & Weisz, J. R. (2009). Provider attitudes toward evidence-based practices: Are the concerns with the evidence or with the manuals? *Psychiatric Services, 60*, 677-681. doi:10.1176/appi.ps.60.5.677

Chambless, D. L., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66*, 7-18. doi:10.1037/0022-006X.66.1.7

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.

David-Ferdon, C. & Kaslow, N.J. (2008). Evidence-based psychosocial treatments for child and adolescent depression, *Journal of Clinical Child & Adolescent Psychology, 37*, 62-104. doi:10.1080/15374410701817865

Curtis-Boles, H., & Bourg, E. (2010). Experiences of students of color in a graduate-level diversity course. *Training and Education in Professional Psychology, 4*(3), 204-212. doi:10.1037/a0017985

Forman, S. G., Fagley, N. S., Steiner, D., & Schneider, K. (2009). Teaching evidence-based interventions: Perceptions of influences on use in professional practice in school psychology. *Training and Education in Professional Psychology, 3*(4), 226-232. doi:10.1037/a0016874

Fouad, N.A. (2006). Multicultural guidelines: Implementation in an urban counseling psychology program. *Professional Psychology: Research and Practice, 37*(1), 6-13. doi:10.1037/0735-7028.37.1.6

Helwick, C. (July 31, 2012). Schizophrenia may be overdiagnosed in Black patients. Medscape. Retrieved from http://www.medscape.com/viewarticle/768391.

Hunsley, J. (2007). Training psychologists for evidence-based practice. *Canadian Psychology/Psychologie Canadienne, 48*(1), 32-42.

Kazdin, A.E. (2005). *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. New York: Oxford.

Kendall, P. C., Chu, B. C., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing life into a manual: Flexibility and creativity with manual-based treatments. *Cognitive & Behavioral Practice, 5*, 177-198. doi:10.1016/S1077-7229(98)80004-7

Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children; Therapist manual (3rd ed.)*. Ardmore, PA: Workbook Publishing.

La Greca, A. M., Silverman, W. K., & Lochman, J. E. (2009). Moving beyond efficacy and effectiveness in child and adolescent intervention research. *Journal of Consulting and Clinical Psychology, 77*(3), 373-382. doi:10.1037/a0015954

Lebow, J. L. (2005). Handbook of clinical family therapy. Hoboken, NJ: Wiley.

Lee, C. M. (2007). From clinical trials to professional training: A graduate course in evidence–based interventions for children, youth, and families. *Training and Education in Professional Psychology, 1*(3), 215-223. doi:10.1037/1931-3918.1.3.215

Leffler, J. M., Jackson, Y., West, A. E., McCarty, C. A., & Atkins, M. S. (2013). Training in evidence-based practice across the professional continuum. *Professional Psychology: Research and Practice, 44*(1), 20-28. doi:10.1037/a0029241

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2*, 53-70. doi:10.1111/j.1745-6916.2007.00029.x

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (in press). Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review*.

Malott, K. M., & Paone, T. R. (2012) Multicultural counselor training: Evaluation of single-course content. *The Journal of the Pennsylvania Counseling Association, 12*(1), 45-55.

March, J. S., & Mulle. (1998). *OCD in children and adolescents: A cognitive-behavioral treatment manual*. New York: Guilford.

Maríñez-Lora, A.M., & Atkins, M.S. (2012). Evidence-based treatment in practice-based cultural adaptations. In G. Bernal and M.M. Domenech Rodríguez (Eds.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp.239-261). Washington, DC: American Psychological Association.

Nathan, P. E., & Gorman, J. M. (2007). *A guide to treatments that work* (3rd ed.). New York: Oxford University Press.

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). 'No-show': Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology, 59*(2), 314-320. doi:10.1037/a0027091

Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. A. (2010). An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population. *Journal of Counseling Psychology, 57*(3), 255-263. doi:10.1037/a0020040

Prieto, L. R. (2012). Initial factor analysis and cross-validation of the Multicultural Teaching Competencies Inventory. *Journal of Diversity in Higher Education, 5*(1), 50-62. doi:10.1037/a0026199

Rose, B. M., Holmbeck, G. A., Coakley, R. M., & Franks, E. A. (2004). Mediator and moderator effects in developmental and behavioral pediatric research. *Developmental and Behavioral Pediatrics, 25*, 58-67. doi:10.1097/00004703-200402000-00013

Sackett, D. L., Straus, S. E., Richardson, W. S., Rosenberg, W., & Haynes, R. B. (2000). *Evidence based medicine: How to practice & teach EBM* (2nd ed.). London: Churchill Livingstone.

Sehgal, R., Saules, K., Young, A., Grey, M. J., Gillem, A. R., Nabors, N. A., & ... Jefferson, S. (2011). Practicing what we know: Multicultural counseling competence among clinical psychology trainees and experienced multicultural psychologists. *Cultural Diversity and Ethnic Minority Psychology, 17*(1), 1-10. doi:10.1097/00004703-200402000-00013

Sheu, H., & Lent, R. W. (2007). Development and initial validation of the Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form. *Psychotherapy: Theory, Research, Practice, Training, 44*(1), 30-45. doi:10.1037/0033-3204.44.1.30

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York: Guilford.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: Wiley.

Thompson, V., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*(1), 19-26. doi:10.1037/0735-7028.35.1.19

Tummala-Narra, P. (2009). Teaching on diversity: The mutual influence of students and instructors. *Psychoanalytic Psychology, 26*(3), 322-334. doi:10.1037/a0016444

Vasquez, M. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 878-885. doi:10.1037/0003-066X.62.8.878

Urban, African American Students and School Success: Creating a Climate of Care

Kathy Christensen & Angela R. Gillem
Arcadia University

Author Note

This manuscript was inspired by a research paper originally written for Cultural Bases of Counseling, a graduate course at Arcadia University. Sincere thanks to Dr. Gillem, my professor and mentor, for her encouragement and guidance during this process. Thanks also to Youth United for Change, whose research study results were published just as I began writing that paper. In many ways, this work is a response to those young voices. Correspondence concerning this article should be sent to: kchristensen@arcadia.edu.

Abstract

Research indicates that African American students attending urban schools continue to lag behind on various measures of academic achievement. Some fault the students, others fault the parents, and many look at the state of urban neighborhoods and cite hopelessness and disadvantage as reasons for student failure. In this article, we look at the education system and the ways it may be hindering opportunity and success for African American students. Specifically, we explore the concept of care, and how a caring school climate can change outcomes for African American students in urban environments. We reflect on research related to cultural differences in behavior norms, racial socialization and critical race consciousness, traditional discipline in schools, and educator bias as factors that may impede school connectedness and academic success. School counselors can support systemic change and promote a climate of care among staff by using approaches that support students as part of a comprehensive developmental guidance program. Counselors must rethink traditional approaches that are not working for this population and advocate for change to improve academic outcomes.

Urban, African American Students and School Success: Creating a Climate of Care

Public education funding is not equitable. Even before the recent cuts in education nationwide, inner city schools were in crisis, with student academic achievement and graduation rates far below suburban schools, and a larger proportion of schools failing to meet adequate yearly progress (AYP). Demographically, 76% of students attending public school in urban areas are African American (Teasley, 2006). Many urban schools are located in areas of extreme "neighborhood disadvantage" (Elias & Haynes, 2008, p. 475) where subpar housing, violent crime, gangs, drugs, poverty, unemployment, and crumbling infrastructure are the norm. These schools have other issues that compound this disadvantage including higher teacher turnover than in suburban schools; lack of appropriate diversity among school staff and administration (Boser, 2011); poorly maintained school buildings; lack of resources; disconnected parents and families; security measures

rendering schools more like prisons, complete with police presence, metal detectors, and zero-tolerance policies; and an overarching sense that communities have given up hope (Elias & Haynes, 2008; Farmer, 2010; Heyman & Vigil, 2008).

Nationally, nearly 30% of all students do not graduate high school and approximately 50% of African Americans fail to do so (Alliance for Excellent Education, 2011; Youth United for Change [YUC], 2011). Dropping out is sometimes viewed as an act taken by a student on one day in his or her academic life; however, dropping out is a process (Heyman & Vigil, 2008; YUC, 2011). It happens over many years, starting in kindergarten. Early literacy issues, misunderstood behavior, repeated disciplinary removal from class or school, life and school stress, and lack of caring adult relationships in school can set in motion the gradual loss of hope that many inner city dropouts report (Elias & Haynes, 2008; Stanard, 2003; YUC, 2011). The negative impact of inner city public school environments has been dubbed by YUC as "the pushout effect," and this group of research-driven and advocacy-minded dropouts refers to themselves as "pushouts" (YUC, 2011, p. 2). Dropping out implies action, even choice, whereas being pushed out speaks to forces that may be beyond an adolescent's control. YUC's members have offered more than just a name change; their perspective represents a paradigm shift regarding what it means when students drop out.

Students who fail to graduate from high school have increased risk for negative outcomes across all life domains (Heyman & Vigil, 2008; Stanard, 2003; YUC, 2011). They account for 52% of people on welfare, more than 80% of prison inmates, and 85% of those in the juvenile justice system. Dropouts use drugs more than any other subgroup in the 17 to 22 age range (Stanard, 2003). Individually, dropouts cost society nearly $300,000 over their lifetime in government spending and lost tax revenues, and they earn, on average, $260,000 less over the lifespan than their peers who receive a high school diploma (Alliance for Excellent Education, 2011). High school graduates earn nearly twice as much as dropouts and have the option of a college degree, leading to double the income potential of high school graduates (YUC, 2011). If all students graduated from high school in the US in a given school year, the economic impact would likely be $154 billion in added income over the lifespan, and that figure reflects the potential income of just one graduating class (Alliance for Education, 2011). Successfully educating our youth is key to reversing the economic disadvantage that persists in inner cities and that has a significant negative impact on the US economy.

In this article, we tackle the systemic bias in schools with regard to behavior norms, expectations, and classroom management of African American (also referred to herein as "Black") students, with emphasis on the moderating factors of racial socialization and climate of care. We review interventions for school counselors and other educators and discuss exemplary schools where students are pushed up, not out. Finally, we address implications of this research for school counselors working in inner city schools, where students are increasingly feeling uncared for and pushed out (YUC, 2011).

Systemic Bias

Ogbu (1991) argued that African American culture is incompatible with academic success; however, research has shown that Ogbu's assertions about academic disengagement and opposition in the face of racism, particularly among Black male students, may be missing the point (Sherrod, Getch, & Ziomek-Daigle, 2009). Ogbu held individuals accountable, blaming them for their own academic failure. Haberman (1991) held responsible the education system as it manifests in low-income urban areas and pointed to the "pedagogy of poverty" (p. 290) where the norm is teacher-directed, low-level, rote

learning, with frequent interruptions for behavior management in overcrowded classrooms. Sherrod et al. found that the system, by its Euro-Americentric design, often gives Black students no room, culturally, to be themselves, and no option except to conform. In most American public schools, standard Euro-centric curricula are taught (Sherrod et al., 2009). In addition, typically Euro-American behaviors are promoted as school norms, including controlled speech, affect, noise, and movement (Fursick & Bordeau, 2004; Carter, 2008). Consequently, the environment may be invalidating Black culture and, by extension, Black students. Educators with limited multicultural experience may view anything non-normative as negative when, in fact, many behaviors are adaptive (Ladson-Billings, 2000) and some may be a normal response to the stress and trauma of everyday life (Hertel & Johnson, 2013; Sanchez, Lambert, & Cooley-Strickland, 2013). Teacher bias may play a role when Black male students are disproportionately reprimanded and reported for poor behavior (Thomas, Coard, Stevenson, Bentley, & Zamel, 2009). Punitive measures often involve separation of students from school, further alienating them (Sherrod et al., 2009). Singling out Black males may be related less to pathology and more to the system's lack of multicultural awareness (Cholewa, Amatea, West-Olatunji, & Wright, 2012; Curwin, 2010; Heyman & Vigil, 2008; Ladson-Billings, 2000; Murray & Zvoch, 2011).

Dominant Culture Behavior Norms

According to Kozol (2005), Blacks are often stereotyped as more active, expressive, and talkative compared to other cultural groups. If the norm is based on the less expressive behaviors of the dominant group, and Blacks are perceived as more disruptive, therein lays the challenge. Blacks often are "treated as if they are corruptions of White culture" (Ladson-Billings, 2000, p. 206) rather than appreciated as individuals with cultural assets. When cultures are understood and culturally relevant pedagogy is employed, educators are better able to view students and their behavior as more functional and adaptive (Cholewa et al., 2012; Esposito & Swain, 2009; Ladson-Billings, 1995). Moreover, there needs to be some consideration of the dynamics that serve to control, pathologize, and even exacerbate certain behaviors (Coggins & Campbell, 2008). Educators could support their students better by rethinking students' behavior patterns and their own personal reactions to and expectations of children (Elias & Haynes, 2008; Ladson-Billings, 2000). Many schools do not use consistent behavioral management systems (e.g., Positive Behavior Supports, Sherrod et al., 2009; Safe and Civil Schools Model, Bryce & Gersten, 2013) and do not recognize alternative cultural norms and the unmet needs of students (e.g., need to belong; Glasser, 1997) that may be prompting their behavior (Walter, Lambie, & Ngazimbi, 2008). Rather than learning how to change their behavior, students experience punitive consequences that further alienate them from school, including suspension, which causes them to fall behind and diminishes their sense of belonging (Sherrod et al., 2009). These consequences can be reinforcing, with some students in a cycle of escalating behavior resulting in repeated suspensions. When students are separated from school repeatedly, they are more likely to drop out (Skiba & Sprague, 2008).

Critical Race Consciousness: Guiding Behavior

Why do some Black students demonstrate problematic behaviors while others respond in prosocial ways? The answer, for many, is critical race consciousness (CRC), an understanding of the role of race as a potential barrier to success (Carter, 2008; Thomas et al., 2009). CRC is brought about by positive racial socialization conducted primarily in the home: exposure to racial, ethnic, and cultural heritage, and an understanding of the role of race in society (Carter, 2008). Children who are brought up understanding that

racism exists, and who hear the counter-narrative of Black success that is largely missing in traditional school curricula (Carter, 2008; Pressley, Raphael, Gallagher, & DiBella, 2004; Sampson & Garrison-Wade, 2010), demonstrate greater persistence and academic success than students who have low racial socialization and negligible CRC (Carter, 2008). In fact, racial socialization acts as a protective factor for urban Black youth (Thomas et al., 2009), providing the context and coping mechanisms needed to deconstruct daily racism and discrimination (Carter, 2008). Students low in racial socialization and lacking CRC are often perceived by teachers as more oppositional and potentially dangerous, whereas racial socialization and CRC tend to have a moderating effect on school behavior, resulting in more positive teacher perception of students (Thomas et al., 2009). While CRC led to greater understanding of race and racism and the ability to defend against discrimination, it did not lead to a victim mentality. Rather, it gave Black youth a sense of having to work hard to overcome obstacles and a desire to persist (Carter, 2008), offering a counterargument to Ogbu's (1991) theory about African American educational failure (Foster, 2004).

