The *Journal of Counseling in Illinois* is a publication of the Illinois Counseling Association.
The Illinois Counseling Association is a partnership of associations representing professional counselors who enhance human development.
CO-EDITORS NOTES: THE JOURNAL OF COUNSELING IN ILLINOIS

Welcome to Volume 3:1 of the Journal of Counseling in Illinois, Fall, 2014. Let’s begin this edition with a NOTE from Fran:

“I would like to announce that I am stepping down as Co-Editor of the Journal for Counseling in Illinois. My job as the Program Director for the Counseling program at Northwestern University has gotten increasing more demanding and I am not able to give the journal the time it deserves. I have really enjoyed being an editor and have appreciated the time and effort that every articles’ author has put into their manuscript. I leave the journal in good hands. Thanks to all of you, Fran.”

From Toni:

It has been my privilege and honor to serve with Fran as Co-Editor of the Journal of Counseling in Illinois for the past three years, and I want to wish her the best. Her contributions have been paramount in giving feedback to authors and to helping put forth the best journal possible for professional counselors in Illinois and across the country. Her contributions to this journal are evident in the six articles that are published here. We hope you will enjoy the research and literature that is shared around the important topics these manuscripts address.

We begin with three excellent articles that focus on the results of research in the field. Authors Lauka, McCarthy and Carter share with us critical results of a national survey they conducted on counseling training clinics in CACREP accredited programs. They report that there is much variability regarding training clinics across the country, and that while programs may have a clinical director, more clarity of duties, support, and time dedicated directly to running the clinic program is needed. These researchers also found that having a clinical director allows for excellent opportunity for collaborative partnerships in the communities. As a result of a grant from the College of Education and Professional Studies at Eastern Illinois University, McKinney, Larson, Moody, Schwartzkopf, Hale, and Conn found results regarding the values of altruism, commitment, and leadership in high school mentors and offer some ideas for developing a mentor program in high schools. Authors Torres, Chavez-Dueñas, and Seal studied gay, bisexual and transgender adolescent males to determine the relationships between the use of alcohol and sensation seeking, impulsivity, self-esteem, loneliness, and internalized homophobia. They also discuss implications for prevention as well as positive clinical interventions when working with this population.

In the section on Clinical Practice, two articles focus on children and clinical interventions. Bamgbose and Myers reviewed the literature surrounding Bowlby’s attachment theory to give us pertinent information about children with attachment difficulties and how play therapy can be a successful technique for working with these school-age children. In a second article, authors Jeon and Myers explore the difficulties that refugees who are children face when they resettle in a new country. They review what the literature identifies as current issues and current mental health services but further suggest that the counseling profession must increase the call for social action and increased awareness in providing quality services to this population.
In the final section of this journal, Oliver presents a compelling piece emphasizing a social imperative for school counseling to examine what is needed in Illinois to meet the needs of students. He suggests five key strategies that he believes can offer meaningful change and serve as a model for the profession.

We hope you will enjoy these articles and find that they increase your sense of awareness within our profession as a mental health professional. May they stimulate your thinking and offer you new strategies for your work as clinicians, educators, and advocates.

TONI TOLLERUD  FRAN GIORDANO
Editor  Editor
tollerud@niu.edu  fgiordano@family-institute.org
**TABLE OF CONTENTS**

Volume 3 Number 1 Fall, 2014

Co-Editors Notes: *The Journal of Counseling in Illinois (JCI)* .......................... Page 2

**Research**

A National Survey on Counseling Training Clinics in CACREP-Accredited Programs  
*Justin D. Lauka, Amanda K. McCarthy, and Danessa A. Carter* .......................... Page 5

Altruism, Commitment, and Leadership in High School Mentors  
*Rob McKinney, Heidi A. Larson, J. Adriane Moody, Margaret F. Schwartzkopf,  
Aaron D. Hale, and Steven R. Conn* ................................................................. Page 17

Sensation Seeking and Alcohol Use among GBT Male Adolescents in the Midwest  
*Hector L. Torres, Nayeli Y. Chavez-Dueñas, David W. Seal* .............................. Page 27

**Practice**

Playing the Hurt Away: Play Therapy as a Technique for Working with School-Age Children having Attachment Difficulties  
*Olamojiba O. Bamgbose and Charles E. Myers* ................................................. Page 38

