The Professional Counselor

Spring 2016

Digest

Volume 6, Issue 1

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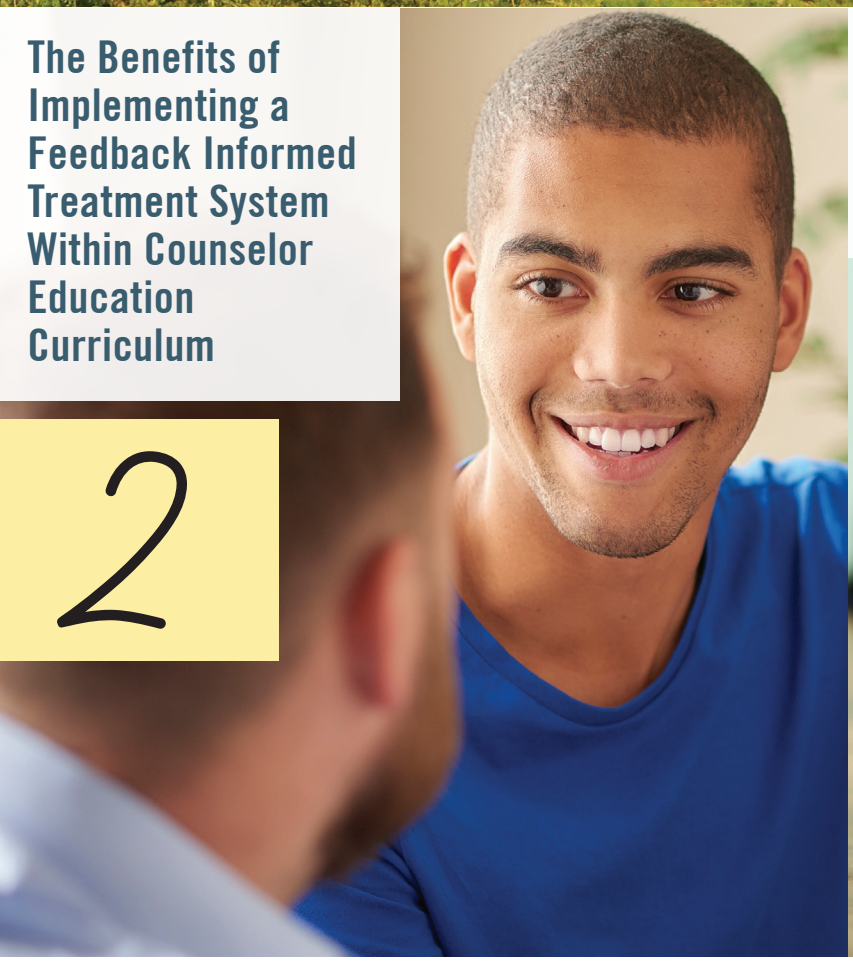

The stock photos in this publication are not intended to indicate an endorsement, attitude or opinion by the models, or to indicate that the models suffer from the mental health concerns mentioned.

The Professional Counselor DIGEST is an abbreviated version of the journal, *The Professional Counselor*, intended for the general public. The National Board for Certified Counselors, Inc. and Affiliates publishes *The Professional Counselor* and *The Professional Counselor DIGEST*.