Related to this, Burchinal, Roberts, Zeisel, and Rowley (2008) found that Black students' academic, social, and externalizing behaviors (i.e., problematic behaviors directed against others) were negatively affected by anticipation or perception of discrimination from teachers and/or peers. In this study, aggression and rejection-sensitivity were key issues. Carter (2008) found that students who often exhibited externalizing behaviors tended to be lower in CRC. Appreciation of their history and culture with an understanding of oppression is helpful in cultivating the group pride, belonging, and self-acceptance needed to succeed in school. Parents play a primary role in racial socialization; however, teachers and counselors of any racial background can and should provide positive racial socialization to students (Carter, 2008).

Educator Multicultural Competence: Reframing Behavior

Educators, particularly White teachers and counselors, should take care in interpreting the behaviors of Black students. Some behaviors, such as strutting, strolling, and posturing, which are representative of Black culture, are often interpreted by White teachers as "indicative of higher levels of aggression, lower levels of academic achievement, and more likely to require special education" (Thomas et al., 2009, p. 185). Moore (2002) found that teachers, regardless of race, can misread students' behavioral styles as demonstrating lack of respect or aggression. These reports indicate the need to train teachers to respond appropriately and to not automatically label behaviors as dysfunctional (Moore, 2002; Thomas et al., 2009). Racial bias stemming from misunderstanding students' behaviors may be a trigger for greater levels of reported behavior problems in school (Sanchez, Lambert, & Cooley-Strickland, 2013; Thomas et al., 2009). Instead, teachers might reframe behavior as "culturally scripted, reacting coping styles to authority figures" (Thomas et al., 2009, p. 195).

There is a need to address inequalities that invalidate Black cultural norms and alienate students (Ladson-Billings, 2000). School counselors should address these and other issues—lack of multicultural curricula (Coggins & Campbell, 2008; Pressley et al., 2004; Sampson & Garrison-Wade, 2010), need for positive behavior supports (Bradshaw, Koth, Bevans, Ialongo, & Leaf, 2008; Bryce & Gersten, 2013; Curtis, Van Horne, Robertson, & Karvonen, 2010; Sherrod et al., 2009), and achievement gaps (Coggins & Campbell, 2008)—starting in elementary school before students begin to show signs of disengagement and failure (Elias & Haynes, 2008). School counselors can advocate for social justice and systemic change to better serve students (American School Counselor Association [ASCA], 2012; Esposito & Swain, 2009; Fursick & Bordeau, 2004; Galassi, Griffin, & Akos, 2008; Salina, Girtz, Eppinga, Martinez, Kilian, & Lozano et al., 2013).

Creating a Caring School Climate

Research has shown that school trajectories can be determined by fourth grade (Elias & Haynes, 2008) with critical factors being literacy, emotion regulation, behavior, attendance, and overall school functioning (Bradshaw, Zmuda, Kellam, & Ialongo, 2009; Burchinal et al., 2008; Coggins & Campbell, 2008; Elias & Haynes, 2008). In urban schools, other factors can distance students from school success, including poorly maintained facilities, prison-like security measures, lack of resources, and curricula with little or no connection to the lives and future prospects of minority students (Kozol, 2010; Ladson-Billings, 1995; Ladson-Billings, 2000; Marbley, Bonner, McKisick, Henfield, & Watts, 2007; YUC, 2011). In short, their school environment can serve as a detriment to their learning.

Factors Contributing to the Pushout Effect

Research by YUC (2011) involving 267 former students in the Philadelphia public school system who call themselves "pushouts" indicated that many aspects of the education system over which students have no control—from curriculum, class size, and teaching, to discipline and school climate—serve, over time, to push students out of school. Students reported boredom and disengagement due to irrelevant curricula and uninspired, often inexperienced, teachers. Disciplinary tactics are employed for minor infractions and result in suspension. Zero tolerance policies offer no second chances. Gone is a sense of community and caring. In its place are poorly maintained buildings outfitted with security systems rather than libraries.

According to Elias and Haynes (2008), educational outcomes are impacted by negative neighborhood, family, school, and resources, disadvantages that increase stress in the lives of children. Stress has a significant impact on adjustment in childhood and puts children at higher risk for anxiety, depression, and maladaptive behaviors that can impede school success (Baker, 1998; Elias & Haynes, 2008; Hertel & Johnson, 2013; Sanchez, Lambert, & Cooley-Strickland, 2013). Research suggests that chronic stress related to poverty can be "toxic" (i.e., traumatic) enough to affect areas of the brain related to language, long-term memory, working memory, and executive control (Booker, 2011; Hertel & Johnson, 2013). Risk factors for school failure abound in poor neighborhoods; in this environment, it can become easy to believe that nobody cares.

Positive School Culture: Connecting through Caring

According to the literature, perception of a caring, supportive school community among urban African American students had the biggest impact on school satisfaction (Baker, 1998; Carter, 2008; Elias & Haynes, 2008; Lemberger & Clemens, 2012; Pressley et al., 2004), which is positively associated with school engagement, achievement, and completion (Baker, 1998). African American students who reported low school satisfaction were three times less likely to receive help when they asked for it and twice as likely to be reprimanded for their behavior (Baker, 1998). YUC (2011) found that similar themes topped the list of reasons pushouts gave for leaving school.

Connection to teachers is key to academic success; it affects a student's overall attachment to school (Lemberger & Clemens, 2012). Particularly in inner city schools, the perception of support has a significant impact on academic performance and social/emotional efficacy and resilience (Baker, 1998; Murray & Zvoch, 2011; Salina et al., 2013). Trust in teachers has been linked to greater self-regulation and increased school identification (Adams, 2014). Baker argued that schools should return to a more well-rounded focus including social development, as opposed to the strictly intellectual, individual approach to academic achievement that has been the primary focus for decades.

Attachment theory (Baker, 1998) and school-based research support the social-emotional aspect of learning as being critical to school adjustment and long-term school success in the elementary years. This supports the importance of social, emotional, and character development interventions for all students (ASCA, 2012; Elias & Haynes, 2008; Fursick & Bordeau, 2004).

What constitutes caring? In "Nice is Not Enough," Nieto (2008) wrote about school and classroom climate and how minority students may be held to different, sometimes lower, standards simply because teachers believe "niceness" equates to caring. A teacher's journal entry in Nieto's essay captured the essence of the concept of care in multicultural settings:

> School is a foreign land to most kids…but the more distant a child's culture and language are from the culture and language of school, the more at risk that child is. A warm, friendly, helpful teacher is nice but it isn't enough. We have plenty of warm friendly teachers who tell the kids nicely to forget their Spanish and ask mommy and daddy to speak to them in English at home; who give them easier tasks so they won't feel badly when the world becomes difficult; who never learn about what life is like at home or…what stories they have been told or what their history is. Instead, we…tell them to eat our food and listen to our stories….We teach them to read with our words and wonder why it's so hard for them. We ask them to sit quietly and we tell them what's important and what they must know to "get ready for the next grade." And we never ask them who they are and where they want to go. (p. 29)

Not surprisingly, this approach is damaging to students, demonstrating a lack of care and sometimes masking racism (Nieto, 2008). Research has shown that teacher expectations can be tied to ethnicity of students, with the lowest expectations held of African Americans (Thomas et al., 2009). According to Rousseau (1979), low, unclear, or unfair expectations contribute significantly to a school climate where delinquency and subpar academic performance prevail.

Caring involves treating every student as an individual with great potential, seeing them through a multicultural lens, and delivering education and counseling in ways that are sensitive, meaningful, and affirming (ASCA, 2012; Fursick & Bordeau, 2004; Nieto, 2008). The keys are consistency, high expectations, understanding cultural differences (Fursick & Bordeau, 2004; Walter et al., 2008), and not running from racism, but rather deconstructing it—in the classroom if necessary.

Ideally, educators create school climates where all students are supported and accepted (Cholewa et al., 2012; Thapa, Cohen, Higgins-D'Allesandro, & Guffey, 2012). Baker (1998) stated that classroom climate "involves factors that impact *student perceptions of care and psychological safety…* including instruction and classroom management, classroom norms, and interpersonal skills related to students perceiving they are respected, affirmed and cared for" (p. 28). Carter (2008) maintained that caring adults in schools have been instrumental in the success of high achieving Black students. Conversely, when teachers hold negative views of students, the climate is conflictual rather than cooperative. Misbehavior is exacerbated when teachers fail to understand and appropriately respond to problem behaviors (Thomas et al., 2009). Murray and Zvoch (2011) studied the impact of teacher-student relationships on emotional and behavioral adjustment to school and found that positive teacher-student relationships are predictive of positive school adjustment. Relationships marked by conflict were reported by teachers and students when students exhibited more challenging behavior and emotional ability. Whether this finding is a reflection of the student responding to the teacher (perception of not being liked) or the teacher to the student (perception of

student being oppositional), the salient point is this: adult responses to students matter. Most studies of this kind have relied on teacher or adult reports; by including student voices, Murray and Zvoch provided more context and a broader view of teacher-student relationships. Students who perceive a teacher as adversarial are less likely to feel that the teacher cares.

This dynamic of conflict can become a power struggle and teachers may not be trained in ways to promote positive relationships. In some cases, rather than handling classroom issues within the classroom, discipline is punitive and students are removed from class (Coggins & Campbell, 2008; YUC, 2011). This system of discipline can start in elementary school and quickly become a negative cycle if the student learns that s/he earns time away from school and does not learn functional, appropriate behaviors to replace the maladaptive ones. Walter et al. (2008) suggested that Glasser's Choice Theory, which posits that all behavior is an attempt to fulfill unmet basic needs (Glasser, 1997), offers another lens through which educators may interpret student behavior by asking, "what is this student trying to gain by doing this?" Likewise, trauma-informed approaches, useful when students live with such toxic stress and disadvantage, encourage educators and practitioners to move from asking, "what's wrong with you?" towards the more affirming, "what happened to you?" (Hertel & Johnson, 2013; Sanchez, Lambert & Cooley-Strickland, 2013).

Thomas et al. (2009) cited the need for relational trust between teachers and students, a condition whereby both parties feel mutually and strongly supported. Adams (2014) considers collective student trust among school faculty to be a free social resource available to all educators, particularly in resource-and-cash-strapped urban schools. Relational trust played a primary role in the "All Hands on Deck" intervention which successfully and significantly raised graduation rates and lowered dropout rates over two school years in one inner city high school (Salina et al., 2013). Pressley and colleagues (2004) found relational trust to be very high among administrators, teachers, parents, and students in the successful Providence St. Mel (PSM) School in inner city Chicago. PSM boasts a 25-year track record of 100% four-year college placement for its graduates, and is notable for their enhanced life outcomes, not just higher standardized test scores. PSM succeeds by engaging students with rich, culturally-relevant curricula and programming infused into the learning environment, with high standards, high parent involvement, and regular monitoring of progress. PSM focuses on personal responsibility, earning one's way, and self-respect, and discourages "welfare mentality" and reliance on affirmative action. PSM students have "effort optimism" (Pressley et al., 2004, p. 227), which gives them a sense that their hard work will lead to positive outcomes in life. Clearly, strong student-educator relationships in climates of care marked by cultural appreciation make a difference in the lives of urban Black students.

Making Parental Involvement a Priority

Research shows that a high level of parental involvement (PI) in elementary school has a protective effect in later school years; it is critical for schools to engage parents early (Burchinal et al., 2008). A welcoming school that genuinely treats parents as partners can enhance the school-to-home connection, improving educational outcomes (ASCA, 2012; Baker, 1998; Heyman & Vigil, 2008). In inner cities, parents often believe they are powerless in the school (Fursick & Bordeau, 2004). There may be barriers related to prejudice and/or perceived discrimination, and educators working with families should be aware of these issues and be willing to address them openly and with sensitivity (Abdul-Alil & Farmer, 2006; Carter, 2008; Fursick & Bordeau, 2004). Multicultural competence is necessary, as race-related issues can impede PI (Carter, 2008; Fursick &

Bordeau, 2004).

In inner-city schools where students are succeeding, such as Rapoport Academy in Waco, Texas, Harlem Children's Zone (HCZ), and PSM, PI is mandatory (Gillem & Lloyd, 2003; Pressley et al., 2004). Parents are accountable to teachers and school administrators for attendance at meetings, and they are expected to monitor homework, attendance, and grades. They volunteer in classrooms and at school events. When parents are engaged at this level and expectations are high, children are encouraged to succeed (Pressley et al, 2004); school becomes an extension of their family.

PI has been studied extensively, and space constraints do not permit full discussion of the research-based ways of approaching PI. Key resources for educators and administrators include Epstein (2005) and the National Network of Partnership Schools (NNPS; 2009).

Implications for School Counselors

As educators, school counselors have the opportunity and latitude to use a variety of approaches to meet the needs of their students. What successful inner city schools demonstrate is that educators should respond quickly to support students *before* they fail. Likewise, counselors can intervene to provide support *before* disciplinary measures are taken, to address underlying issues *before* they become larger challenges. If all educators demonstrate that they care about every student in their classroom or on their caseload, they can improve academic performance.

Wes Moore (2010), who grew up poor in Baltimore, wrote poignantly about the other Wes Moore's brother, his bravado, and what lies beneath so much posturing among African American inner city youth:

> There's a term in the hood for a face like Tony's, that cold, frozen stare. The *ice grille. …* A look of blank hostility that masks two intense feelings—the fire evoked by the *grille* (which is also slang for *face*), and the cold of the ice. But the tough façade is just a way to hide a deeper pain or depression that kids don't know how to deal with. A bottomless chasm of insecurity and self-doubt that gnaws at them. Young boys are more likely to believe in themselves if they know that there's someone, somewhere, who shares that belief. To carry the burden of belief alone is too much for most young shoulders. (p. 28)

School counselors can be that person who shares the "burden of belief" to lift students to higher levels of achievement. Particularly in single-parent homes like Moore's, educators can be another adult to whom a student can be accountable. Trust is critical; counselors must ensure that students understand confidentiality and the counselor's role and responsibility to the student (ASCA, 2012; Kemp, 1994). This perception of support not only boosts academic performance; it also enhances social and emotional competence and resilience (Baker, 1998), and self-regulation (Adams, 2014)—key areas connected to school success (Elias & Haynes, 2008).