Neglected Child Refugees: Undiscovered Issues and Suggestions for Services  
*Mi-Hee Jeon and Charles E. Myers* ................................................................. Page 48

**Professional Dialogue**

Examining Illinois School Counseling as a Social Imperative  
*Ken Oliver* ............................................................................................................. Page 60
A National Survey on Counseling Training Clinics in CACREP-Accredited Programs

Justin D. Lauka  
*Adler University*

Amanda K. McCarthy  
*Northern Illinois University*

Danessa A. Carter  
*Northern Illinois University*

Abstract

Information regarding the operation and maintenance of counselor education and supervision (CES) training clinics is lacking in the professional literature. A survey study was conducted to identify how CACREP accredited programs operate their CES training clinic and determine attitudes toward the implementation of guidelines for CES training clinics. A further exploration of the data illuminates challenges and opportunities for clinic directors, counselor educators, professional counselors, and the larger community.

Within the counseling profession, clinical experiences, such as practicum and internship, are designed to assist trainees in developing the clinical skills necessary for practice as a professional counselor (CACREP, 2009) and the development of a professional counselor identity. Such clinical experiences may occur at external sites with supervision from a professional working in the field or at training centers with supervision from program faculty members or similar. Regardless of the setting, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) stipulates certain requirements for the clinical training of all accredited programs (see CACREP, 2009). Specifically, CACREP (2009) requires the completion of a supervised practicum experience that equates to a minimum of 100 clock hours over an academic term. Additional practicum requirements include a minimum of 40 hours of direct work with actual clients; weekly individual/triadic, and group supervision; video recordings, observations, and evaluation of the student’s performance (CACREP, 2009).

Upon successful completion of practicum, students advance to an internship, which requires a minimum of 600 clock hours and is “intended to reflect the comprehensive work experience of a professional counselor” (CACREP, 2009, p. 16). Additional CACREP (2009) requirements include a minimum of 240 hours of direct work with clients; weekly individual/triadic, and group supervision from designated site and university supervisors; greater exposure to professional activities; video recordings, observations, and evaluation of the student’s performance (CACREP, 2009). These standards help ensure that graduates of CACREP programs have the minimum competencies to ethically and effectively practice as a professional counselor.

Although CACREP provides standards for practicums and internships with the programs it oversees, programs with counselor education and supervision (CES) training clinics may not
have sufficient information to operate and maintain their entity. For the purpose of clarity, this article makes a distinction between a CES training clinic and a counseling lab. The term “counselor education and supervision (CES) training clinic” is used throughout this article to describe a counseling instruction environment that offers clinical and field experiences, provides services to actual clients, in many ways parallels a typical counseling settings, and may be located on a university campus or in the community. The term counseling lab is used to refer to a facility that is primarily used for role-playing, supervision, and skill demonstrations, but does not serve clients” (Lauka & McCarthy, 2013, p. 109). Information regarding the operation and maintenance of CES training clinics is lacking in the professional literature. Specifically, the most recent study investigating CES training clinics is over 17 years old (Myers & Smith, 1995) and several authors have called for research on the topic (Myers & Smith, 1994; Mobley & Myers, 2010). This gap in the literature has implications for the counseling profession in that students may be graduating that have not received a well-rounded or realistic introduction to professional counseling.

The survey study conducted by Myers and Smith (1995) emerged from a Think Tank sponsored by the Association for Counselor Education and Supervision (ACES) in 1992. A primary purpose for this survey was to create a detailed database of counseling training clinics that included information such as the nature, scope, and types training provided (Myers & Smith, 1995). Additionally, the results of the survey were intended to serve as “baseline data as a foundation for future research and program development regarding on-campus clinical training” (Myers & Smith, 1995, p. 71). Unfortunately, subsequent survey data was never captured.

Several researchers have attempted to provide guidance and clarity regarding CES training clinics. Ametrano and Stickel (1999) proposed a model of accountability for CES training clinics, noting the absence of standards and quality assurance mechanisms. The intent of this model was to create consistency and increase clarity of service delivery of clients and training of students. Mobley and Myers (2010) edited a book about developing and maintaining counseling training clinics. The book covered relevant topics including the role of the clinic director, legal and ethical issues, necessary infrastructure, and other emerging topics. This text also noted several gaps in the CES training clinic literature. These publications have proved valuable in identifying pressing issues and providing preliminary suggestions. However, to this day, counselor educators are not much closer to understanding precisely how other programs are operating and maintaining CES training clinics.