The Professional Counselor™

The Professional Counselor Digest

Table of Contents

Volume 6, Issue 1

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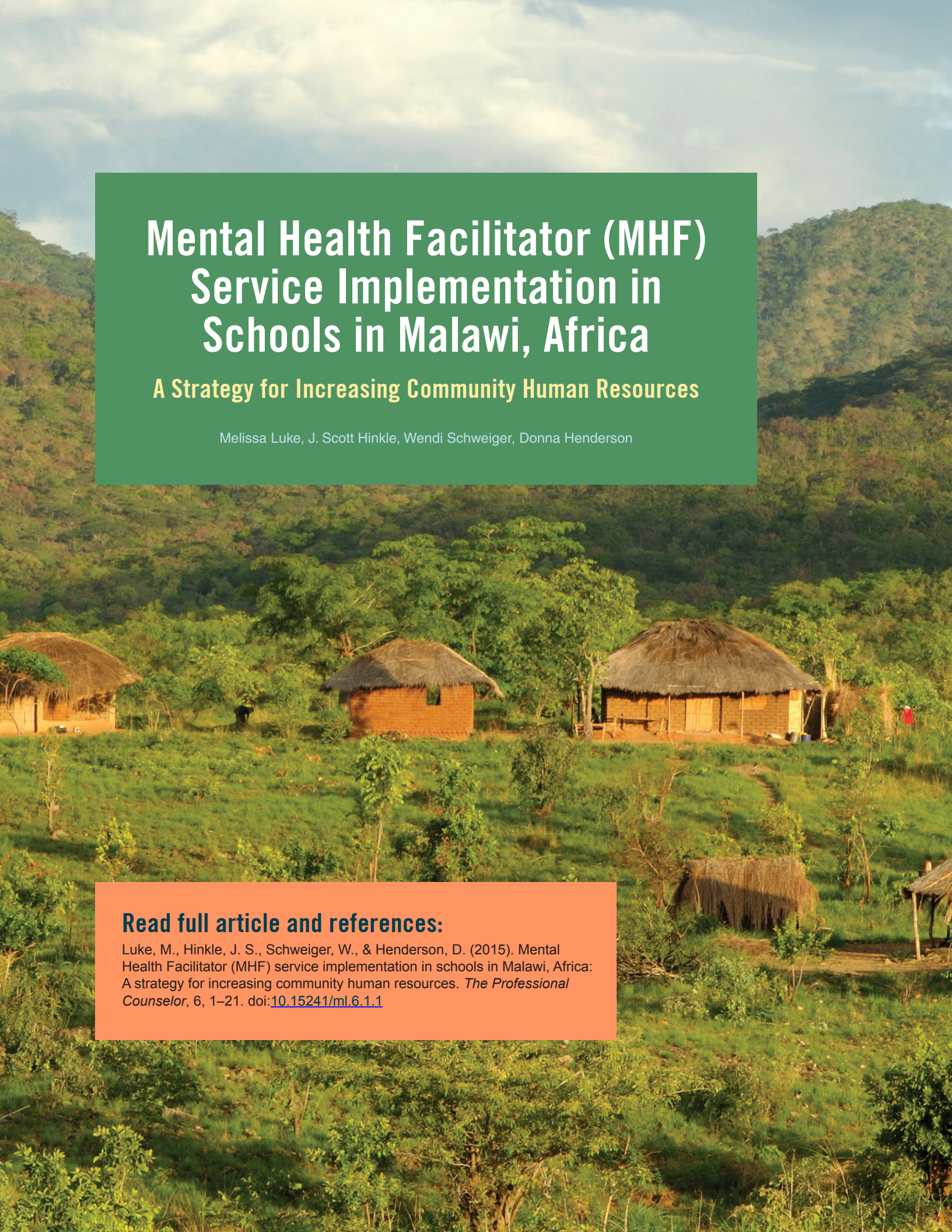

Mental Health Facilitator (MHF) Service Implementation in Schools in Malawi, Africa

A Strategy for Increasing Community Human Resources

Melissa Luke, J. Scott Hinkle, Wendi Schweiger, Donna Henderson

Read full article and references:

Luke, M., Hinkle, J. S., Schweiger, W., & Henderson, D. (2015). Mental Health Facilitator (MHF) service implementation in schools in Malawi, Africa: A strategy for increasing community human resources. *The Professional Counselor*, 6, 1–21. doi:10.15241/ml.6.1.1

Although the prevalence of mental disorders in Africa in general, and Malawi in particular, is a significant health problem, treatment remains a low priority and is often placed at the bottom of the public health care agenda. Developing communities in countries like Malawi have historically lacked opportunities for mental health training, skill development and capacity building, although mental health research supports the notion that better care management is achieved when people receive education, training and support to carry out the role of informal caregivers. Children and their families with mental health issues are too often invisible, voiceless and living at the margins of society. Moreover, they are rarely mobilized to advocate for themselves. In Africa, mental health receives less attention due to a plethora of problems with communicable diseases and malnutrition, and the contribution of mental distress to morbidity, as well as mortality, largely goes underappreciated.

A large proportion of the population of Malawi does not receive mental health services for four basic reasons—first, few services are available (*resources and needs*); second, when services are sought out they are inadequate (*outcomes*); third, people often prefer self-care and traditional healers (*processes*); and lastly, stigma leads people to hide their mental health problems (*processes and outcomes*). These reasons are all relevant to school children and communities in that mental health can no longer be ignored as a building block of population health as well as social, educational and economic development.