As leaders in the school and advocates for all students, school counselors are in a unique position to effect systemic change in the level of caring within their schools. Because of high dropout/pushout rates, school counselors must make pushout prevention top priority as early as elementary school (Stanard, 2003). Use of attendance, grade, and retention data to identify at-risk students is part of the ASCA model (2012) and an essential role of the school counselor (Neild, Balfanz, & Herzog, 2007; Sparks, Johnson, & Akos, 2010; Stanard, 2003). Counselors and other educators may consider using one or more of the following interventions. Data collection and program evaluation will help determine what works for their students.

School-Based Interventions

The Good Behavior Game (Bradshaw et al., 2009; Nolan, Houlihan, Wanzek, & Jenson, 2014) is a positive behavioral intervention that promotes prosocial behavior among African American students, with lasting effects into high school. This whole-class intervention specifically defines off-task and anti-social behavior, focusing on disruption, aggression, and shyness; students are assigned to groups and "win" based on how the individuals in the group behave over increasing periods of time. Students earn rewards such as two-minute movement breaks or additional recess time. Bradshaw et al. demonstrated that targeted behavioral and academic interventions delivered in first grade for part of one school year could serve a preventive role lasting into secondary school. In addition, The Good Behavior Game has a strong evidence base of success across culturally and socioeconomically diverse student populations (Nolan et al., 2014).

Other interventions for dropout prevention are small therapeutic groups focused on academic and life skills such as assertiveness, time management, decision making, goal setting, friendship, conflict resolution, and stress reduction (Stanard, 2003). Also shown to be effective with this population are Choice Theory groups. These groups include both at-risk students and successful students with the goal of improving behavior through choice-making and teamwork (Walter et al., 2008). Likewise, strengths-based school counseling (SBSC) programs can help students build a strong self-concept and increase self-efficacy, rather than approaches geared toward "fixing" students. SBSC, part of the positive psychology movement, is based on identifying and promoting cultural assets and personal capabilities (Galassi et al., 2008).

Addressing social justice issues directly is also an option for small group work. This approach helps change individual beliefs and attitudes, empowering youth to consider their role in societal change. In one study, Shin et al. (2010) used such a transformative approach to help liberate youth from internalized oppression and school-based barriers. Groups of students with academic and social difficulties met over 20 weeks and were offered guidance, empowerment, and "psychopolitical education" (p. 232) as part of the therapeutic intervention. This approach was found to support counselor efforts to provide CRC and helped students gain skills in advocating for social justice. Groups required two co-facilitators, at least one being African American, to help students trust and engage fully with the transformative process.

Participatory action research projects focus on empowerment and social justice (Smith, Davis, & Bhowmik, 2010). Smith et al. provided middle and high school students with a full-year, small group experience that allowed them to address sociopolitical issues in a trusting environment; identify key areas for improved educational support, including health, well-being, and sexuality; and prepare recommendations for administrators as advocates for positive change. Having decision-making responsibility proved to be an empowering exercise for the students, boosting their sense of self-efficacy and connectedness to school. Handing over the power to construct knowledge, rather than telling students what to learn, can be a powerful tool for counselors to use when working with students at upper elementary through high school levels.

For many students in inner cities, home and school environments represent a chronic threat to their sense of self, and schools can compound that when they perpetuate negative stereotypes (Cook, Purdie-Vaughns, Garcia, & Cohen, 2012) that can affect identity development. Cook et al. (2012) found that a values affirmation approach with middle school students, as a means to combat negative stereotypes and chronic threats, increased Black students' sense of belonging and boosted their ability to accept a poor grade or constructive criticism without letting it define them as intellectually inferior. This contributed to more positive identity formation and overall school performance.

The intervention included writing about personal beliefs, ranking a list of values, and writing about why their top five values were important to them. Subsequent interventions allowed students to write about one or more of their personal values using a specific writing prompt (e.g., why family or friends are important). Sense of belonging for students in the experimental group improved and stabilized over a two-year period during the transition from elementary to middle school. This intervention was conducted by teachers; however the approach can be adapted by counselors for developmental classroom guidance lessons, small therapeutic groups, and individual counseling. Use of a School Connectedness Scale (SCS) to measure levels pre- and post-intervention—or simply to evaluate connectedness among students to their school at various times during the school year—may offer concrete data on which to base further interventions and systems changes (Lemberger & Clemens, 2012; Lohmeier & Lee, 2011).

As one might expect from its name, All Hands on Deck (Salina et al., 2013) is a school-wide intervention involving all educators in a school with a shared goal, in this case to increase graduation rates in an urban high school with 95 percent of students on subsidized lunch. This counselor-led intervention used three strategies—academic press (i.e., pushing students to achieve by giving them real-time data about their performance towards successfully graduating), social support (i.e., adults in the school reaching out to students individually and families to offer help and guidance; students supporting students in reaching group goals in areas such as classroom attendance), and relational trust (i.e., staff trusting staff, collaborating more freely, empowered to act). The graduation rate went up nearly 20 percentage points in two years. This case underscores the power of relationships and the value of data-driven programming where academic success is the goal (Salina et al., 2013).

Lee and Simmons (1988) called for the Life-Planning Model, a counseling approach that can help students consider the big picture of their lives, addressing education, obstacles, dreams, and an ideal world of work. It takes them out of their present reality and into the future, allowing them a sense of control and responsibility. The use of personal portfolios, starting in kindergarten, can help organize interests, abilities, and accomplishments and can provide tangible evidence of a student's developing sense of self and self-worth.

School-based afterschool programs can provide added support to students. For example, the Young Empowered Sisters (YES!) Program focuses on "promoting cultural assets" through exploration of racial and ethnic identity and strategies for empowerment and activism (Thomas, Davidson, & McAdoo, 2008, p. 281). The program targets adolescent girls and is designed to give girls the tools they need to protect themselves from racism.

Finally, there is evidence supporting the use of therapeutic approaches to promote academic success. Specifically, Fearrington, McCallum, and Skinner (2011) found that low-performing fifth grade students receiving solution-focused brief counseling (SFBC) improved their math performance as measured by assignment completion. SFBC is a problem-solving approach rooted in the present and based on motivating individuals to change (Fearrington et al., 2011). If this approach can work for a small group of students referred for math remediation, consider the expanded role counselors could play in more directly supporting positive academic outcomes.

Positive Behavioral Support

Traditional disciplinary measures have not been effective in curbing undesirable behavior and improving academic achievement (Stanard, 2003; Walter et al., 2008). Positive Behavior Support (PBS) and Restorative Practices (RP) (Sherrod et al., 2009;

Walter, 2008) provide evidence-based, prevention-driven strategies to improve school behavior, resolve conflict, and reduce disciplinary measures that separate students from school. Bryce and Gersten (2013) found the Safe and Civil Schools Model effective at the elementary level in a large urban district. The school counselor could advocate for these approaches as part of a school-wide behavior expectations program. PBS works by establishing behavior norms, creating classroom communities, and training teachers and staff regarding positive ways to encourage pro-social and pro-academic choices among students (Bradshaw et al, 2008; Curtis et al., 2010; Sherrod et al., 2009; Skiba & Sprague, 2008). RP involves harnessing the power of a group or classroom and using peer discussion and support to resolve conflict, solve problems, and promote the well-being of all members. This gives students a voice, eliminates the authoritarian approach to discipline, and incorporates the collectivistic cultural norms of many Black students (Lange, 2008). PBS and RP require a paradigm shift in thinking about how adults and students work together to create harmonious school environments. PBS in particular reframes student behavior so that it can be understood as serving a function, rather than viewing it as "something wrong" with a student who repeatedly misbehaves (Ladson-Billings, 2000; Sherrod et al., 2009).

Multicultural Competence

Counselors and educators in schools with predominantly Black students should be mindful that Black students and their families are not homogenous. Counselors should understand the process of racial identity formation (Carter, 2008; Marbley et al., 2007). Ethnic identity groups can be very effective for students who are struggling with their changing sense of self and future prospects. Groups should focus on empowerment; expanding student understanding of options available to them; support for personal beliefs and values; and perception of race, social class, and self as a member of one's family, school, and society (Cook, Purdie-Vaughns, Garcia, & Cohen, 2011; Curwin, 2010; Fursick & Bordeau, 2004; Galassi et al., 2008). Counselors can expand their focus into other areas, including the formation of mentoring programs; securing multicultural curricula (Coggins & Campbell, 2008; Pressley et al., 2004; Sampson & Garrison-Wade, 2010); assisting staff in multicultural and professional development (Fursick & Bordeau, 2004); building multicultural competence (Coggins & Campbell, 2008; Fursick & Bordeau, 2004; Holcomb-McCoy, 2004; Kemp, 1994; Marbley, 2007); and attending community events (Curwin, 2010; Kemp, 1994; Marbley et al., 2007).

Conclusion

School counselors should not tolerate programs and policies that harm African American students. Systemic racial discrimination creates a school culture marked by failure to care. Counselors should be involved in school policy development, discipline and behavior programs, and procedures related to school norms and standards (ASCA, 2012; Stanard, 2003). It behooves all school counselors to resolve personal biases (Fursick & Bordeau, 2004; Holcomb-McCoy, 2004) and have "a little humility, some admitted ignorance, and a willingness to learn more about the other's culture" (Bennett, 1999, p. 24) if they are to serve as culturally-responsive educators. Further, school counselors should be willing to discuss racist or discriminatory remarks made by other educators, school staff, and students, and address discriminatory treatment of students by teachers and staff (Cholewa et al., 2012; Kozol, 2010; Ladson-Billings, 2000). In their role as advocates for all students and as representatives of the school community, counselors can reach out to families and become familiar with and to the community at large. The ASCA

National Model (2012) provides the framework for this work, based on four key pillars: leadership, advocacy, collaboration, and systemic change. It is incumbent upon school counselors to think creatively about their role in helping every child succeed in school.

References

Adams, C. M. (2013). Collective student trust: A social resources for urban elementary students. *Educational Administration Quarterly, 50*(1), 135-159 doi:10.1177/0013161X13488596

Abdul-Alil, J. K., & Farmer, Jr., A. D. (2006). Inner-city African American parental involvement in elementary schools: Getting beyond urban legends of apathy. *School Psychology Quarterly, 21*(1), 1-12. doi:10.1521/scpq.2006.21.1.1

American School Counselor Association. (2012). *The ASCA national model: A framework for school counseling programs, third edition*. Alexandria, VA: Author.

Baker, J. A. (1998). The social context of school satisfaction among urban, low-income, African American students. *School Psychology Quarterly, 13*(1), 25-44. doi:10.1037/h0088970

Bennett, C. (1999). *Multicultural education*. Needham Heights, MA: Viacom Company.

Booker, K. (31 January 2011). *Chronic stress seems linked to achievement gap*. Retrieved from http://physorg.com/news/2011-01-chronic-stress-linked-gap.html

Boser, U. (2011). *Teacher diversity matters: A state-by-state analysis of teachers of color.* Center for American Progress: Author. Retrieved from http://www.americanprogress.org.

Bradshaw, C. P., Koth, C. W., Bevans, K. B., Ialongo, N., & Leaf, K. J. (2008). The impact of school-wide positive behavioral interventions and supports (SWPBIS) on the organizational health of elementary schools. *School Psychology Quarterly, 23*(4), 462-473. doi:10.1037/a0012883

Bradshaw, C. P., Zmuda, J. H., Kellam, S. G., & Ialongo, N. S. (2009). Longitudinal impact of two universal preventive interventions in first grade on educational outcomes in high school. J*ournal of Educational Psychology, 101*(4), 926-937. doi:10.1037/a0016586

Bryce, W., & Gersten, R. (2013). A randomized evaluation of the Safe and Civil Schools Model for positive behavioral interventions and supports at elementary schools in a large urban school district. *School Psychology Review, 42*(3), 317-333.

Burchinal, M. R., Roberts, J. E., Zeisel, S. A., & Rowley, S. J. (2008). Social risk and protective factors for African American children's academic achievement and adjustment during the transition to middle school. *Developmental Psychology, 44*(1), 286-292. doi:10.1037/0012-1649.44.1.286

Carter, D. J. (2008). Cultivating a critical race consciousness for African American school success. *Educational Foundations, Winter-Spring edition*, 11-28.

Cholewa, B., Amatea, E., West-Olatunji, C. A., & Wright, A. (2012). Examining the relational processes of a highly successful teacher of African American children. *Urban Education, 47*(1), 250-279. doi:10.1177/0042085911429581

Coggins, P., & Campbell, S. D. (2008). Using cultural competence to close the achievement gap. *The Journal of Pan African Studies, 2*(4), 44-59.

Cook, J. E., Purdie-Vaughns, V., Garcia, J., & Cohen, G. L. (2011). Chronic threat and contingent belonging: Protective benefits of values affirmation on identity development. *Journal of Personality and Social Psychology, 102*(3), 479-496. doi:10.1037/a0026312

Curtis, R., Van Horne, J. W., Robertson, P., & Karvonen, M. (2010). Outcomes of a school-wide positive behavioral support program. *Professional School Counseling, 13*(3), 159-164. doi:10.5330/PSC.n.2010-13.159

Curwin, R. L. (2010). Motivating urban youth. *Reclaiming Children and Youth, 19*(1), 35-39.

Elias, M. J., & Haynes, N. M. (2008). Social competence, social support, and academic achievement in minority, low-income, urban elementary school children. *School Psychology Quarterly, 23*(4), 474-495. doi:10.1037/1045-3830.23.4.474

Epstein, J. (2005). A case study of the partnership schools comprehensive school reform (CSR) model. *Elementary School Journal, 106*(2), 151-170. doi:10.1086/499196

Esposito, J., & Swain, A. N. (2009). Pathways to social justice: Urban teachers' uses of culturally relevant pedagogy as a conduit for teaching for social justice. *Penn GSE Perspectives on Urban Education, 6*(1), 38-48.

Farmer, S. (2010). Criminality of black youth in inner-city schools: "Moral panic," moral imagination, and moral formation. *Race, Ethnicity and Education, 13*(3), 367-381. doi:10.1080/13613324.2010.500845

Fearrington, J. Y., McCallum, R. S., & Skinner, C. H. (2011). Increasing math assignment completion using solution-focused brief counseling. *Education and Treatment of Children, 34*(1), 61-80. doi:10.1353/etc.2011.0005

Foster, K. M. (2004). Coming to terms: A discussion of John Ogbu's cultural-ecological theory of minority academic achievement. *Intercultural Education, 15*(4), 369-384. doi:10.1080/1467598042000313403

Fursick, L., & Bordeau, W. C. (2004). Counseling at-risk Afro-American youth: An examination of contemporary issues and effective school-based strategies. P*rofessional School Counseling, 8*(2), 102-116.