Additionally, guidelines for the administration of CES training clinics are lacking (Mobley & Myers, 2010; Myers & Smith, 1995; Myers & Smith, 1994) in that directors and program faculty do not have one set of best-practice guidelines for the operation of training clinics. Establishing CES training clinic guidelines may provide many benefits such as providing the infrastructure necessary for promoting social justice by serving uninsured and underinsured clients (Robinson-Wood, 2008), positioning training clinics to collaborate with community partners (Allan et al., 2011) and providing structure to train and evaluate students in providing counseling services to diverse populations (Mobley & Myers, 2010). Alternatively, the lack of CES training clinic guidelines may expose training programs, students, and clients to legal and ethical challenges (Wise et al., 2011; Henderson, 2009).
Closing the Gap

A strong impetus for better understanding CES training clinics lie in the call for better preparation of mental health professionals. More specifically, a “training gap” has been identified by researchers and educators throughout the years (Hoge et al., 2002; Teachman et al., 2012). One researcher has gone so as far to describe this gap “as an acute crisis that impedes the delivery of effective and efficient mental health and addiction services” (Hoge, p. 305, 2002). A related and equally prominent gap noted in the literature exists “between academic scholars and community practitioners that limits the use of evidence-based treatments” (Abdul-Adil et al., 2010, p. 417). These gaps are interconnected; in order to improve the quality of training of counseling students it is necessary that research is produced that identifies best practices for how to train our students as well as counseling practitioners in the field. Clearly, counselor educators bear a significant responsibility.

It has been argued that training clinics may serve as the ideal setting to bridge both gaps (Hershenberg, Drabick, & Vivian, 2012; Neufeldt & Nelson, 1998). Training clinics allow students to provide counseling to actual clients while receiving multiple channels of feedback through live observation, faculty and peer supervision, and self-review of recorded counseling sessions. Furthermore, training clinics are typically well-equipped to conduct research and “have the potential to provide a partial bridge between the scientist's need for monitoring investigations and the practitioner's need for information about what works best under conditions that are similar to those the practitioner encounters in the workplace” (Neufeldt & Nelson, 1998, p. 315).

The potential value that CES training clinics may bring to the community cannot be overstated. In addition to free or low-cost counseling services, CES training clinics present numerous avenues for collaboration and partnerships with school and community agencies (Allan et al., 2011). Many benefits have been documented from the collaborative agreements between universities and community agencies (Abdul-Adil et al., 2010). Consequently, the counseling profession and greater society has much to gain through closer study of CES training clinics. Therefore the purpose of this study was to identify how CACREP accredited programs operate their CES training clinic by gathering detailed descriptive information on how CACREP accredited programs operate their CES training clinic.

Methods

Research approval was secured from the authors’ academic institution. In April 2013, all CACREP-accredited clinic directors or program coordinators were contacted by United States mail and electronic mail and invited to participate in the current study and were provided a description of the study. Contact information was located from the CACREP directory of accredited programs located on their website (CACREP, 2013). Two weeks later a description of the study and a link to the survey instrument was sent to the same program contact. In three week intervals reminders to participate were sent, with the final reminder occurring in June 2013.

Instrument

A 59-item electronic survey was developed by the authors to gather information on counseling training clinics in CACREP-Accredited programs. Major sections of the survey included demographic information (i.e., director, clinic staff, graduate assistants, student
counselors, facility, and community-university relationship), perceptions regarding clinic’s operational status, reporting of policies and procedures, perceptions of implementing guidelines for CES training clinics, and overall utilization of the clinic.