The National Board for Certified Counselors (NBCC) International developed the Mental Health Facilitator (MHF) curriculum as well as an implementation method that is making an impact in Malawi. The MHF program utilizes a population-based curriculum and has been implemented in Malawi for the past 7 years. This study demonstrates that the MHF program addresses many mental health concerns and is making a modest impact in Malawi. Ethnographic investigators explored how 40 MHF stakeholders have experienced the MHF program. This transdisciplinary program is a 30-hour training in community mental health that focuses on fundamental helping skills, identification of stress, distress and mental disorders, and appropriate community referral and follow-up. Results indicated four interrelated themes representing participants' beliefs about their experiences with the training, including the curriculum's responsiveness to the Malawian context, the availability and limitations of resources, the processes involved, and a variety of identified outcomes. Implications for community implementation and future directions are identified.

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The Benefits of Implementing a Feedback Informed Treatment System Within Counselor Education Curriculum

Chad M. Yates, Courtney M. Holmes, Jane C. Coe Smith, Tiffany Nielson

Counselor education departments have a unique opportunity to implement feedback informed treatment (FIT) systems that serve as continual assessment procedures by informing counselors, clients, supervisors and educators about client functioning and progress toward goals. FIT systems are beneficial to counselors and clients as they provide clinicians with a wide array of client information such as which clients are plateauing in treatment, deteriorating, or at risk for dropping out. To date, however, few resources exist on how to infuse FIT systems into counselor education curriculum and training programs.

This article addresses the current lack of information regarding the implementation of a FIT system within counselor education curricula by discussing: (1) an overview and implementation of a FIT system; (2) a comprehensive review of the psychometric properties of three main FIT systems; (3) benefits that the use of FIT systems hold for counselors-in-training; and (4) how the infusion of FIT systems within counseling curricula can help assess student learning outcomes.

The implementation of FIT systems contains several procedures including: (1) the routine measurement of a client's symptomology or distress during each session, (2) showcasing the results of the client's symptomology or distress level in a concise and usable way, and (3) the adjustment of counseling approaches based upon the results of the feedback. FIT systems have beneficial training qualities when utilized with counselor education curriculum. Within counselor training laboratories, feedback systems have shown promise in facilitating the growth and development of beginning counselors, and the incorporation of FIT systems into supervision and training experiences has been widely supported. One such benefit is that counseling students' self-efficacy improved when they saw evidence of their clients' improvement. Additionally, the FIT system allowed the counselor trainees to observe their effectiveness during session, and more importantly, helped them alter their interventions when clients deteriorated or plateaued during treatment. Another benefit was that counseling students felt as if consistent use of a FIT system lowered their anxiety and relieved some uncertainty regarding their work with clients. It is developmentally appropriate for beginning counselors to struggle with low tolerance for ambiguity and the need for a highly structured learning environment when they begin their experiential practicums and internships.

Several positive benefits are added to the clinical supervision of counseling students. One such benefit is that clinical supervisors found weekly objective reports of their supervisees helpful in providing evidence of a client's progress during session that was not solely based upon their supervisees' self-report. This is crucial because relying on self-report as a sole method of supervision can be an insufficient way to gain information about the complexities of the therapeutic process. In addition to these training benefits, FIT systems also serve as a way to intentionally measure CACREP Student Learning Outcomes with specific attention to client care and therapeutic outcomes. Overall, counselor educator programs can use FIT systems to meet multiple needs across their curricula including more advanced supervision practices, CACREP Student Learning Outcome Measurement and better overall client care.