Galassi, J. P, Griffin, D., & Akos, P. (2008). Strengths-based school counseling and the ASCA National Model. *Professional School Counseling, 12*(2), 176-181. doi:10.5330/PSC.n.2010-12.176

Glasser, W. (1997). A new look at school failure and school success: Use of choice theory to motivate students. *Phi Delta Kappan, 78*, 596-602.

Haberman, M. (1991). The pedagogy of poverty versus good teaching. *Phi Delta Kappan, 73*(4), 290-294.

Hertel, R., & Johnson, M. M. (2013). How the traumatic experiences of students manifest in school settings. In E. Rossen, & R. Hull (Eds.), *Supporting and educating traumatized students: A guide for school based professionals*. New York, NY: Oxford University Press.

Heyman, E. L., & Vigil, P. (2008). *Creating change in the large urban public schools of the United States*. Washington, DC: Forum on Public Policy.

Holcomb-McCoy, C. (2004). Assessing the multicultural competence of school counselors: A checklist. *Professional School Counseling, 7*(3), 178-187.

Kemp, A. D. (1994). African American students' expectations about counseling: A comparative investigation. *Journal of Multicultural Counseling & Development, 22*(4), 257-264. doi:10.1002/j.2161-1912.1994.tb00259.x

Kozol, J. (2005). *The shame of the nation*. Three Rivers Press: Pittsburgh, PA.

Kozol, J. (2010). No half steps, no equivocation. *Educational Leadership, 68*(3), 28-29.

Ladson-Billings, G. (2000). Fighting for our lives: Preparing teachers to teach African American students. *Journal of Teacher Education, 51*(3), 206-214. doi:10.1177/0022487100051003008

Ladson-Billings, G. (1995). But that's just good teaching! The case for culturally relevant pedagogy. *Theory into Practice, 34*(3), 159-165. doi:10.1080/00405849509543675

Lange, B. (2008). The power of community. *Reclaiming Children and Youth, 17*(3), 27-29

Lee, C. C., & Simmons, S. (1988). A comprehensive life-planning model for Black adolescents. *School Counselor, 36*(1), 5-10.

Lemberger, M. E., & Clemens, E. V. (2012). Connectedness and self-regulation as constructs of the student success skills program in inner-city African American elementary school students. *Journal of Counseling & Development, 90*, 450-458. doi:10.1002/j.1556-6676.2012.00056.x

Lohmeier, J. H., & Lee. S. W. (2011). A school connectedness scale for use with adolescents *Educational Research and Evaluation, 17*(2), 85-95. doi:10.1080/13803611.2011.597108

Lunenberg, F. C. (1999). Helping dreams survive: Dropout interventions. *Contemporary Education, 71*, 9-14.

Marbley, A. F., Bonner, II, F. A., McKisick, S., Henfield, M. S., & Watts, L. M. (2007). Interfacing culture specific pedagogy with counseling: A proposed diversity training model for preparing preservice teachers for diverse learners. *Multicultural Education, 14*(3), 8-16.

Matthews, J. (2009). *Work hard. Be nice. How two inspired teachers created the most promising schools in America*. Chapel Hill, NC: Algonquin Books of Chapel Hill.

Moore, A. L. (2002). African-American early childhood teachers' decisions to refer African-American students. *International Journal of Qualitative Studies in Education, 15*, 631-652. doi:10.1080/0951839022000014358

Moore, W. (2010). *The other Wes Moore: One name, two fates*. New York: Spiegel & Grau.

Murray, C., & Zvoch, K. (2011). Teacher-student relationships among behaviorally at-risk African American youth from low-income backgrounds: Student perceptions, teacher perceptions, and socioemotional adjustment correlates. *Journal of Emotional and Behavioral Disorders, 19*(1), 41-54. doi:10.1177/1063426609353607

National Network of Partnership Schools. (2009). *Epstein's six types of parent involvement*. Retrieved from http://www.csos.jhu.edu/htm.

Neild, R. C., Balfanz, R., & Herzog, L. (2007). An early warning system. *Educational Leadership, 65*(2), 28-33.

Nieto, S. (2008). Nice is not enough: Defining caring for students of color. In Pollock, M. (Ed.) *Everyday antiracism: Getting real about race in school*. New York, NY: The New Press.

Nolan, J. D., Houlihan, D., Wanzek, M., & Jenson, W. R. (2014). The Good Behavior Game: A classroom-behavior intervention effective across cultures. *School Psychology International, 35*(2), 191-205. doi:10.1177/0143034312471473

Ogbu, J. (1991). Minority coping responses and school experience. *Journal of Psychohistory, 18*(4), 433-456.

Pressley, M., Raphael, L., Gallagher, J. D., & DiBella, J. (2004). Providence-St. Mel school: How a school that works for African American students works. *Journal of Educational Psychology, 96*(2), 216-235. doi:10.1037/0022-0663.96.2.216

Rousseau, J. –J. (1979). *Emile or On Education*. Translation by Alan Bloom. New York: Penguin Books.

Schellengerg, R. & Grothaus, T. (2009). Promoting cultural responsiveness and closing the achievement gap with standards blending. *Professional School Counseling, 12*(6), 440-449. doi:10.5330/PSC.n.2010-12.440

Salina, C., Girtz, S., Eppinga, J., Martinez, D., Kilian, D. B., & Lozano, E., et al. (2013). All

hands on deck: A comprehensive, results-driven counseling model. *Professional School Counseling, 17*(1), 63-75. doi:10.5330/PSC.n.2014-17.63

Sampson, D., & Garrison-Wade, D. F. (2010). Cultural vibrancy: Exploring the preferences of African American children toward culturally relevant and non-culturally relevant lessons. *Urban Review, 43*, 279-309. doi: 10.1007/s11256-010-0170-x

Sanchez, Y. M., Lambert, S. F., & Cooley-Strickland, M. (2013). Adverse life events, coping and internalizing and externalizing behaviors in urban African American youth. *Journal of Child and Family Studies, 22*, 38-47. doi: 10.1007/s10826-012-9590-4

Sherrod, M. D., Getch, Y. Q., & Ziomek-Daigle, J. (2009). The impact of positive behavior support to decrease discipline referrals with elementary students. *Professional School Counseling, 12*(6), 421-427. doi:10.5330/PSC.n.2010-12.421

Shin, R. Q., Rogers, J., Stanciu, A., Silas, M., Brown-Smythe, C., & Austin, B. (2010). Advancing social justice in urban schools through the implementation of transformative groups for youth of color. *The Journal for Specialists in Group Work, 35*(3), 230-235. doi:10.1080/01933922.2010.492899

Skiba, R. & Sprague, J. (2008). Safety without suspensions. *Educational Leadership*, September issue, 38-43. Retrieved from http://www.ascd.org.

Smith, L., Davis, K., Bhowmik, M. (2010). Youth participatory action research groups as school counseling interventions. *Professional School Counseling, 14*(2), 174-182.

Sparks, E., Johnson, J. L., & Akos, P. (2010). Dropouts: Finding the needles in the haystack. *Educational Leadership, 67*(5), 46-49.

Stanard, R. P. (2003). High school graduation rates in the United States: Implications for the counseling profession. *Journal of Counseling & Development, 81*, 217-221. doi:10.1002/j.1556-6678.2003.tb00245.x

Teasley, M. (2006). School social workers and urban education reform with African American children and youth: Realities, advocacy, and strategies for change. *The School Community Journal, 14*(2), 19-38.

Thapa, A., Cohen, J., Higgins-D'Allesandro, A., & Guffey, S. (2012). *School climate research summary: August 2012*. New York, NY: National School Climate Center.

Thomas, D. E., Coard, S. I., Stevenson, H. C., Bentley, K., & Zamel, P. (2009). Racial and emotional factors predicting teachers' perceptions of classroom behavioral maladjustment for urban African American male youth. *Psychology in the Schools, 46*(2), 184-196. doi:10.1002/pits.20362

Thomas, O., Davidson, W., & McAdoo, H. (2008). An evaluation study of the Young Empowered Sisters (YES!) program: Promoting cultural assets among African American adolescent girls through a culturally relevant school-based intervention. *Journal of Black Psychology, 34*(3), 281-308. doi:10.1177/0095798408314136

Walter, S. E., Lambie, G. W., & Ngazimbi, E. E. (2008). A choice theory counseling group succeeds with middle school students who displayed disciplinary problems. *Middle School Journal, 40*(2), 4-12.

Youth United for Change. (2011). *Pushed out: Youth voices on the dropout crisis in Philadelphia*. Retrieved from http://www.youthunitedforchange.org

Electronic and Face-to-Face Bullying among Middle and High School Students

Rebecca Kozlosky
Cornwall Lebanon School District

Gail Cabral
Marywood University

Mary Salvaterra
Marywood University

Author Note
Gail Cabral, IHM, Ph.D., Department of Psychology and Counseling, Marywood University, Scranton, PA 18509. Email: cabral@marywood.edu

Abstract
The extent to which adolescents experience bullying and cyberbullying was investigated by an in-school survey administered to a population of 6th through 12th graders. Students endorsed statements about having been bullied or having acted as a bully in both face-to-face (FTF) and electronic settings. The usefulness of general versus specific questions was examined, as well as whether students maintained consistency of roles. Face-to-face bullying was more prevalent than cyberbullying. Prevalence estimates were larger when participants were asked to endorse specific examples of being victimized rather than responding to generic questions. Twenty-two percent of FTF targets were bullied electronically; 17% of FTF bullies also bullied online. Those who both bullied and were victimized FTF were most likely to be bullied electronically (28%). Males more frequently reported bullying others both directly and electronically; girls were more likely to be victims of cyberbullying than were boys.

Electronic and Face-to-face Bullying among Middle and High School Students

Although the presence of bullying has always been a reality in elementary and secondary schools (Olweus, 1993), the increasing use of electronic means of communication provides a new opportunity for bullying behavior to take place. This report reviews the literature on what constitutes face-to-face (FTF) and electronic bullying, how bullying has been measured, and its effects. Data is presented from the population of middle and high school students in one Pennsylvania school district on the frequencies of bullying and being bullied in both types of settings, and whether the same role is played in both FTF and cyber settings. Effects of types of measurement items, gender and grade patterns, and reporting behaviors are also reported.

The scientific study of bullying behavior began with the work of Dan Olweus in Sweden, in the 1970s and 1980s. The Olweus definition of bullying has been widely used in bullying research and bully prevention programs (Olweus, 1993, 1994). Bullying has

been defined as ongoing, negative behavior intended to cause harm to another. In addition to the components of repetition and intention, Olweus (1993) and other writers (Spears, Slee, Owens, & Johnson, 2009) highlight the presence of a power differential. Bullying involves deliberate words or actions intended to harm the other, in a situation in which one person has a persistent advantage.

Electronic bullying or cyberbullying is defined as "being cruel to others by sending or posting harmful material or engaging in other forms of social cruelty using the Internet or other digital technologies" (Willard, 2006, p. ix). Face-to-face (FTF) bullying has been repeatedly shown to cause the victim to experience immediate anxiety; serious, long lasting consequences include anger, depression, somatic symptoms, eating disorders, chronic illness, impaired school functioning, school avoidance, and suicidal ideation (Esbensen & Carson, 2009; Espelage & Swearer, 2003; Juvonen, Graham, & Schuster, 2003; Patchin & Hinduja, 2006; Seals & Young, 2003). Recent research indicates that cyberbullying has similar effects, causing fear, sadness and depression, anger, frustration, and social anxiety (Dempsey et al., 2009; Juvonen & Gross, 2008; Mitchell, Finkelhor, & Wolak, 2004; Raskauskas & Stoltz, 2007; Spears, Slee, Owens, & Johnson, 2009; Ybarra & Mitchell, 2004a; Ybarra, Finkelhor, & Wolak, 2007).

Bullying research has been conducted on every continent, sometimes with large cross-national studies (Esbensen & Carson, 2009; Konishi & Hymel, 2009). Although the image of face-to-face bullying is hitting a weaker person, a great deal of face-to-face (FTF) bullying is verbal or indirect. Physical action is often preceded by threats, and accompanied by insults. As children become older, a greater amount of FTF bullying behavior takes the form of name-calling, insulting, spreading rumors, or excluding. Cyberbullying may include all of these activities. Some forms of bullying behavior are more suited to the electronic venue, for example, sharing embarrassing photos, or sending messages in someone else's name, while physical bullying takes place only in face-to-face settings.

In some reports of FTF bullying, being victimized is more prevalent among females, and bullying others is more prevalent among males (Esbensen & Carson, 2009). In the present study, frequencies of both FTF and cyberbullying were analyzed for grade level and gender. This study reports on both the experiences of being bullied and of bullying others.

Research on bullying frequently classifies individuals in four categories: "victims" (or targets), i.e., those who are bullied; "bullies", those who threaten or harm; "bully/victims", those who both bully and are bullied; and observers (those who neither bully nor are targeted (Pornari & Wood, 2010). This organizing pattern is often used in studies which examine prevalence and/or suggest interventions (Peskin et al., 2006; Yang & Salmivalli, 2013).

The occurrence of violent retaliatory acts by former victims of bullying (e.g., at Columbine), and the need to know whether cyberbullying is unique or a subcategory of school bullying (Dooley, Pyzalski, & Cross, 2009) have raised the question of whether those who are face-to-face victims are also victims of cyberbullying. Some studies have suggested that those who have been bullied at school are more likely to be bullied electronically (Juvonen & Gross, 2008; Raskauskas & Stoltz, 2007). In addition to the types of devices used, specific forms of bullying or harassment activities have also been studied. Juvonen and Gross (2008), for example, compared the following behaviors in terms of whether they were experienced online or in school: insults, threats, sharing embarrassing pictures, and privacy violation.

Studies have ranged from small convenience samples to large Internet samples, and data has been collected in person or online. The present study was aimed at the entire population of a school district in Pennsylvania, by means of in-school data collec-

tion. The school district informed parents that the study would be occurring, but only required passive parental consent. No parent declined to have his or her child participate in the study.

Juvonen and Gross (2008) noted that students fear that parents will restrict their Internet access if they perceive danger for their children; therefore, students may be less likely to report cyberbullying in situations where parental consent is required. Thus, in the present study students were surveyed in school about their experiences of bullying or being bullied. The main research questions involved the relationship of FTF bullying to cyberbullying, in particular, (1) whether single generic items or multiple behavioral items would provide similar information regarding the extent of bullying, (2) whether students held the same role (bully or victim) in both FTF and cyber bullying, and (3) whether bullying was significantly affected by gender.

It was hypothesized that students would be more likely to indicate that they had been bullied when asked specific questions, that students would be likely to have the same role in both settings and that boys would be more likely to be bullies and girls to be victims of bullying. Exploratory questions included whether fewer participants would inform adults about cyberbullying than FTF bullying, and whether prevalence rates of bullying would vary by grade level.