Participants were asked to respond to 12 items regarding the CACREP program in which they were associated (e.g., specializations, number of students). Participants were then provided with a definition of a counseling training clinic and asked to indicate if their program has a CES training clinic. If respondents responded “no” they were directed to respond to two opened ended items related to their interest in, barriers for, and any plans to create a CES training clinic and then were thanked for participating in the survey. If respondents answered “yes” to having a CES training clinic, they were asked to report on the director position (9 items; e.g., what credentials does the director have; how many years has the clinic director been in this position), clinic staff (3 items; e.g., how many staff are employed in the clinic; who evaluates employees in your clinic), graduate assistants (3 items; e.g., how many graduate assistants are employed in your clinic; what duties are assigned to the graduate assistants), student counselors (5 items; e.g., how are student counselors eligible for work in your clinic; who provides supervision to students in your clinic), facility (18 items; e.g., please indicate the number of rooms in your clinic; what type of technology is your clinic equipped with), and community-university relationships (2 items; i.e., does your clinic have established relationship with external or internal agencies; for what purpose do you have these relationship).

Respondents were asked to provide perceptions they hold regarding their clinic’s operational status by indicating their level of agreement with nine statements on a 5-point Likert-type scale with anchors Strongly Disagree and Strongly Agree. For example, the purpose and mission of your clinic is well defined and consistent with your priorities and goals or hiring practices and job descriptions for all clinic staff are established.

To assess establishment of clinic policies and procedures, respondents were asked to respond to 17 items and indicate level of agreement on a 5-point Likert-type scale with anchors Strongly Disagree and Strongly Agree (e.g., policies and procedures are established for research and training activities conducted in your clinic; policies and procedures are established for the screening and admission of new clients).

Finally, to determine attitudes toward the implementation of guidelines for CES training clinics, participants were provided with an explanation of CES training guidelines asked to indicate how beneficial guidelines would be, in their opinion. Respondents were asked to respond to this item on a 5-point Likert-Type scale with anchors not beneficial and extremely beneficial. Participants were also asked to indicate the level of difficulty (i.e., Not difficult at all to extremely difficulty) for implementing CES training guidelines.

Results

A total of 29 surveys were returned yielding an 11% response rate. Of those responding, nearly 58% (n = 17) reported having a counseling training clinic. Six counseling specializations were represented in the sample: clinical mental health counseling (98%), school counseling (84%), marriage, couple and family counseling (28%), student affairs and college counseling (24%), addiction counseling (14%), and career counseling (11%). Most programs (n = 26) reported a combination of counseling specializations offered through their program. A total of 10 programs (34%) offered a doctoral degree in counselor education and supervision.
The number of full-time faculty members in programs ranged from as few as 2 to 12 or more with modal responses of 6 (n = 5) and 10 (n = 5) faculty members. The most common response to the number of adjunct faculty members utilized was 10 or more (n = 7), with 4 programs each indicating using 2, 4, and 5 part-time or adjunct faculty members. Most programs (54%) reported admitting 26-60 master’s program students each year; however, responses ranged from 16 student to 101 or more.

All five ACES regions were represented in the sample: North Atlantic (n = 3), North Central (n = 8), Rocky Mountain (n = 3), Southern (n = 12), and Western (n = 3). University size represented in the sample ranged from very small (fewer than 1000) to large (15,000 plus). Over half of the sample was medium sized universities (3,000 – 14,999, n = 15), with large (n = 9), small (1,000 – 2,999, n = 2), and very small (n = 1) each representing a portion of responses.

A total of 14 (48%) respondents reported being a private institution with the remaining 52% (n = 15) reported being a public institution. More than half (n = 16) reported being located in an urban environment with the remaining respondents identifying as rural (n = 11), suburban (n = 1), or a combination of campus locations (n = 1).

Nearly 41% (n = 12) of the sample reported not having a counseling training clinic. Among those programs, the most common barrier to implementing a clinic was funding (n = 5). Other barriers were reported as lack of client base, fear of liability on the part of the university, or the program being fully online.

### Clinic Director

A full-time clinic director was indicated by 70% (n = 12) of the programs and part-time director by 11% (n = 2). The remaining 3 programs indicated that the clinic director role is taken on by a full-time faculty member or clinical coordinator. Of the individuals in the clinic director role, the majority (n = 13) had doctorate degrees with top tier counseling license (n = 15). Nearly half (n = 8) also held a national counseling certification. Employment status of the clinic director, most commonly was clinical faculty, clinical assistant professor, or similar (n = 7), followed by a non-tenure administrative position (n = 4), tenure-track senior faculty member (n = 4). Regarding years that the clinic director had been in current position, responses ranged from less than 1 year to 10 or more years, with the most common response being 2 years (n = 6).