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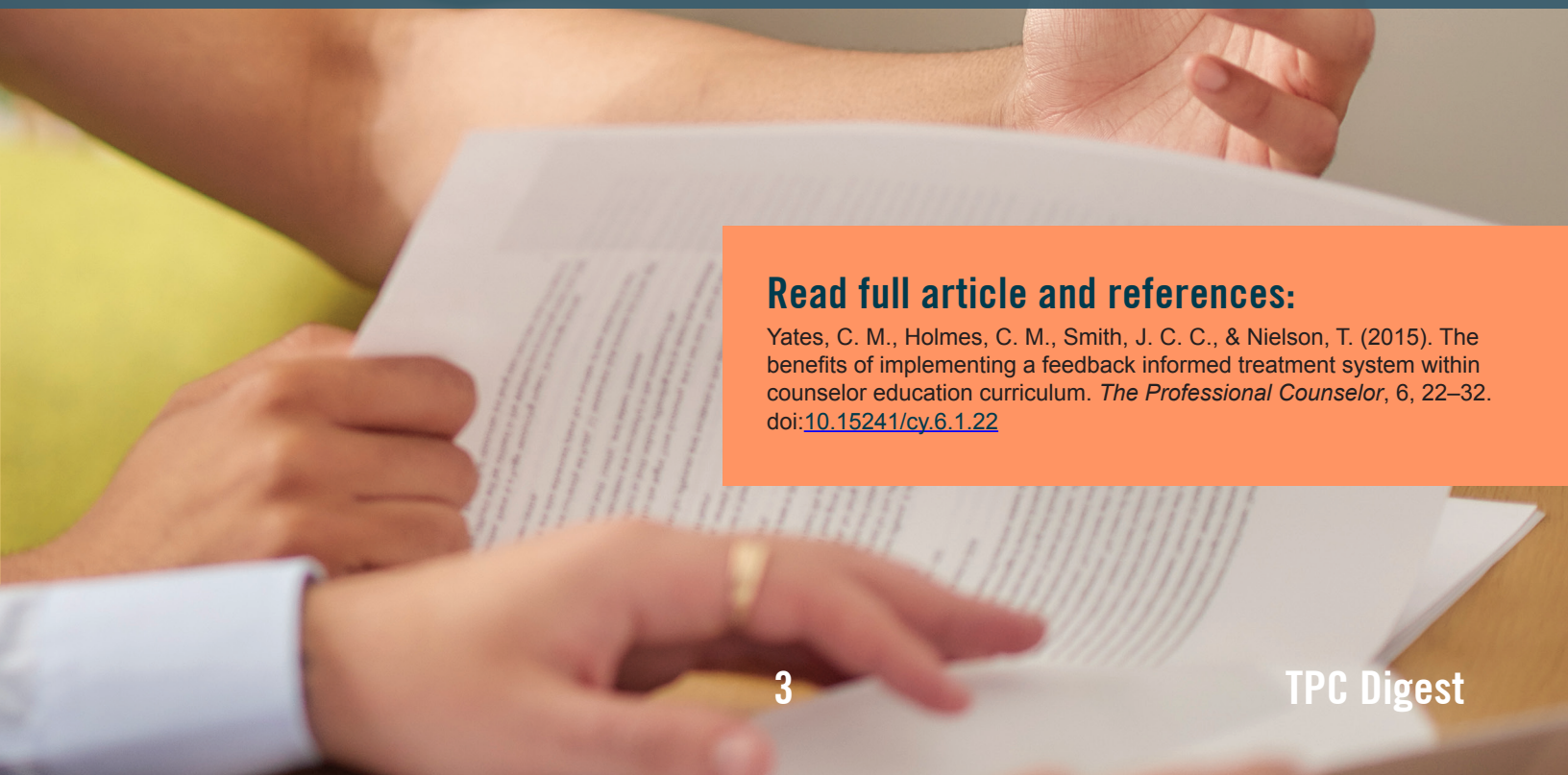

Read full article and references:

Yates, C. M., Holmes, C. M., Smith, J. C. C., & Nielson, T. (2015). The benefits of implementing a feedback informed treatment system within counselor education curriculum. *The Professional Counselor*, 6, 22–32. doi:10.15241/cy.6.1.22

The attachment work of John Bowlby affords clinicians and researchers the opportunity to view psychopathology as relationally based, rather than as unique to the individual. Anxiety is a particularly fitting place to focus this type of investigation since understanding its meaning and function within the context of human development lies at the center of attachment theory. Through the use of instruments designed to measure attachment style, early bonding memories, and five types of anxiety, the study presented here utilized an attachment perspective to examine the correlations between adults' perceptions of their past and present relational experiences and their current anxiety levels.

Predictions for the study flowed from the research literature and our premise was that adult attachment and parental bonding are interconnected but separate aspects of relational experience. We conjectured a low to moderate relationship between attachment and early bonding memories; a strong negative association between each type of anxiety studied and secure attachment style; a strong positive correlation between these same types of anxiety and insecure styles of attachment (e.g., fearful, preoccupied and dismissing); positive correlations between anxiety and the overprotection dimension of parental bonding; and negative correlations between anxiety and the care dimension.

To index our variables of interest, we utilized seven self-report instruments to assess adult attachment style, early bonding memories, and the tendency toward obsessive-compulsive symptomatology, panic, worry, post-traumatic symptomatology, and social anxiety in a sample of 201 undergraduate psychology students. Data analysis involved the calculation of Pearson's r for the relationships between attachment and bonding scores, between attachment scores and scores on each of the five anxiety indices we used, and between bonding scores and scores on each of the five anxiety indices. Results supported the majority of our predictions. However, contrary to prediction, only post-traumatic and social anxiety were negatively associated with the care dimension of bonding and positively associated with the overprotection dimension. In addition, the dismissing attachment preference did not correlate with any anxiety type or with either the care or overprotection dimension of parental bonding.