Method

Participants

The sample of 2,337 students in grades 6 through 12 represented 84% of the total school population in a suburban public school district in south central Pennsylvania. Students attending Intermediate Unit special education classes or Career Technology classes were not included. All students in regular classes who were present on the days the survey was given were invited to participate in the study. The response rate (the percentage of those present who agreed to participate) was 97%. Therefore this study provides a thorough picture of bullying in the total population of one PA school district. Gender was equally distributed. Racial and ethnic distribution was highly similar to that of the total school population (see Table 1 for a summary of demographic information).

Procedures

Parents were notified of the study via a letter mailed to each household. Surveys were administered by teachers during the school day. Spanish versions were offered to all students who were enrolled in ESL classes; nine elected to take the survey in Spanish (.003 % of the population). Participation was voluntary and anonymous, and preceded by informed written assent. Students were offered opportunities to speak confidentially with school counselors about their experiences with bullying if they wished. A counselor saw the 50 Middle School and 14 High School students who requested such a meeting and appropriate courses of action were pursued. Interestingly, more student concerns involved bullying in school, not via the Internet or other electronic venues.

Instruments

The Revised Olweus Bully/Victim Questionnaire (ROBVQ; Olweus, 2003) was used to measure participants' experiences with FTF bullying at school. This instrument includes 39 questions concerning students' experiences as both targets and perpetrators of bullying, including methods and frequency. Students' feelings about bullying and the degree to which they reported bullying are included. Bullying is clearly defined at the start of the survey, providing consistency in the interpretation of the construct.

Reliability coefficients of the ROBVQ have ranged from .87 to .90. Measures of discriminant validity of the ROBVQ have indicated significant differences between the sub-groups of bullies and non-bullies on aggression and antisocial behavior, and between victims and non-victims on social disintegration and global negative self-evaluations. "Cohen's *d* was very large for most of the dependent variables," ranging from 0.62 to 1.05 (Solberg & Olweus, 2003, p. 260).

Added to the questionnaire were 23 questions about the frequency of cyberbullying experiences, designed by Limber and Kowalski to parallel the Olweus format (Kowalski et al., 2005). For both FTF bullying and cyberbullying, a general item asked how often the student had had the experience (of being bullied, bullying, being cyberbullied, cyberbullying) in the last two months. Eight items about specific behaviors followed each of these general items. Students were questioned about specific acts of cyberbullying and the electronic sites on which they occurred (e. g., Instant Messaging (IM), cell phones). Data on the electronic devices used will be made available upon request but are not presented in this report. Reliability and validity data were not available for these questions.

Because the questions on cyberbullying parallel the format and content of the Olweus scale, direct comparisons between bullying in the two venues were possible for most items. Likert-type items described the frequency with which the questioned behaviors occurred. Participants were asked about the extent to which they feared being cyberbullied, and if they had told anyone about their experiences. A seven-part question addressing reporting cyberbullying paralleled items on the Olweus survey of FTF bullying.

Results

Frequency of Victimization and Bullying

Of the 2,337 students responding to the survey, 57% directly reported having been bullied FTF (42% at least once or twice in the past couple of months; 15% two to three times a month or more (see Table 2). Fewer students reported being victims of cyberbullying. Twenty-five percent reported having been bullied electronically (19 % at least once or twice in the past couple of months; 6%, two to three times a month or more).

More students indicated that they had experienced specific bullying events than the number who identified themselves as victims when asked the question directly. When specific victim experiences were reported, 74% of the sample disclosed having been bullied FTF (as opposed to 52% who endorsed the general question). Forty percent of the sample indicated specific experiences of being bullied as opposed to 19% who responded positively to a direct general question (see Table 2).

Those who admitted to bullying others in the face-to-face manner at least once or twice comprised 38% of the sample; 10% reported bullying others two to three times a month or more. This percentage rose to 57% when asked if one had engaged in one or more of the specific activities included in the definition of bullying. Those who directly admitted to cyberbullying others at least once or twice included 12% of the sample; three percent indicated having done so at least two to three times a month. When asked whether they had engaged in specific cyberbullying activities, 25 % responded positively (see Table 3).

Continuity of Roles

When individuals in all four bullying categories were compared across both cyber and FTF bullying, 22% of FTF victims were cyberbullied. FTF bully/victims were electronic victims 28% of the time, and bullied electronically 15% of the time. FTF bullies were engaged in cyberbullying 17% of the time (see Table 4).

Analysis of Findings by Gender and Grade

Findings about gender differences are reported first for FTF bullying and then for cyberbullying (see Tables 5 and 6). Students' responses were used to place them in one of the following categories: victim, bully, one who engages in both behaviors (bully/victim), or one who engages in neither. Chi-square tests of independence revealed no significant relationship between gender and the experience of being a victim of face-to-face bullying, χ^2 (1, N = 2,333) = 0.99, p = .32; Φ = .021. Males did report engaging in significantly more bullying behaviors, however, χ^2 (1, N = 2,328) = 29.63, p < .01; Φ = .113. Males were also more likely to fall in the victim/bully category, χ^2 (1, N = 2,336) = 12.01, p < .01; Φ = .072, and females were more likely to report that they were neither face-to-face victims nor bullies, χ^2 (1, N = 2,336) = 10.93, p < .01; Φ = -.068.

Analysis of cyberbullying behaviors via chi-square tests of independence indicated that females in this study were more likely to be victims of cyberbullying than males were, χ^2 (1, N = 2,331) = 4.74, p < .05; Φ = -.045. Males reported significantly more cyberbullying activities than females, χ^2 (1, N = 2,333) = 8.00, p < .01; Φ = .059, at rates identical to their reports of face-to-face bullying. Although more males indicated that they were bully-victims, this difference did not reach significance.

Findings regarding grade differences indicate that students in grades 6 through 9 were more likely to report being the victims of face-to-face bullying than students in other grades, χ^2 (6, N = 2,334) = 67.43, p < .01; V = .170. However, analyses indicated no relationship between grade and self-report of engaging in FTF bullying behaviors, χ^2 (6, N = 2,329) = 11.93, p = .06; V = .072. Being a victim of cyberbullying was not significantly related to grade in school, χ^2 (6, N = 2,332) = 9.56, p = .14; V = .064. Admissions of bullying others electronically were significantly related to school grade, with the highest in grades 7, 9, and 11 and the lowest in grades 6 and 8, χ^2 (6, N = 2,334) = 15.16, p < .05; V = .081 (see Tables 7 and 8).

Fear of Bullying and Reports of Bullying

Traditional bullying was feared at least occasionally by 50.7% (n = 612) of the girls and by 36.4% (n = 409) of the boys responding to these items. Electronic bullying was feared at some level by 31.3% (n = 378) of the girls and by 12.3% (n = 137) of the boys.

Bullying episodes often go unreported and research suggests that this is even more prevalent with cyberbullying (Finkelhor et al., 2000; Newman & Murray, 2005; Patchin & Hinduja, 2006); the current study reflects similar patterns. Just over half of the victims reported their episodes of face-to-face bullying (56%, n = 449 of 799), but the majority of these reports were to friends (see Table 9). About half of those who experienced cyberbullying reported the event (52%, n = 185 of 356), also usually to a friend. Teachers were the least likely to be told of episodes of face-to-face bullying and cyberbullying.

Discussion

In the literature, estimates of cyberbullying are often smaller in size (ranging from 6% to 36%) than estimates of face-to-face bullying, estimated to influence 29% to 77% of youth (Espelage & Swearer, 2003). Nevertheless, the consequences of cyberbullying may be no less severe (Mitchell et al., 2004; Ybarra, Diener-West, & Leaf, 2007). The frequencies reported here are in keeping with those found in the literature. In the present study 52% reported experiencing FTF bullying, 15% two or more times per month. The frequencies for cyberbullying are approximately half the percentages observed for FTF bullying (19% having been victimized electronically, 6% two or more times per month). The findings of the present study fall in the middle of the ranges reported by Espelage and Swearer (2003) for FTF and cyberbullying.

Rates of bullying observed in written surveys have been found to be lower than those obtained through online or telephone polls (Hinduja & Patchin, 2005; Opinion Research Corporation, 2006). However, the findings in this study are similar to data collected through using direct survey methods (Kowalski & Limber, 2007). Dempsey et al. (2009) found that 14% of middle school students had experienced cyberbullying in the last 30 days. These rates reflect an increase from initial data gathered in the late 1990s (Finkelhor et al., 2000). Given the negative consequences suggested in the literature (Hinduja & Patchin, 2005; Mitchell et al., 2004; Raskauskas & Stoltz, 2007; Wolak et al., 2007; Ybarra et al., 2007), these numbers are cause for concern.

Investigating the prevalence estimates of bullying with single generic items or with questions about specific behaviors is important in ascertaining the "magnitude and distribution of the problem" (Esbensen & Carson, 2009, p. 212). In the present study students claim that they have not been bullied, but then respond positively to items like "I was called mean names, was made fun of, or teased in a hurtful way" or "Other students told lies or spread false rumors about me." When using these specific questions, 74% of the sample disclosed experiences of face-to-face bullying and 40% reported experiences of being cyberbullied. This finding contrasts with that of Juvonen and Gross (2008) who asked about bullying experiences over the past year. In their study the estimate for online bullying based on responses to five different forms of bullying experience was identical to that obtained on a single item. Our findings, however, support those of Esbensen and Carson (2009) who found higher prevalence rates when using behaviorally specific questions in contrast to a single generic question. The immediate and practical concern about this measurement issue is whether bullying is being underestimated. There are serious consequences of bullying to the victim, the bully, the observers and the school; thus it was important to determine whether specific behavior items or general ratings better estimate the frequency of bullying behavior. These results indicate specific behavioral questions should be used in studies investigating the frequency of bullying and cyberbullying.

According to Esbenson and Carson (2009), this discrepancy between answering negatively to a single question about bullying and answering positively to specific questions about bullying behaviors also raises concerns about the actual concept of bullying. How essential is the component of repetition in the definition of bullying? In Olweus' widely accepted definition, repeated acts of hostility or violence are required for bullying to have occurred. More recently, questions have been raised in the literature regarding whether repeated acts are necessary to label aggression as bullying. The lack of repetition may explain why someone does not admit he or she was bullied (or is a bully), despite answering positively to specific questions. At issue is the question, "How often may I do something or experience something before acquiring a label or a self-label?" It is easy to imagine a child (or an adult) replying to the accusation of being a bully, "But I only did it once!" Even in examining face-to-face bullying, one might raise the issue of a single aggressor who threatens several victims. Several researchers question the necessity of repeated acts before bullying is said to occur; a single dramatic act may be experienced by a child as bullying, even if the act does not meet the criteria of researchers (Dooley et al., 2009; Harris, 2009; Kowalski, 2003).

Related to the issue of the interpretation of behaviors is the question of the fear and anxiety that result. As was the case in earlier literature, students reported fear of both FTF and cyberbullying. In an earlier longitudinal study of FTF bullying in primary and secondary schools, Schäfer et al. (2005) described the social hierarchy of secondary schools as making it difficult to protect victims from bullying. Fear is a natural result of being unable to prevent, abort or escape that which is unpleasant. The issues of fear and repetition need to be addressed relative to cyberbullying. The resultant fear of even a

single act may be personally significant in some cases (Kowalski, 2003) as has been illustrated in well-publicized incidents of student suicide.

The issue of repetition is even more problematic in cyberbullying than in FTF bullying. Does one posted humiliating picture which goes out to hundreds of people, and which may be reproduced and spread, count as only one aggressive act? Debate among researchers on this issue needs to be paired with education about the extent of harm that can occur with cyberbullying. In the present study 31% of the girls and 12 % of the boys reported fear of cyberbullying. This finding is very similar to data found by Dooley (2009) on research carried out in Australia, and adds to the considerable literature on negative consequences of bullying. The role of repetition becomes more problematic in electronic forms, when a picture or a maligning label may be distributed repeatedly, and when others may reiterate exclusion, name-calling, etc., over a period of time. However, each aggressive participant may be only committing one act, or simply sending out once the "information" originally created by another.

The finding regarding gender differences supported analyses from Dempsey et al. (2009) in which boys were more frequently bullies in both electronic and FTF venues. On the other hand, Ybarra and Mitchell found that face-to-face bullies were more likely to be male, but Internet bullies were just as likely to be female (2004a; 2004b). Further investigation of specific types of acts may help shed light on these divergent results.

In regard to the question of whether FTF bullies are electronic bullies, and whether FTF victims are electronic victims, the data in the present study provide limited support for findings in previous literature. Similar to other research (Raskauskas & Stolz, 2007; Ybarra et al., 2007), the present study found significant but weak associations between being a bully in both FTF and cyber forms, and being victimized in both forms.

The fact that only a small percentage of students bully others both ways suggests that these may be two different groups of individuals, with different dynamics fueling the bullying behaviors. This finding suggests that considerably more attention be paid to the conceptual analysis of FTF bullying and cyberbullying. The thoughtful discussion of Dooley (2009) and his associates provides the beginning of such an effort, and suggests important research directions. Dooley (2009) suggests that the face-to-face bully gets immediate feedback in the form of the terror of the victim actually present to him/her, whereas "the reward for engaging in cyberbullying is often delayed" (p. 187). On the other hand, social-cognitive abilities, especially the ability to imagine the victim's reaction, could provide considerable indirect and lasting reward to the perpetrator. Caravita (2010) and her associates noted the controversy regarding the role of "theory of mind" as a factor influencing bullying. They found that cognitive (as opposed to empathic) theory of mind skills were correlated with ringleader bullying behaviors among boys. However, theory of mind skills were also correlated with defending behaviors among both boys and girls.

The fact that victims of cyberbullying in the present study are even less likely to tell adults than those who experience FTF bullying is problematic for school authorities and parents. This fact highlights the need for counselors to question clients about their peer relations both in general and in relation to bullying. It highlights the need for anti-bullying programs to focus more directly on cyberbullying (Willard, 2007) and for broader educational interventions related to the development of empathy, civility and communication skills. Focusing on creating a school climate of general respect and recognition would provide a setting in which personal power is available without recourse to bullying. Counselors can suggest interventions that assist victims to find friends and supporters (Somkowski & Kopacz, 2005). As cyberbullying prevention programs become more widespread, evaluation of such programs and analysis of elements related to their effectiveness should be undertaken.