Hiring practices for clinic directors was most commonly a competitive external hire (n = 11) followed by an appointed position or based on a position that rotates among faculty members (n = 5). The most frequent response to hours per week that the director has officially allocated to overseeing clinic operations was 1-10 hours (n = 5); however, responses also included 11-20 hours (n = 4), 21-30 (n = 4), 31-40 (n = 3), and 41 or more (n = 1). Table one lists out additional responsibilities of directors and the percentage of time allocated for each. The majority of respondents reported (n = 12) between 1-20% of their time as allocated for university service, (n=14) 0% for obtaining funding, and 0% for counseling (n = 11).
Table 1: Additional duties of clinic director and percent of time allocated for each (N = 17)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1-20</th>
<th>21-40</th>
<th>41-60</th>
<th>61-80</th>
<th>81-100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Counseling</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervision</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Field Placement and Coordination</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Research</td>
<td>8</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>University Service</td>
<td>5</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Service</td>
<td>9</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Obtaining Funding</td>
<td>14</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Student Counselor Learning Outcomes**

Multiple sources of data were listed by respondents as being used to assess student learning outcomes. Responses included standardized competencies scale (n = 10), live observation (n = 13), review of audio/video recordings (n = 16), client survey feedback (n = 12), case presentations (n = 16), peer evaluation (n = 9), and review of transcribed sessions (n = 5).

**Counseling services**

With the exception of one program, master’s students were indicated as providing counseling services in the clinics. Master’s and doctoral internship and practicum students, clinic director, faculty, employed counselors, and volunteer counselors were listed by respondents as also providing counseling services. The types of counseling services provided in clinics included individual (100%), couples (88%), family (82%), group (59%), and career (47%), psychoeducational workshops (47%), and psychological assessments (29%).

Respondents indicated a brief phone screening assessment (n = 13) and intake interview at first counseling session (n = 12) as the most common way client screenings took place. Some initial intake interviews are held separate from first counseling session (n = 4). Respondents indicated a variety of individuals as conducting initial screenings in the clinic including employed staff, master’s and doctoral students, faculty, graduate assistants, and clinic director.

Ten problems were listed as presenting problems inappropriate for clinic services. Problems included severe and persistent mental illness, eating disorders, substance dependence,
suicidal or homicidal ideation, non-suicidal self-injury, sexual abuse/assault, active psychosis, severe trauma, history of violence, and legally mandated services.

Most clinics (n = 12) reported that at least 60% of clients are community members. A total of 5 clinics (30%) indicated that at least 60% of their clients are university students. Fewer than 5% of the reporting clinics reported university faculty/staff making up any percent of clientele. When asked to approximate the number of clients served annually, responses ranged from 25 to 4005 with a mean response of 702 (SD = 1127). The most common forms of client recruitment were reported to be flyers/brochures (n = 15), class presentations (n = 8), and community presentations (n = 10). Other methods of recruitment were listed as direct mail, e-mail, social media, radio or television, yellow pages, words of mouth, and community contacts.

Administration of clinic

Most programs (82%) reported having a written mission statement that included the description of the scope of services as well as an emphasis on training students. Less common responses (fewer than 11%) reported research or community service as information in the mission statement.

A variety of technology was reported as used in the clinic. A type of electronic student skills assessment (e.g., Landro, etc.) was reported used in 41% (n = 7) of programs. Electronic client management systems such as Titanium Schedule or Therасrcribe were also reported as being used by 41% of programs. T.V. monitors (n = 12), digital cameras (n=13), computers (n = 13), DVRs/CD (n = 11) were also commonly used. Less common technology used were bug-in-the-ear, intercom systems, panic buttons, and electronic student data management systems.

The majority of clinics indicated that services are provided at no cost (n = 10). Also common (n = 6) was a sliding scale fee. Less common was a flat rate fee or a student fee that is assessed on each student through the university. No respondents indicated third party payment as part of the current fee structure.

Multiple methods of evaluation were indicated by respondents to evaluate the effectiveness of client services and the clinic overall. Most clinics reported using multiple methods of evaluation. Most respondents (n = 11) indicated that no research is conducted in the clinic. If respondents indicated that the clinic was involved in research the purpose for that included client satisfaction, clinical practice, program evaluation, scholarly research, grant funded projects, or performance evaluation of clinic director.