Counselors who consider client attachment style and early bonding memories may provide enhanced treatment for clients with anxiety conditions. The idea that attachment and bonding are related but distinct and separate constructs has the potential to broaden counselors' conceptualization of the manner in which relational involvement may impact anxiety and thereby contribute to improved treatment efficacy. Ideally, treatment of anxious clients will include an individualized approach that takes into account the way in which each person forms attachments to others and with regard for the relationship between the type of anxiety being treated and memories of the early child–caregiver bond.

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Adult Attachment and Parental Bonding

Correlations Between Perceived Relationship Qualities and Self-Reported Anxiety

Ellen W. Ambruster, David C. Witherington

Read full article and references:

Armbruster, E. W., & Witherington, D. C. (2016). Adult attachment and parental bonding: Correlations between perceived relationship qualities and self-reported anxiety. *The Professional Counselor*, 6, 33–49. doi:10.15241/ewa.6.1.22

Excoriation Disorder

Assessment, Diagnosis and Treatment

Nicole A. Stargell, Victoria E. Kress, Matthew J. Paylo, Alison Zins

Excoriation disorder (ED) is also called skin picking disorder. Affecting up to 5.4% of the general population, ED is a newly added mental disorder in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). Diagnostic features of ED include a preoccupation with picking behaviors (e.g., ripping skin from the hands, face or scalp), difficulty controlling skin picking behaviors and distress as the result of the behaviors. Because ED is a new diagnosis, it is often overlooked by clinicians or addressed as a symptom of obsessive-compulsive disorder (OCD). However, ED is now listed as a unique diagnosis under the general category of *obsessive-compulsive and related disorders* in the *DSM-5*.

Skin picking is a body-focused repetitive behavior similar to trichotillomania (hair pulling) and is rooted in biological and psychological factors. Individuals with ED often have first-degree relatives who also have this disorder as well as generally high levels of impulsivity and sensation-seeking behaviors. Skin picking behaviors are associated with obsessions regarding the way the skin feels and looks. Individuals with ED are compelled to pick their skin in order to make it smooth or otherwise altered. Skin picking behaviors are often ritualistic, involving focused examination of the skin, strategic picking habits and disposal of the skin in a customary way (e.g., playing with or eating).

Related to the obsessions and compulsions associated with ED, skin picking behaviors are often reinforced as an effective way to minimize unwanted emotions that accompany obsessive thoughts. However, individuals often feel a sense of shame or guilt after picking. Skin picking creates physical damage to the body, which leads to regret and further contributes to preexisting feelings of anxiety, stress and irritability.

Skin picking behaviors can develop during early adolescence through middle age. Many formal assessments for ED exist, such as the Skin Picking Scale, the Skin Picking Impact Survey and The Milwaukee Inventory for the Dimensions of Adult Skin Picking. A functional analysis that includes a behavioral scale and multiple interviews with a client's loved ones can also be used to identify the antecedents and rewards associated with skin picking behaviors.

Cognitive behavioral therapy (CBT) has been identified as an effective strategy for working with clients who have ED. CBT is used to restructure and reframe dysfunctional thoughts while integrating behavioral interventions such as homework, preventative measures, activity replacement and relapse prevention. Habit reversal training can also be used to foster awareness, identify triggers for picking behaviors and integrate alternative behaviors (e.g., clenching fists rather than picking). Acceptance and commitment therapy can be used in conjunction with habit reversal training to incorporate mindfulness techniques, values clarification and goal setting. Medication also can be helpful when indicated.

Continued research on ED is required to expand upon our current understanding of the etiology and treatment of skin-picking behaviors. ED should be distinguished from non-suicidal self-injury (which also involves physical harm to the body in order to regulate emotions) and general OCD. Professional counselors should maintain an awareness of the diagnostic criteria associated with ED and assess for this new disorder when appropriate.