References

Caravita, S., Di Blasio, P. & Salmivalli, C. (2010). Early adolescents' particiption in bullying: Is TOM involved? *Journal of Early Adolescence, 30*, 138-170. doi:10/1177/0272431609342983

Dempsey, A.G, Sulkowski, M. L, Nichols, R., & Storch, E.A. (2009). Differences between peer victimizations in cyber and physical settings and associated psychosocial adjustment in early adolescence. *Psychology in the Schools, 46* (10). doi:10.1002/pits

Dooley, J. J, Pyzalski, J., & Cross, D. (2009). Cyberbullying versus FTF bullying: A theoretical and conceptual review. *Journal of Psychology, 217* (4). doi:10.1027/0044-3409.217.4.182

Esbensen, F.; & Carson, D. C. (2009). Consequences of being bullied: Results from a longitudinal assessment of bullying victimization in a multisite sample of American students. *Youth Society, 41*. doi:10.1177/0044118X09351067

Espelage, D. L., & Swearer S. M. (2003). Research on school bullying and victimization: What have we learned and where do we go from here? *School Psychology Review, 32*(4), 365-383.

Finkelhor, D., Mitchell, K. J., & Wolak, J. (2000). *Online victimization: A report on the Nation's Youth*. Alexandria, VA: National Center for Missing & Exploited Children. Retrieved November 6, 2005, from http://www.unh.edu/ccrc/pdf/jvq/CV38.pdf

Harris, M. J. (2009). Bullying, Rejection, and Peer Victimization: A Social Cognitive Neuroscience Perspective. New York: Springer.

Hinduja, S., & Patchin, J. W. (2005). Research summary: Cyberbullying victimization. Retrieved August 5, 2006, from http://www.cyberbullying.us

Juvonen, J., Graham, S., & Schuster, M.A. (2003). Bullying among young adolescents: The strong, the weak, and the troubled [Electronic version]. *Pediatrics, 112*(6), 1231-1237. doi:10.1542/peds.112.6.1231

Juvonen, J. & Gross, E. (2008). Extending the school grounds? – Bullying experiences in cyberspace. *Journal of School Health, 78,* 496–505. doi:10.1111/j.1746-1561.2008.00335.x

Konishi, C. & Hymel, S. (2009). Bullying and stress in early adolescence: The role of coping and social support. *Journal of Early Adolescence, 29*(3), 333-356. doi:10.1177/0272431608320126

Kowalski, R. (2003). Complaining, teasing, and other annoying behaviors. New Haven, Ct: Yale University Press.

Kowalski, R., & Limber, S. (2007). Cyberbullying among middle school students [Electronic version]. *Journal of Adolescent Health, 41*, S22-S30. doi:10.1016/j.jadohealth.2007.08.017

Kowalski, R., Limber, S., Scheck, A., Redfearn, M., Allen, J., & Calloway, A., et al. (2005, August). *Cyberbullying among school-aged children and youth*. Paper presented at the annual meeting of the American Psychological Association, Washington, DC.

Mitchell, K. J., Finkelhor, D., & Wolak, J. (2004). Victimization of youths on the Internet. In J. L. Mullings, J. W. Marquart, and D. J. Hartley (Eds.), *The victimization of children: Emerging issues* (pp. 1 – 39). New York, NY: The Haworth Maltreatment & Trauma Press.

Mitchell, K. J., Ybarra, M. L., Finkelhor, D. (2007). The relative importance of online victimization in understanding depression, delinquency, and substance abuse. *Child Maltreatment, 12*, 314-324. doi:10.1177/1077559507305996

Newman, R. S., & Murray, B. J. (2005). How students and teachers view the seriousness of peer harassment: When is it appropriate to seek help [Electronic version]. *Journal of Educational Psychology, 97*(3), 347-365. doi:10.1037/0022-0663.97.3.347

Olweus, D. (1993). *Bullying at school*. Oxford, England: Blackwell.
Olweus, D. (1994). Annotation: Bullying at school: Basic facts and effects of a school-based intervention program. *Journal of Child Psychology and Psychiatry*. 35 (7), 1171-1190. doi:10.1111/j.1469-7610.1994.tb01229.x
Olweus, D. (2003). *Revised Olweus Bully/Victim Questionnaire*. Center City, MN: Hazelden Publishing and Education Services.
Opinion Research Corporation. (2006, July 6). *Cyber bully teen*. Retrieved from http://attorneygeneral.utah.gov
Patchin, J. W., & Hinduja, S. (2006). Bullies move beyond the schoolyard: A preliminary look at cyberbullying [Electronic version]. *Youth Violence and Juvenile Justice, 4*(2), 148-169. doi:10.1177/1541204006286288
Peskin, M., Tortolero, S., & Markham, C. (2006). Bullying and victimization among Black and Hispanic adolescents. *Adolescence, 41*,467-484.
Pornari, C. D. & Wood, J. (2010). Peer and cyber aggression in secondary school students: The role of moral disengagement, hostile attribution bias, and outcome expectancies. *Aggressive Behavior, 36*, 81-94. doi:10.1002/ab.20336
Raskauskas, J., & Stoltz, A. D., (2007). Involvement in face-to-face and cyberbullying among adolescents [Electronic version]. *Developmental Psychology, 43*(3), 564-575. doi:10.1037/0012-164943.3.564
Schäfer, M., Korn, S., Brodbeck, F.C., Wolke, D., & Schulz, H. (2005). Bully roles in changing contexts: The stability of victim and bully roles from primary to secondary school. *International Journal of Behavioral Development, 29* (4), 323-335. doi:10.1080/01650250544000107
Seals, D., & Young, J. (2003). Bullying and victimization: Prevalence and relationship to gender, grade level, ethnicity, self-esteem, and depression [Electronic version]. *Adolescence, 38* (152), 735-747.
Solberg, M. E., & Olweus, D. (2003). Prevalence estimation of school bullying with the Olweus Bully/Victim Questionnaire [Electronic version]. *Aggressive Behavior, 29*, 239-268. doi:10.1002/ab.10047
Somkowski, P., & Kopacz, K. H. (2005). Bullying in school: An overview of types, effects, family characteristics, and intervention strategies. *Children and Schools, 27* (2), 101-110. doi:10.1093/cs/27.2.101
Spears, B., Slee, P., Owens, L., & Johnson, B. (2009). Behind the scenes and screens: Insight into the human dimension of covert and cyberbullying. *Zeitschrift fur Psychologie/Journal of Psychology, 217* (4), 189-196. doi:10.1027/0044-3409.217.4.189
Willard, N. (2006). Cyberbullying and cyberthreats: Responding to the challenge of online social cruelty, threats, and distress. Eugene, OR: Center for Safe and Responsible Internet Use.
Willard, N. (2007). Cyberbullying and cyberthreats: Responding to the challenge of online social aggression, threats, and distress. Champaign, IL: Research Press.
Wolak, J., Mitchell, K. J., & Finkelhor, D. (2007). Does online harassment constitute bullying? An exploration of online harassment by known peers and online-only contacts [Electronic version]. *Journal of Adolescent Health, 41*, S51-S58. doi:10.1016/j.jadohealth.2007.08.019
Yang, A. & Salmivalli, C. (2013). Different forms of bullying and victimization: Bully-victims versus bullies and victims. *European Journal of Developmental Psychology, 10* (6), 723-738. doi:10.1080/17405629.2013.793596
Ybarra, M. L., Diener-West, M., & Leaf, P. J. (2007). Examining the overlap in Internet harassment and school bullying: Implications for school intervention [Electronic ver-

sion]. *Journal of Adolescent Health, 41*, S42-S50. doi:10.1016/j.jadhealth.2007.09.004

Ybarra, M. L., & Mitchell, K. J. (2004a). Online aggressor/targets, aggressors, and targets: A comparison of associated youth characteristics. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 45*(7), 1308-1316. doi:10.1111/j.1469-7610.2004.00328.x

Ybarra, M. L., & Mitchell, K. J. (2004b). Youth engaging in online harassment: Associations with caregiver-child relationships, Internet use, and personal characteristics. *Journal of Adolescence, 27*(3), 319-336. doi:10.1016/j.adolescence.2004.03.007

Table 1

Demographic Characteristics of the Sample

Grade	6	7	8	9	10	11	12	Total	Percent
Female	188	199	199	201	187	226	191	1,391	50.05
Male	175	193	189	215	232	205	179	1,388	49.95
Asian	7	8	4	7	9	11	9	55	1.98
African American	2	5	12	16	10	10	7	62	2.23
Hispanic	37	37	37	48	24	35	28	246	8.85
Native American	1	0	3	1	0	1	1	7	0.25
Caucasian	294	326	326	337	371	369	313	2,336	84.06
Mixed ethnicity	22	16	6	5	0	0	2	51	1.84
Unspecified ethnicity	0	0	0	2	5	5	10	22	0.79
Low income	58	67	68	58	48	40	40	379	13.63
Total	363	392	388	416	419	431	370	2,779	

Table 2

Percentage of Respondents Indicating Frequencies of Being Bullied

	Type of Victim Experience	
Responses	Face-to-face	Electronic
At least once or twice	42.0%	19.0%
Two to three times per month or more	15.0%	6.4%
Report of any specific victim experiences	74.5%	39.7%

Table 3

Responses Indicating Frequency of Engaging in Bullying Behaviors

	Type of Bullying	
Responses	Face-to-face	Electronic
At least once or twice	38.5%	12.1%
Two to three times per month or more	10.4%	3%
Report of any specific bullying behaviors	57.1%	25.2%

Table 4

Percent of Face-to-face Bullying Groups Who Are Also Electronic Victims or Bullies

	Percent who are also electronic victims		Percent who also bully electronically	
	n	%	n	%
Face-to-face victim	58	22.14%	6	2.29%
Face-to-face bully	14	9.21%	26	17.10%
Face-to-face bully/victim	25	28.09%	13	14.61%
Neither face-to-face victim nor bully	52	2.84%	26	1.42%

Table 5

Membership in Face-to-face Bullying Sub-groups by Gender

	Females		Males	
	n	%	n	%
Victim	173	49.3%	178	50.7%
*Bully	85	35.1%	157	64.9%
*Both (bully/victim)	30	33.7%	59	66.3%
*Neither	981	53.5%	851	46.5%

Indicates a significant relationship, $p < .01$

Table 6

Membership in Cyberbullying Sub-groups by Gender

	Females		Males	
	n	%	n	%
*Victim	90	60.4%	59	39.6%
*Bully	25	35.2%	46	64.8%
Both	13	39.4%	20	60.6%
Neither	1107	51.5%	1042	48.5%

* Indicates a significant relationship, $p < .05$

Table 7

Membership in Face-to-face Bullying Sub-groups by Grade

Grade:	6	7	8	9	10	11	12
	n %	n %	n %	n %	n %	n %	n %
*Victim	68	88	58	58	36	27	16
	19.4%	25.1%	16.5%	16.5%	10.3%	7.7%	4.6%
Bully	22	46	35	48	39	28	24
	9.1%	19%	14.5%	19.8%	16.1%	11.6%	9.9%
Both	14	19	12	16	13	9	6
	15.7%	21.3%	13.5%	18%	14.6%	10.1%	6.7%
*Neither	240	256	284	262	279	282	230
	13.1%	14%	15.5%	14.3%	15.2%	15.4%	12.5%

*Indicates a significant relationship, $p < .05$

Table 8

Membership in Cyberbullying Sub-groups by Grade

Grade:	**6**	**7**	**8**	**9**	**10**	**11**	**12**
	n %	**n %**	**n %**	**n %**	**n %**	**n %**	**n %**
Victim	21 14.4%	28 18.8%	16 10.7%	27 18.1%	17 11.4%	28 18.8%	12 8.1%
*Bully	4 5.6%	15 21.1%	3 4.2%	16 22.5%	10 14.1%	14 19.7%	9 12.7%
Both	1 3%	8 24.2%	2 6.1%	7 21.2%	4 12.1%	9 27.3%	2 6.1%
Neither	292 (13.6) 13.6%	336 15.6%	348 16.2%	316 14.7%	318 14.8%	295 13.7%	245 11.4%

*Indicates a significant relationship, $p < .05$

Table 9

Reporting of Episodes of Bullying

	Face-to-face bullying	Cyberbullying
Was bullied and reported it	56.2%	52%
To a friend	77.7%	77.7%
To a parent or guardian	62.4%	49%
To a sibling	39.2%	41.8%
To an adult at school other than teacher	31.6%	16.9%
To somebody else	19.8%	15.4%
To a teacher	15.7%	8.8%

Animal Assisted Therapy in Schools

Sarah Carlisle & Holly Branthoover
Indiana University of Pennsylvania

Author Note
Correspondence concerning this article should be sent to Carlisle.e.sarah@gmail.com.

Abstract
Animal Assisted Therapy (AAT) is the deliberate inclusion of an animal (dog) in an already established treatment plan for an individual. This type of therapy involves an AAT credentialed treatment provider who guides interactions between an individual and a certified therapy dog (facility dog) to accomplish specific goals. This article seeks to examine AAT as an appropriate school counseling intervention program where AAP can benefit students in the career, personal/social and academic domains of a comprehensive school counseling program. This article provides information on AAT, presents existing research on AAT, and outlines benefits and challenges of using AAT in the schools.

Keywords: school counseling, dogs, counseling, Animal Assisted Therapy.

Animal Assisted Therapy in Schools

In the 1960's, child psychologist Boris Levinson was the first to introduce the notion of using animals to provide therapeutic benefits for children (Chandler, 2012). Research in the past two decades has found a positive association for use of therapy dogs with some children (Nimer & Lundahl, 2007). The introduction of a dog can be designed to aid in the accomplishment of predefined outcomes for many children, and may also enhance an outcome for some children who do not respond to traditional therapy methods (Nimer & Lundahl, 2007). Levinson was one of the first people to express, "the benefits that his dog brought to counseling sessions with children and youth, and provided numerous examples of ways in which animals could enhance therapy" (as cited in Fine, 2010, p. 33). Having a trained therapy dog in a counseling session is a unique deviation from traditional talk therapy. Using Animal Assisted Therapy (AAT) in a school setting may benefit individual students and enhance the success of a comprehensive school counseling program. It is important to note that AAT was not created to be a students' only intervention, but instead to be a supplement to an already established intervention program. AAT needs to be seen as an alternative option for students in the school that are not positively benefiting from their current school intervention program. The purpose of this article is to provide information about how (AAT) can be appropriately used in many school settings. Information on AAT and research supporting this methodology will be provided, including challenges and multiple solutions for most cases. Specifically, information will be provided on how AAT can be used as an intervention in a comprehensive school-counseling program in school settings.