Most respondents indicated having established relationships with external community agencies or internal university/college programs (n = 15). Although there was much variability, the purpose of relationship was most commonly cited to be for workshops, consultations, advanced training, and client referrals.

Respondents were asked to respond to a series of questions where they indicated their level of agreement regarding the status of their clinic, using a rating system of 1 = strongly agree to 5 = strongly disagree. Overall, respondents agreed with the statements regarding the status of the clinic and responses showed little variability. Although a positive response was indicated for all items, the largest issue was reported in the area of adequate professional and clerical staff.
Level of agreement with policies and procedures

Finally, respondents were asked to indicate their level of agreement regarding policies and procedures that are currently in place in their clinic. Respondents indicated the fewest policies and procedures existed in the area of research and training activities. When asked how beneficial guidelines for CES training clinics would be, 83% (n =10) responded “extremely beneficial” and two responded “neutral” to that item. Fifty percent of responding programs responded “not difficult at all” when asked how difficulty it would be to implement guidelines in CES training clinics and the remaining 50% responded “neutral” to that item.

Discussion

The results of this study provide information about the CES training clinics in which professional counselors are trained. This information is helpful for professional counselors so they can better understand the experiences of recent graduates as they are hired in agencies and schools. Furthermore, practicing counselors may benefit from greater awareness of the resources and opportunities that collaborating with CES training clinics may provide. A further exploration of the data illuminates challenges and opportunities for clinic directors, counselor educators, professional counselors, and the larger community.

Due to the low response rate, one should interpret the data cautiously. However, for the programs that did respond, several themes were evident. First, much variability exists within CES training clinics regarding operation and maintenance. Clinics differ significantly on items such as the age of the clinic, number of clients seen every year, the roles of clinic director and staff, and community and university relationships among other items. When hiring new counselors it is important to understand that some variability exists in their on-campus training. However, there was convergence on several challenges that programs faced, particularly regarding an overall lack of staffing and funding support for the clinic director.

Staffing as a challenge is indicated by the low level of agreement of having adequate professional and clerical staff. Furthermore, the number of graduate assistants working in the clinic was most frequently reported as zero. While this may not appear alarming, when combined with the degree of time allotted to the clinic director, the picture is clearer. Although the majority of responses indicated that the clinic director was a full-time employee (70%), more than half (53%) reported that between 1 to 20 hours a week were allocated to the actual oversight of the clinic, with 76% reporting between 1 to 30 hours a week. This is disconcerting given the significant responsibility and liability that overseeing a training clinic entails (Wise et al., 2011). Variability was present in the duties of the clinic director, in which all 8 responsibilities (teaching, counseling, supervision, field placement coordination, research, university and community service, obtaining funding) was reported as part of a director’s job. Adding to this concern is the finding that most clinical directors reported having been in their position for only 2 years. A new clinic director may find acclimating to this position challenging, particularly when only a minimal amount of time is allotted to overseeing the clinic.

Funding was also identified as a challenge that programs experienced. The majority of participants (82%) indicated that no time was allocated to the clinic director for seeking external funding. Indeed funding is a crucial issue and was the most common barrier reported by counseling programs that did not currently operate a CES training clinic. Although conducting
research for obtaining grant funding could be a viable option, currently 65% reported that no research at all was conducted in the training clinic.

**Opportunities for Collaboration**

Along with challenges lie great opportunities for CES training clinics and counseling programs. More specifically, collaborations and partnerships with community mental health agencies and other public and nongovernmental organizations (NGOs) offer vast potential. Such relationships have become increasingly common. Lending support to this trend is the recent addition of the Carnegie Community Engagement classification in 2005 (Driscoll, 2007). The Carnegie Foundation defines community engagement as “collaboration between institutions of higher education and the larger communities for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity” (Carnegie, 2013). Counselor education programs and community agencies may benefit from such collaborations. Study results indicated that the majority of CES training clinics provided a disproportionate amount of services to community clients. Given that CES training clinics potentially share the same pool of clients with many other human service providers, a focused collaborative approach may be warranted. Furthermore, it has been argued that not only do university-community partnerships make practical sense, but it is also an ethical imperative on part of the college/university, and the lack of collaboration to be “a mutually detrimental dynamic that harms research, practice, and (ultimately) the target communities” (Abdul-Adil et al., 2010, p. 418).