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Read full article and references:

Stargell, N. A., Kress, V. E., Paylo, M. J., & Zins, A. (2016). Excoriation disorder: Assessment, diagnosis and treatment. *The Professional Counselor*, 6, 50–60. doi:10.15241/nas.6.1.50

Adolescent Non-Suicidal Self-Injury

Analysis of the Youth Risk Behavior Survey Trends

Kelly Emelianchik-Key, Rebekah J. Byrd, Amanda C. La Guardia

Self-injury is a significant issue with a variety of psychological, social, legal and ethical consequences and implications. Self-injurious behavior is commonly associated with the cutting, bruising or burning of the skin. The typical duration of a self-injurious act is usually less than 30 minutes, resulting in immediate relief from emotional turmoil. It is difficult to estimate the prevalence of self-injury for many reasons. It is vital to understand how self-injury typically manifests itself, how it affects differing populations based on gender and cultural differences, and the level of danger it truly represents to the person choosing to utilize it. Research proposes that males are just as likely as females to self-injure and perhaps go about it differently or are more secretive.

As self-injury and other self-harming behaviors continue to be identified, researched and understood, new methods of evaluating these behaviors are developed. Suicide and self-injury are typically two different behaviors, but often are aggregated in reports and evaluations. Given that self-injury, self-harm and suicide attempts are a growing area of study, reliance on current and previous data sources for analysis of self-injury and self-harm behaviors can be used in order to highlight possible areas for research. In this study, data from the Youth Risk Behavior Survey (YRBS), as gathered by the Centers for Disease Control and Prevention, has been used for the purpose of determining the prevalence of possible self-injurious behaviors among young women, men and youth from differing ethnic backgrounds.

The information presented in this article is posed to present further evidence that suggests male self-injury exists and needs to be addressed in the assessment and treatment of presenting issues related to self-injury. Since depression is sometimes associated with suicidal ideation, self-injury and other harmful behaviors, recognition of the severity of client depressive symptoms, through thorough assessment techniques, becomes vital to treatment and selection of therapeutic interventions regardless of gender. This article used the data from the YRBS and analyzed it to provide empirical evidence for why issues of diversity need to be addressed within the self-injury and suicidality literature. Comparisons were made with regard to gender and ethnicity to evaluate issues related to possible self-injurious behaviors, since the YRBS does not differentiate between suicidal attempts and self-injurious behaviors.

In completing this analysis, it is evident that further study is needed in the area of self-injury with regard to outward expression in the form of extremely aggressive behaviors, prevalence among differing ethnic groups and prevalence in the male population. Data from the current study indicate that males and members of diverse ethnic groups also are engaging in this destructive coping mechanism, perhaps in differing ways than are being addressed by current conceptual and empirical works. The results of this analysis are consistent with the literature that indicates self-hitting or physically aggressive behaviors resulting in injury are a more typical typology of self-injurious behaviors for adolescent males. Results from the YRBS provide further evidence that this is indeed an issue that spans culture and gender domains. Further research that expands to fully include gender, racial, cultural and age differences is certainly warranted.

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Read full article and references:

Emelianchik-Key, K., Byrd, R. J., & La Guardia, A. C. (2016). Adolescent non-suicidal self-injury: Analysis of the Youth Risk Behavior Survey trends. *The Professional Counselor*, 6, 61–75. doi:10.15241/kk.6.1.61

Mental Health Practitioners' Perceived Levels of Preparedness, Levels of Confidence and Methods Used in the Assessment of Youth Suicide Risk

Robert C. Schmidt

Occurring every 1 hour and 42 minutes, youth suicide has been identified as a national public health concern and priority, yet practitioner preparedness and competency skills to assess for suicide risk continue to be neglected. Despite identified training and preparation gaps affecting their ability to perform suicide risk assessments, well-intended practitioners are making significant clinical decisions that have substantial legal and ethical ramifications.

Although previous research sought to examine practitioner preparedness levels, it was limited to specific disciplines. This study surveyed a broader representation of practitioners (N = 339), including school counselors, professional counselors, psychologists, social workers and school psychologists. This study was guided by a single question: What is the relationship among the self-perceived levels of preparedness, levels of confidence and methods used in the assessment of suicide risk for practitioners whose responsibilities require suicide risk assessment and management?

The instrument designed for this study was The Child and Adolescent Suicide Intervention Preparedness Survey. This 23-item questionnaire covered practitioner levels of training, preparedness, confidence and additional trainings needed to fill voids not adequately taught in graduate school. Guided by a quantitative study design, the results of the survey were analyzed using descriptive data and chi-square to determine if relationships existed among variables, including participant perceptions of feeling prepared and confident, and if this contributed to the methods used to determine suicide risk in youth. This study highlighted the critical role of school counselors as being identified by participants (53%) to be the most likely practitioner to respond and provide a suicide assessment.