Information of Animal-Assisted Therapy

There are over 20 different definitions of the term Animal-Assisted Therapy. Delta Society, now called Pet Partners, created a definition for the term in order to encourage standardization of terminology for AAT (Fine, 2010). Pet Partners, not to be confused with the human society, is a non-profit organization that promotes many animal programs that create positive human-animal interactions to enhance people's lives (Pet Partners, 2012b). Pet Partners is one of the largest AAT organizations in the United States and has created the following definition of AAT:

> Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process. AAT is directed and/or delivered by a health/human service professional with specialized expertise, and within the scope of practice of his/her profession. Key features include: specific goals and objectives for each individual; and measured progress. (Pet Partners: What are Animal-Assisted Activities/Therapy)

"AAT is the deliberate inclusion of an animal in a treatment plan," and is not a stand-alone treatment for one individual (Nimer & Lundahl, 2007, p. 225). This treatment plan should state specific goals, which may help to create certain outcomes in an individual and are measured by a credentialed treatment provider that guides the interactions (Nimer & Lundahl, 2007). When the definition states "specific criteria" it is referring to having the animal properly certified through an organization that meets the standards of the school and of Animal-Assisted Therapy guidelines. Not only must the therapy animal be properly certified, but the treatment provider should also be AAT certified through courses that can be found at many colleges or universities. AAT can be used with many students, such as a student who is distressed, trauma affected, or one that is having difficulty with other interventions and may benefit from the presence of an animal (dog) as an alternative intervention in the school (Nimer & Lundahl, 2007). It is important to note that AAT is not an intervention for all students, for example, a student who is highly allergic or aggressive towards animals. It is important that the well-being of the student and the dog does not decrease with the intervention of AAT. Dogs are the most commonly used animals in AAT because they are domesticated and easily accessed and trained (Nimer & Lundahl, 2007).

Differentiating AAT with Other Types of Popular Animal Interventions/Therapy

There are two types of interventions that can be designed with the presence of an animal, AAT and Animal-Assisted Activity (AAA). As with AAT, there are many different terms used among professionals for AAA. For consistency, this article relies on the definition from Pet Partners.

Animal-Assisted Activity (AAA): AAA provides opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. AAA's are delivered in a variety of environments by specially trained professionals, paraprofessionals, and/or volunteers, in association with animals that meet specific criteria. Key features include: absence of specific treatment goals; volunteers and treatment providers are not required to take detailed notes; visit content is spontaneous (Fine, 2010, p. 34).

It is significant that both definitions outline that the animals should be handled by specifically trained individuals, such as those certified in AAT and AAA courses (Fine, 2010). In most cases, the animals undergo behavioral evaluations to assure appropriate temperament before the animal can be in a facility with clients/students (Fine, 2010).

Pet Partners created the chart shown in Table 1 to provide a comparison between AAA and AAT (Pet partners: 2012a).

Table 1

Comparison of AAA and AAT

AAA	AAT
Casual "meet and greet" activities that involve pets visiting people	Significant part of treatment for many people who are physically, socially, emotionally or cognitively challenged
No specific treatment goals planned	Stated goals for each session
Same activity can be used with many people	Individual treatment for each patient
Detailed noted unnecessary	Notes on patient progress taken at each session
Visit content is spontaneous	Visit scheduled, usually at set intervals
Visit can be as long or short as desired	Length of visit is pre-determined to best fit needs of patient

It is important to note that guide, assistance, and service animals do not fall under the umbrella of either AAA or AAT. The *Americans with Disabilities Act of 1990* definition of a service animal(s) is "any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability" (U.S. Department of Justice, 2008, p. 1). The service animal(s) role is to "perform some of the functions and tasks that the individual cannot perform as a result of their disability" (U.S. Department of Justice, 2008, p. 1). There may also be social and other benefits to the individual receiving assistance from the service animal, but that is not the main purpose of service animals. These service animals are viewed as "tools" and not part of treatments with specific goals for an individual child as an intervention, such as AAT (Fine, 2010).

Research

AAT has been practiced for many years as part of the therapeutic process, and there has been an increase in research in this area demonstrating its use as an effective intervention (Nimer & Lundahl, 2007). Investigations have examined AAT benefits for children in multiple areas such as special education, students with autism, attention deficit hyperactivity disorder (ADHD), undesirable behaviors, medical difficulties, behavior disorders, and emotional disabilities (ED) at all ages and grade levels (Nimer & Lundahl, 2007). Animals can create a warm and safe environment for the therapeutic process, making the student more comfortable to open up, express themselves, and accept intervention steps and techniques from the school counselor (Nimer & Lundahl, 2007). One study examined multiple elementary age children with developmental disabilities to determine the effects of the presence of a trained dog with a child in social interactions, especially with their classroom teacher (Esteves & Stokes, 2008). All of the children increased in positive initiated behaviors (non-verbal and verbal) toward the teacher and the dog, and positive social responsiveness by classmates (Esteves & Stokes, 2008). The children also decreased negative initiated behaviors (Esteves & Stokes, 2008). The study by Esteves and Stokes (2008) supports the idea that some children with developmental disabilities may benefit from the presence of a trained dog such as a therapy dog.

The use of a dog in therapeutic interventions may be beneficial because of the calming effects associated with the interaction of dogs and children (Gee, 2011). In some

mental health settings, patients have been able to address and/or work through, with the intervention of AAT in the counseling session, the areas of psychophysiological health, anxiety/distress, dementia, depression, emotional regulation, emotional recognition, motivation, self-esteem enhancement, developmental disorders, emotional/behavioral problems, physically disabled persons, substance abuse and psychiatric patients (Chandler, 2012). Nimer and Lundahl (2007) conducted a meta-analysis of over 200 AAT studies. They concluded, based on this review, that AAT was an effective intervention plan.

Application to Schools

Research

Animals, especially dogs, have been shown to help children in school with developing empathy and caring attitudes, improving physical abilities and motor skills, practicing communication, practicing reading skills, experiencing calm and emotional well-being, coping with loss/grief, and improving cognitive task performance and motivation to learn (Nimer & Lundahl, 2007). Animals have been used in schools for many years and have been coined as "natural motivators" for learning and creating "teachable moments" for students in the school (Rud Jr. & Beck, 2003, p. 248). Students learn in different ways using a variety of motivational strategies in school (Jonassen & Grabowski, 2011; Schmeck, 1988). Given what is known about the benefits of AAT, individualized intervention plans using AAT may be an option that would benefit some students.

Gee (2011) identifies multiple studies demonstrating the benefits of the presence of a dog in the classroom as a helper. Gee looked at the effects of animals in the classroom among six educational goals such as: developing empathy and caring attitudes towards animals, improving physical abilities and motor skills, practicing communication and reading, experiencing calm and emotional well-being, coping with loss/grief, and improving cognitive task performance and motivation to learn. Many studies found a positive connection with preschool children and dogs (Gee, 2011). Some of the studies found that animals help with children learning motor skills, including the ability to perform many exercises faster and with improved accuracy when a dog was present (Gee, 2011). In a preschool study, the presence of a dog got the children to focus more on the task that they were expected to perform after watching the dog do it, in comparison to other conditions (Gee, Harris, Bennett & Harris, 2009). In another instance, a preschooler had a therapy dog (miniature poodle) in physical therapy that helped to motivate her (Gee, 2008). An older teenager, who was diagnosed with schizophrenia, was able to increase the average of words per answer to questions with visits from a dog (Corson & Corson, 1980). Another study showed that peers were 10 times more likely to interact with another peer that had a disability if a dog was present with the child (Katcher, 1997). Children in general were found to be 70% more likely to converse with and open up to animals (Serpell, 2000). When children were asked to read aloud in a study, they had a decrease in anxiety and were more calm and attentive with a dog compared to another adult or friend/peer (Friedmann, Thomas & Eddy, 2000). The use of an animal can help achieve communication with a child about the process of death and coping with grief and loss of a loved one (Gee, 2011). Many times the first loss a child will experience will be of a household pet (Robin & Bensel, 1985). If a child is able to learn the process and cope successfully with the loss of a pet, then they may be able to use that knowledge and apply those concepts to other death situations they will encounter in life.

In 2006, Anderson and Olson observed the effects of the presence of a dog in a self-contained classroom for children with severe emotional disorders. The study found that the dog's placement in the classroom "contributed to students overall emotional stability

evidenced by prevention and de-escalation of episodes of emotional crisis; improved students' attitudes toward school and facilitated students' learning lessons in responsibility, respect and empathy" (Anderson & Olson, 2006, p. 35). Law and Scott (1995) conducted a study with pet care programs and children with pervasive developmental delays or autism. While these children worked with the animals in the classroom, they decreased or eliminated worrying and fear and in turn increased their comfort level and confidence (Law & Scott, 1995). Law and Scott also noticed an improvement among these children in decision-making, problem solving skills, and social interactions with others around them.

Several factors may lead to parent support for using AAT, specifically with dogs, in a school setting. The majority of families in the United States have pets and many of those are dogs in the household (Gee, 2011). One study by Nielsen and Delude (1989) found that children preferred dogs to the other animals in the study. This research indicates it may be the most beneficial to have a dog as part of the AAT program at a school, rather than another animal. Parents often express that having a pet dog at home has been associated with their child having an increase in responsibility, caring attitudes, and provided companionship and security (Gee, 2011). Children (school students) may be able to generalize the acquired behaviors observed from a household pet to use in other situations such as school settings, increasing the likelihood that they may receive benefits from AAT as an intervention in the school. "A majority of parents believe that children benefit from interactions with animals" (Gee, 2011, p. 117). The concepts addressed above are very important to the indication that many parents may be willing to be invested in AAT part of their child's intervention program at school.

Challenges

The research stated above indicates that AAT can be an effective alternative to helping some children as one part of their intervention program at school. However, not every child will benefit from having AAT. Some challenges that arise with use of AAT in schools are children with dog allergies, sanitation, insurance/liability coverage on the dog that is providing the intervention in the school, and children being fearful of the dog. Students in these situations may not benefit from receiving AAT in the school. It is also important to be aware and respectful of personal and cultural concerns of the students and/or families of students in the school when preparing and implementing an AAT program at any school. Additionally, it is critical to have administrative support, such as school principals, for use of AAT as apart of the school counselors' comprehensive school-counseling program. Looking at these potential limitations and preparing for concerns can be addressed by establishing a policy for AAT in any school before the introduction of AAT in the school counseling program. It is also important to have a dog specifically trained to work in a school facility, such as a facility dog, so the dog is best prepared for work in this type of educational setting and is trained to be around school students all day (Canine Companions for Independence, 2013). "Facility Dogs are expertly trained dogs who partner with a facilitator working in a health care, visitation or education setting" (Canine Companions for Independence, 2013, para. 1). In addition to this, it maybe beneficial if the person conducting AAT is certified, having an understanding in utilizing AAT effectively in an educational setting. The person handling the dog needs to have background knowledge of dog safety procedures to create an atmosphere of animal well-being (Chandler, 2012). Planning for these potential problems is important for the success of an AAT program in any school.

Recommendations for Comprehensive School Counseling Programs and Research

In establishing an AAT program for a school, as stated above, it is important that the dog is certified to become part of an animal assisted therapy program, with specific training for working in a school and students with special needs. This will be necessary for liability/insurance reasons. It is also important to develop policies to establish the responsibility of the designated handler(s) of the dog, as well as guidelines for the interaction(s) of the dog with the children, specifically the child receiving AAT. There are conferences held in the United States on AAT and graduate courses offered at many universities to obtain an AAT certificate. If school counselors are uncomfortable with AAT, an alternative may be to integrate a trained therapy dog and handler from outside the school for specific children or special programs. Students may then meet with a professional provider for one-on-one sessions. There are AAT teams that can be brought into the schools if that fits the schools needs more than having their own dog as part of the school counseling program. Pet Partners outlines a four-step process to acquire an animal assisted therapy team for a school. The process includes recommendations for the initial set-up, site assessment/policies and procedures, guidelines to register your facility, and directions for recruiting therapy animal teams (Pet partners, 2012a).

AAT is not intended to be the only intervention for children that need help in schools, but it may provide an addition to already established programs with interventions for some children. There have been some studies done with AAT outside of school, but none have been done inside the school as a part of a comprehensive school-counseling program. While the results to date have been promising, additional investigations will help in addressing the most effective use of AAT in schools including: number of therapy sessions needed, ideal length of time for therapy sessions and specific diagnosis or behavioral issues most likely to benefit from AAT.

Conclusion

AAT is an alternative intervention for students/children to increase the benefits of their current intervention program. In such cases, children could benefit from having an appropriately trained dog as part of their intervention within a school-counseling program. There are some obstacles that must be addressed and overcome during the planning process to effectively implement AAT into an intervention program for a school student. Research has shown that AAT can be effective for children of special needs in many different areas. It is important to create a specific plan for AAT to be a part of any school counseling comprehensive program outlined with specific measurable goals for a student to be highly effective.

References

Anderson, K. L., & Olson, M. R. (2006). The value of a dog in a classroom of children with severe emotional disorders. *Anthrozoos,* 19(1), (pp. 35-49). doi:10.2752/089279306785593919

Canine Companions for Independence. (2013). *Facility dogs*. Retrieved from http://www.cci.org/site/c.cdKGIRNqEmG/b.4011121/

Chandler, C. K. (2012). *Animal assisted therapy in counseling* (2nd ed.). New York, NY: Routledge Taylor & Francis Group.

Corson, S.A., & Corson, E. O. (1980). Pet animals as nonverbal communication mediators in psychotherapy in institutional settings. In S. Corson, E. O'Leary Corson, & J.A. Alexander (Eds.), *Ethology and nonverbal communication in mental health: an interdisciplinary biopsychosocial exploration* (pp. 83-110). Oxford: Pergamon Press, 1980.

Esteves, S., & Stokes, T. (2008). Social effects of a dog's presence on children with disabilities. *Anthrozoos*, 21(1), 5-15. doi:10.2752/089279308X274029

Fine, A. (2010). *Animal-assisted therapy: Theoretical foundations and guidelines for practice* (3rd ed.). New York: Academic Press is an imprint of Elsevier.

Friedman, E., Thomas, S.A., & Eddy, T.J. (2000). Companion animals and human health: Physical and cardiovascular influences. In A.L. Podberscek, E.S. Paul, & J.A. Serpell (Eds.), *Companion animals and us: Exploring the relationship between people and pets* (pp. 125-142). New York: Cambridge University Press.

Gee, N. R. (2008). Describing that which cannot be measured, catalogued, or classified. *Reflections*: *Narratives of Professional Helping, 14* (4), 23-26.

Gee, N. R. (2011). Animals in the classroom. In P. McCardle, S. McCune, J.A. Griffin, L. Esposito, L. S. Freund (Eds.), A*nimals in our lives: Human–animal interaction in family, community, and therapeutic settings* (pp. 117-141). Baltimore, MD US: Paul H Brookes Publishing.

Gee, N. R., Sherlock, T. R., Bennett, E.A., & Harris, S. L. (2009). Preschoolers' adherence to instructions as a function of presence of a dog and motor skills task. *Anthrozoos*, 22(3), 267-276. doi:10.2752/175303709X457603

Jonassen, D. H., & Grabowski, B. L. (2011). *Handbook of individual differences, learning and instruction* (2nd ed.). New York, NY: Routledge Taylor and Francis Group.