According to Agranoff (2012), a primary tool for which collaboration occurs across sectors is through federal, state, and local grants. While most programs reported having established relationships with external community agencies or internal university/college programs, the nature and extent of these relationships is unclear. Responses do indicate that little to no collaborative efforts are being undertaken for the purpose of securing external funding. This is peculiar given that CES training clinics have been identified as an ideal setting to conduct research (Mobley & Myers, 2010; Neufeldt & Nelson, 1998). Furthermore, counselor education programs that award doctorates possess a significant resource in doctoral students for assisting with research. CACREP (2009) requires that accredited programs equip doctoral students with the knowledge, skills, and internship experiences to conduct research. However, unless support is given to the director to pursue such initiatives, it is questionable whether or not it will occur.

**Future Research**

Due to the low response rate in the current study, replication is suggested. This will provide some additional evidence of reliability. To increase response rates and get a larger sample of the population, perhaps data collection could be completed in conjunction with a professional conference. Regional or national counselor education conference organizers could be contacted so that survey materials can be included in conference materials. Additionally, it was speculated that due to faculty turnover, the CACREP directory was not up to date regarding contact information. Perhaps phone calls could be made to each individual program to obtain more accurate information and possibly greater buy-in from the participants. Furthermore, it is possible that only those counseling programs that operated a CES training clinic chose to respond. In the future, it would be wise to provide clarity that all programs should participate, in order to identify how prevalent CES training clinics are.
The role of the clinic director should be studied exclusively. The variance of the composition among the role, responsibilities, employment status, and time allotted to the clinic director is disconcerting. Surveying mental health counselors who supervise new counselors could also be helpful to inform changes in university practicum training. This might help to identify gaps in training. For example, study results indicate that research policies are lacking in CES training clinics. This might leave students unprepared to apply research and program evaluation to promote positive client outcomes. Research should also be conducted that identifies exemplar models of collaboration between CES training clinics and community providers.

Limitations

Findings from this study must be considered with several potential limitations. Because respondents were aware of the purpose of the study, they may have responded differently based on them knowing what was being assessed. The low response rate must also be considered in that responses of those who completed the survey may be different that those who did not respond to the survey.

Summary

Based on the results of this study, much variability exists within CES training clinics. This finding suggests trainees have different experiences and perhaps different learning outcomes. Recent efforts (Lauka & McCarthy, 2013) have been proposed that provide guidance to counseling training clinics related to their operation and administration. It is imperative that training clinics and programs remain autonomous, yet address training needs of students. State-level efforts could be helpful here. Advisory committees consisting of local community partners, including professional counselors, could help to inform counseling training clinics. Counselor educators, students, universities, professional counselors, and surrounding communities stand to benefit from greater collaboration. Grant funded research should be explored. Opportunities abound for CES training clinics to be perceived as legitimate counseling training centers. To receive greater legitimacy, counselor educators, administrators, and the larger counseling profession must invest in this. Increased support for the clinic director, greater clarity and structure of CES training clinics, and further research to explore models for collaboration and partnership with communities is needed to assist with this effort.

References


Author Note

Justin D. Lauka, Ph.D., LCPC, CCMHC, NCC, ACS, is a core faculty member in Clinical Mental Health Counseling at the Department of Counselor Education and Counseling, Adler University in Chicago, IL. He can be contacted at jlauka@adler.edu.

Amanda K. McCarthy, Ed.D., is an Assistant Professor at the Rehabilitation Counseling Program at Northern Illinois University. She can be contacted at amccarthy@niu.edu.

Danessa A. Carter, MS, LPC, is a current doctoral candidate in Counselor Education and Supervision at Northern Illinois University and an addictions counselor. She can be contacted at danessacarter@gmail.com.
Altruism, Commitment, and Leadership in High School Mentors

Rob McKinney  
*Kent State*

Heidi A. Larson  
*Eastern Illinois University*

J. Adriane Moody  
*Northern Illinois University*

Margaret F. Schwartzkopf  
*Eastern Illinois University*

Aaron D. Hale  
*Eastern Illinois University*

Steven R. Conn  
*Eastern Illinois University*

**Abstract**

This study investigated the effects of mentoring on selected attributes among high school mentors. Three attributes were explored: altruism, commitment to school, and student leadership. Seventy-four high school juniors and seniors participated as mentors to high school freshmen students. Mentors participated in a leadership training program prior to beginning their mentoring activities. Pre- and post-test measures of the three attributes were administered. Results showed no significant increase in altruism or commitment scores. Unexpectedly, the mentoring experience produced a significant decrease in the perception of leadership scores. Implications for implementing a mentoring program in a high school setting are discussed.