The findings indicated 86% of the participants have worked with a suicidal youth, yet there were noticeable inconsistencies related to practitioners feeling prepared and confident while assessing for suicide risk in youth. The inconsistent responses reflected a self-evaluative dilemma for the practitioners wanting to self-report a feeling of being prepared to work with suicidal youth, yet not feeling adequately prepared or confident to provide a suicide intervention or complete an assessment. This was reflected in the method most practitioners (64%) reported using to obtain a youth's suicide risk level. These practitioners based their clinical judgment solely on using an informal, non-structured interview (i.e., winging it). Contrary to self-reported feelings of not being adequately prepared, despite having good intentions but limited confidence, practitioners using formal suicide risk assessment tools reported higher levels of confidence and greater preparedness levels and training.

Despite youth suicide prevention being identified as a national priority, colleges and universities in general must better prepare the practitioners represented in this study. To fill the void of being inadequately prepared, practitioners reported an urgent need for more training on warning signs, symptoms and suicidal behaviors in addition to receiving training in suicide assessment. Most often, graduates entering the field are finding themselves in situations whereby their preparation and training may mean the difference between life and death based on their clinical judgment.

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Read full article and references:

Schmidt, R. C. (2016). Mental health practitioners' perceived levels of preparedness, levels of confidence and methods used in the assessment of youth suicide risk. *The Professional Counselor*, 6, 76–88. doi:10.15241/rs.6.1.76

Fostering Non-Cognitive Development of Underrepresented Students Through Rational Emotive Behavior Therapy

Recommendations for School Counselor Practice

Jeffrey M. Warren, Robyn W. Hale

Non-cognitive factors (NCFs) are skills, strategies, attitudes and behaviors that contribute to student success. While aptitude and general intelligence are important, NCFs are the mediating factor that can assist or hinder achievement in academic and career settings. Examples of these factors include positive self-concept, grit, growth mindset, and social belonging. NCFs align with the tenets and principles of rational emotive behavior therapy (REBT)—a cognitive behavioral framework developed by Ellis. By implementing REBT-based strategies, school counselors can cultivate NCFs to close the achievement gap and foster a college-going mindset, particularly for students from historically underserved groups.

Ellis proposed that humans were genetically predisposed to think in a rigid and irrational manner. REBT seeks to encourage self-actualization, minimize distress, lengthen life and maximize happiness in all aspects of an individual's existence. Several sub-goals that help facilitate REBT values include (a) self-interest, (b) social interest, (c) self-direction, (d) tolerance, (e) flexibility, (f) acceptance of uncertainty, (g) commitment, (h) self-acceptance, (i) risk-taking, (j) realistic expectations, (k) high frustration tolerance, and (l) self-responsibility. These REBT values promote rational beliefs (RBs), or preferential thoughts, which are logical and realistic in nature. RBs are non-awfulizing, demonstrate a tolerance for frustration, and do not indicate global evaluations of self, others or life. Healthy negative emotions such as bother, concern or annoyance stem from these RBs. These healthy negative emotions tend to lead to functional behaviors and outcomes related to success.

The core values of REBT overlap with NCFs endorsed by Sedlacek. The eight NCFs that predict educational outcomes for students, especially those from underrepresented backgrounds, are (a) positive self-concept, (b) realistic self-appraisal, (c) leadership experience, (d) preference for long-term goals, (e) successfully handling the system, (f) availability of strong support person, (g) community involvement, and (h) knowledge in an acquired field. Various research studies have demonstrated the impact REBT can have on NCFs. For instance, REBT can be used to promote self-concept through an emphasis on unconditional self-acceptance. When REBT interventions were used with second graders, their self-concept flourished.

School counselors can work to promote the non-cognitive development of students in elementary, secondary and postsecondary settings. Numerous psychosocial barriers impede students' educational goals and lead to disparities in graduation rates, discipline referrals, and teacher expectations. In the United States, 7% of African American students and 12% of Hispanic students do not complete high school. Likewise, American Indian students are three times more likely to drop out of school than Caucasian students. Using the REBT framework, school counselors can help students uncover beliefs that impede their ability to attain postsecondary credentials, as some students may not aspire for postsecondary education due to irrational beliefs and unrealistic self-appraisal. Through comprehensive programs that incorporate REBT, school counselors can deliver direct and indirect student services that enhance student educational experiences and prepare them for college and future careers.