Katcher, A.H. (1997). New roles for companion animals mean new roles for veterinarians. *The Newsmagazine of Veterinary Medicine, 29* (6), 12-16.

Katcher, A., & Teumer, S. (2006). A 4-year trial of animal-assisted therapy with public school special education students. In A. H. Fine (Ed.), *Handbook on animal-assisted therapy: Theoretical foundations and guidelines for practice* (2nd Ed) (pp. 227-242). San Diego, CA US: Academic Press.

Law, S., & Scott, S. (1995). Pet care: A vehicle for learning. *Focus On Autistic Behavior*, 10(2), 17.

Nielsen, J.A., & Delude, L.A. (1989). Behavior of young children in the presence of different kinds of animals. *Anthrozoos,* 3(2), 119-129. doi:10.2752/089279390787057711

Nimer, J., & Lundahl, B. (2007). Animal-Assisted Therapy: A Meta-Analysis. *Anthrozoos*, 20(3), 225-238. doi:10.2752/089279307X224773

Pet partners. (2012a). Retrieved from http://www.deltasociety.org/page.aspx?pid=183

Pet Partners. (2012b). *About us*. Retrieved from http://www.petpartners.org/page.aspx?pid=251

Prothmann, A., Bienert, M., & Ettrich, C. (2006). Dogs in child psychotherapy: Effects on state of mind. *Anthrozoos*, 19(3), 265-277. doi:10.2752/089279306785415583

Robin, M., & Bensel, R.A. (1985). Pets and the socialization of children. *Marriage and Family Review, 8*(3-4), 63-78. doi:10.1300/J002v08n03_06

Rud Jr., A. G., & Beck, A. M. (2003). Companion animals in Indiana elementary schools. *Anthrozoos,* 16(3), 241-251. doi:10.2752/089279303786992134

Schmeck, R. R. (1988). *Learning strategies and learning styles. perspectives on individual differences*. (Vol. 368). New York, NY: US:Plenum Press.

Serpell, J.A. (2000). Creatures of the unconscious: Companions animals as mediators. In A.L. Podberscek, E.S. Paul, & J.A. Serpell (Eds.), *Companion animals and us: Exploring the relationship between people and pets* (pp. 108-124). New York: Cambridge University Press.

Solomon, O. (2010). What a dog can do: Children with Autism and therapy dogs in social interaction. *Ethos* (00912131), 38(1), 143-166. doi:10.1111/j.1548-1352.2010.01085.x

U.S. Department of Justice. (January, 14 2008). *Commonly asked questions about service animals in places of business*. Retrieved from http://www.ada.gov/qasrvc.htm

Mentoring Student Research: An Overview of Statistical Power

Francis J. DeMatteo
Marywood University

Author Note

Francis J. DeMatteo, Ed.D., NCSP is an Associate Professor and Director of the School Psychology Program at Marywood University. His research agenda focuses on improving outcomes for PK through grade 12 students in public education settings. Correspondence concerning this article should be addressed to Dr. Francis DeMatteo at fjdematteo@maryu.marywood.edu.

Abstract

Mental health practitioners seeking an advanced degree are often required to complete a formal research project. Due to limited resources, these projects are likely to have small sample size, thereby affecting statistical power. The current article provides an overview of statistical power in a practitioner-friendly manner, and it offers suggestions for mentors and student researchers when designing studies.

Mentoring Student Research: An Overview of Statistical Power

As part of advanced counseling and psychology training programs, students are often required to complete a formal research project such as a thesis, professional contribution, or dissertation. Although some projects may be qualitative, many are likely to require data analysis through descriptive and inferential statistics. Recognizing that sample sizes of these projects are generally small and resources are limited, it is necessary for faculty mentors and advisors to remind student researchers about the importance of statistical power when proposing their projects. The purpose of this paper is to review the concept of statistical power in a practitioner-friendly manner. Effect size will be highlighted and an example of a power analysis will be provided. Conclusions and implications will then be offered for research mentors and students.

What is power?

Power can be defined through an analogy. If you are in a field, and you are looking for something big (effect), like an elephant, you do not need binoculars with great "power" to see it. However, if you are looking for something small (effect), like a mouse, you need binoculars with more "power." In a similar illustration, "conducting a study with 'low power' is like fishing for minnows with a tuna net: you probably won't catch any minnows, but you can't conclude that there are none in the pond, everything just slips through the net" (Fagley & McKinney, 1983, p. 298).

Power gauges the capacity to detect effects that actually exist in the population under examination (Cohen, 1988; Jones & Sommerlund, 2007). When discussing power, researchers need to consider: (a) the significance level adopted for the study (e.g., alpha = $p < .05$), (b) the amount of variability in the measure of the independent variable, (c) the magnitude of the effect created by the independent variable (i.e., effect size),

and (d) sample size (Cohen, 1988; Kiess, 1989). The current article focuses on the latter two factors.

How does a researcher determine power?

A functional relationship exists among power, alpha, effect size, and sample size (Cohen, 1992). For the purpose of research planning, "it is most useful to determine the sample size necessary to have a specified power (.80) for a given alpha and effect size" (Cohen, 1992, p. 156). Thus, from the researcher's perspective, sample size becomes the key factor in obtaining power with one caveat. Assuming that alpha is set at .05, the determination of power or sample size can not be established until the researcher acknowledges effect size for a particular intervention/treatment (Cohen, 1988; 1992).

What is effect size?

Effect size (ES) is "…a measure of the strength of the relationship between two variables" (Hedges & Rhoads, 2010, p. 2) or the degree to which the null hypothesis is believed to be false (Cohen, 1992). In other words, the effect size is the index of the discrepancy between the null hypothesis and the research/alternate hypothesis-commonly referred to as "*d*" (Cohen 1988, Kiess, 1989). This index is scale-free and continuous, ranging from zero upward. Effect size is categorized in terms of small (.20), medium (.50), and large (.80) (Cohen, 1988). Effect size forces the researcher to examine the impact the independent variable had in changing the sample mean. Thus, effect size is a measure of meaningfulness, and it is an important tool when considering the statistical significance of the study, which is largely dependent on sample size. Sample sizes that are too large for a predetermined effect size can yield statistical significance of little or no practical value, as the resulting difference between mean scores might be considered meaningless (Cohen, 1990). Conversely, a sample size that is too small for a given effect size may result in findings of practical importance, but did not achieve statistical significance (Cohen, 1990).

Where do I find the effect size for my topic of study?

Effect size is dependent on previous research in a topic area and/or the specific nature of the research question (Cohen, 1992). Examining meta-analyses in the topic area is usually the first step for researchers to identify an effect size for a particular treatment/intervention (Cohn & Becker, 2003). With treatments and interventions where meta-analyses have yet to be completed, researchers evaluate the methodology, sample sizes, and results of previous studies in the topic area, developing a rationale to support an estimated effect size (small, medium, large). This rationale should specifically address the degree to which previous sample means changed due to the treatment/intervention. In such instances, researchers are recommended to err on the side of caution, assuming that a small effect size is likely more probable than a large effect size. Small effect sizes seem to commonly occur in psychological research and educational studies that examine interventions with less direct methods and a high need for generalization (Cohen, 1988; Jones & Sommerlund, 2007; Lloyd, Forness, & Kavale, 1998).

Practical Example

In the following example, a researcher is investigating the effect of social skills training with students with behavioral needs. There are 24 students in each group (treatment/no treatment), the data are intended to be analyzed by a t-test, the effect size was expected to be small (d=.20) given previous research on social skill training effectiveness, and the alpha for the current study is set at .05.

Referring to a power table (Hedges & Rhodes, 2010), locate the appropriate column and row for effect size (d = .20) and sample size (n = 24), respectively (Table 1). The intersection point is .08, which is the probability of detecting the effect of the treatment. In other words, there is an 8% chance of detecting a small effect in treatment with 24 participants per cell.

Table 1

Power of the Test for Treatment Effects and a Function of Operational Sample Size and Operational Effect Size

	Effect Size									
N	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1.0
22	0.06	0.07	0.10	0.15	0.20	0.27	0.35	0.43	0.52	0.61
23	0.06	0.07	0.11	0.15	0.21	0.28	0.36	0.45	0.54	0.63
24	0.06	**0.08**	0.11	0.16	0.22	0.29	0.37	0.47	0.56	0.65

Note. Abbreviated table presented for illustration purposes.

Given the same example, suppose the researcher wanted to increase the power of the study to the recommended .80 level. In other words, how many participants (n) will be needed in each cell to have the probability of .80 of detecting if the treatment worked (Table 2)? The answer will be approximately 400 (Cohen, 1988). Four hundred participants per cell will be needed to have an 80% chance of detecting a small effect in the treatment.

Table 2

Sample Size (rounded) Required to Detect "Small" Effect at .05, Two-tailed

Power	*t*	*r*	$r_1 - r_2$
.70	300	600	1250
.80	**400**	800	1600
.90	550	1000	2100

Note. Abbreviated table presented for illustration purposes.

In both of these instances, the researcher will need to examine her or his resources and critically question the utility of the study while reflecting on previous literature in the topic area. This information should then be documented in the methodology section of the project, highlighting the rationale to sample size determination and the potential of the project's ability to detect a meaningful effect from the onset. Such information will then provide a backdrop to interpret the statistical results obtained.

Conclusions and Implications

Advanced degree programs in counseling and psychology typically require students to propose studies and become critical consumers of published research. These research projects often involve small sample sizes given limited resources and time. The following recommendations and implications are offered to guide faculty mentors and student researchers when considering the nature of their proposed study. First, by completing a power analysis prior to conducting a study, researchers acknowledge their chances of finding differences between samples. In this sense, researchers are predicting the probable success of the study. The probability of success and significance need to be in-balance with the researcher's access to resources. Although higher power is obtained with a larger sample size, achieving this requires the commitment of greater resources and participant cooperation.

Second, power is a function of alpha, the amount of variability in the measure of the independent variable, effect size, and sample size. Alpha and effect size are difficult to control because they are generally predetermined by the degree of risk a researcher is willing to take and previous studies within the specified research area. Accordingly, to increase the power of a study or chances of finding a meaningful difference, it seems most realistic for a researcher to increase the sample size, if possible.

Finally, power enhances the interpretability of research findings, whether or not the findings are deemed statistically significant. When presented with research results or designing a research study, one might ask, does (did) the researcher have an adequate chance of finding significant differences between samples, if differences are believed to truly exist? If the answer to this question is no, then a replication of the study seems warranted, or the researchers may wish to abandon conducting the study all together. Alternatively, if the answer is yes, then the conclusions of the study are likely to be more meaningful, whether or not the null hypothesis was rejected.

References

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). New Jersey: Lawrence Erlbaum Associates.

Cohen, J. (1990). Things I have learned (so far). *American Psychologist, 45*(12), 1304-1312 doi: 10.1037/0003-066x.45.12.1304

Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112(1), 155-159. doi: 10.1037/0033-2909.112.1.155

Cohn, L. D., & Becker, B. J. (2003). How meta-analysis increases statistical power. *Psychological Methods, 8*(3), 243-253. doi: 10.1037/1082-989x.8.3.243

Fagley, N. S., & McKinney, I. J. (1983). Reviewer bias for statistically significant results: A reexamination. *Journal of Counseling Psychology, 30*(2), 298-300. doi: 10.1037/0022-0167.30.2.298

Hedges, L. V., & Rhoads, C. (2010). *Statistical power analysis in education research*. National Center for Education Research Institute of Education Sciences: United States Department of Education. Retrieved from: http://ies.ed.gov/ncser/

Jones, A., & Sommerlund, B. (2007). A critical discussion of null hypothesis significance testing and statistical power analysis within psychological research. *Nordic Psychology, 59*(3), 223-230. doi: 10.1027/1901-2276.59.3.223

Kiess, H. O. (1989). *Statistical concepts for the behavioral sciences*. Boston: Allyn and Bacon.

Lloyd, J. W., Forness, S. R., & Kavale, K. A. (1998). Some methods are more effective than others. *Intervention in School and Clinic, 33*(4), 195-200.

Guidelines for Authors

The *Journal of the Pennsylvania Counseling Association* is a professional, refereed journal dedicated to the study and development of the counseling profession. The Editor invites articles that address the interest, theory, scientific research, and innovative programs and practices of counselors. Generally, authors may expect a decision regarding a manuscript within three months of acknowledgement of receipt. Following are guidelines for developing and submitting a manuscript.

Specific Requirements

1. Manuscripts should not exceed 20 pages.
2. Manuscripts should be typewritten, double-spaced (including references and extensive quotations) with 1" margins on all sides.
3. The title page should include title, author, affiliation, and an author's note with contact information. Identify the title page with a running head.
4. Begin the abstract on a new page, and identify the abstract page with the running head and the number 2 typed in the upper right-hand corner of the page. The abstract should be approximately 125 words.
5. Begin the text on a new page, and identify the text page with the running head and the number 3 typed in the upper right-hand corner of the page. Type the title of the article centered at the top of the page, double-spaced, and then type the text. Each following page of the text should carry the running head and page number.
6. Adhere to all requirements of the *Publication Manual of the American Psychological Association 6th Edition.*
7. Authors should avoid the use of the generic masculine pronouns and other sexist terminology. See "Gender Equity Guidelines" available from the American Counseling Association (ACA).
8. Manuscripts will be selected on the basis of a blind review. Three months should be allowed between acknowledgement of receipt of a manuscript and notification of its disposition. All manuscripts become the property of the Journal and will not be considered by PCA if currently under consideration by other publications.
9. An electronic copy of the manuscript should be e-mailed to the editor: Dr. Richard Joseph Behun (behun@maryu.marywood.edu).

The Journal of the Pennsylvania Counseling Association (ISSN 1523-987X) is a biannual publication for professional counselors. It is an official, refereed branch journal of the American Counseling Association, Inc.

Editor
Dr. Richard Joseph Behun
Assistant Professor
Department of Psychology and Counseling
Marywood University
2300 Adams Avenue
Scranton, PA 18509
behun@maryu.marywood.edu
Phone: (570) 348-6211 ext. 2685
Fax: (570) 340-6040

Associate Editor
Dr. Janet L. Muse-Burke
Associate Professor
Department of Psychology and Counseling
Marywood University
2300 Adams Avenue
Scranton, PA 18509
jlmuse-burke@marywood.edu
Phone: (570) 348-6211 ext. 2367
Fax: (570) 340-6040

THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Pennsylvania Counseling Association, Inc.
Counseling and Human Services Department
Scranton, Pennsylvania 18510-4523

100321