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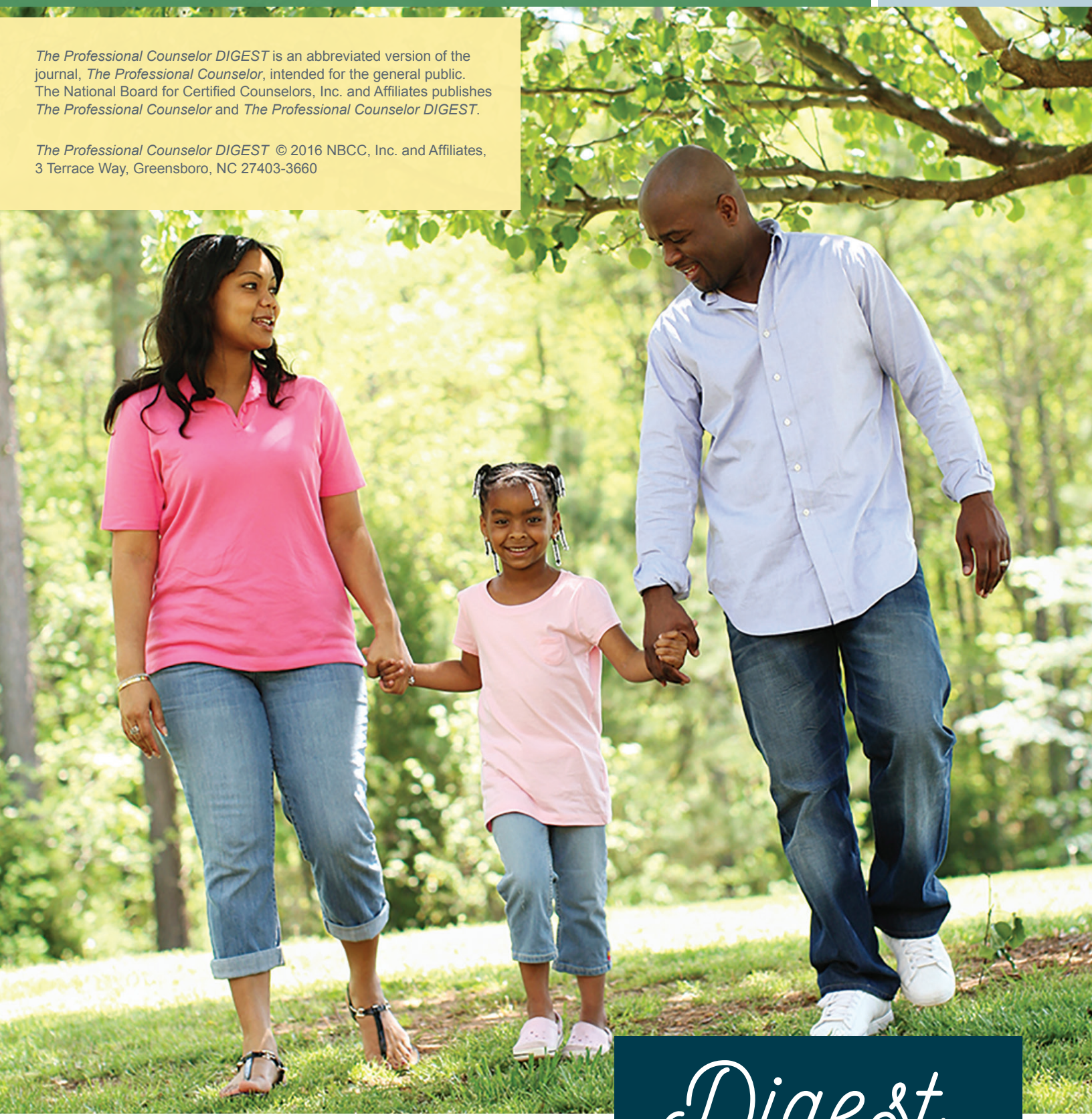
Read full article and references:

Warren, J. M., & Hale, R. W. (2016). Fostering non-cognitive development of underrepresented students through rational emotive behavior therapy: Recommendations for school counselor practice. *The Professional Counselor*, 6, 89–106. doi:10.15241/jw.6.1.89

The Professional Counselor

Spring 2016

The Professional Counselor DIGEST is an abbreviated version of the journal, *The Professional Counselor*, intended for the general public. The National Board for Certified Counselors, Inc. and Affiliates publishes *The Professional Counselor* and *The Professional Counselor DIGEST*.



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Volume 6, Issue 1