While peer mentoring programs have existed for decades for various groups, in many environments, and working in a multitude of capacities, they are becoming increasingly popular for the development and education of younger individuals. Indeed, many programs have emerged recently and are operating to connect youth with much needed mentors (Rhodes, Haight, & Briggs, 1999). These programs offer the opportunity for mentors to share and showcase their advanced experiences, understanding of a particular area of expertise, and dedication to junior members of a specific organization (Kram, 1985).

One such organization in which mentoring has become popular is in schools. Since the development of school-based mentoring programs, researchers have become interested in studying the effectiveness of those programs on students who are involved (McGannon, Carey, & Dimmitt, 2005; Whiston & Sexton, 1998). In recent years, schools across the country have
had an increasingly high demand placed upon them to improve student achievement. In response to this demand, mentoring programs have become one method of increasing student achievement and involvement.

Bowman & Myrick (1987) found that student mentees who participated in a mentoring program reported improvement in attitudes to, and connectedness with, one’s peer group and school, as well as an increase in academic grades and achievement. Studies have shown that mentors engaging in a mentoring program can experience positive effects similar to those of adolescents who assist in service-learning events (Stukas, Clary, & Snyder, 2000) as well as extracurricular activities (Eccles & Barber, 1999; Hamilton & Fenzel, 1988). The present study investigated the implementation of a school-based mentoring program called B.I.O.N.I.C.: Believe It Or Not, I Care (Austin, 2012) in a Midwestern high school and examined selected attributes possessed by effective high-school student mentors.

**Literature Review**

**High School Mentoring Benefits**

It is clear that the literature describes a wide variety of positive impacts that peer-mentoring can have on mentees (Karcher, 2008; O’Hara, 2011; Rhodes & Dubois, 2008). For example, Cary, Rosenbaum, Lafrenie, and Sutton (2000) found increased coping skills and social support among a group of high-school mentees over a four-year period. Karcher (2005) found a stronger sense of connectedness to school and parents, improved social skills, and increased self-esteem among high-school mentees. Longitudinal research in a university setting has shown that senior mentors can positively influence freshmen’s overall satisfaction with the university: a level of satisfaction that was maintained over the subsequent semester (Sanchez, Bauer, & Paronto, 2006).

**Mentor Attributes**

In addition to finding benefits for mentees, research has shown that mentoring programs have benefited mentors as well. (Kram, 1985; Allen, 2003; Sanchez, et al., 2006; McQuillin, Smith, & Strait, 2011). For example, Karcher (2009) found significantly higher levels of connectedness to friends, culturally different peers, extracurricular self-esteem, school, sports self-esteem, and school self-esteem among high-school mentors. Overall, a number of mentor attributes have been the focus of several studies. In the present study, three selected mentor attributes were investigated: mentors’ altruism, commitment to school, and leadership skills.

**Altruism.** At present, there is a paucity of research with respect to mentor altruism, or taking an interest in the welfare of others. The few studies that have been published are focused primarily on the health and motivational effects of altruism in those who choose to mentor others. For example, in a general adult sample, Allen (2003) found significant associations between the pro-social personality traits of empathy and helpfulness with choosing to mentor others. Similarly, Aryee, Chay, and Chew (1996), found that the impulse to be a mentor may be anticipated by certain characteristics of the individuals, such as positive affectivity and altruism.

A more recent study of the relationship between altruism and the effects on physical health as well as psychological well-being among adolescents showed mixed results (Schwartz, Keyl, Marcum, & Bode, 2009). For male participants, no relationship was found between
altruistic behaviors and either physical health or psychological well-being. However, for female participants, a significant relationship was found between altruism and physical health.

**Commitment.** A student’s commitment to school is important to school administrators as well as researchers (see Sanchez et al., 2006). In particular, researchers have investigated the effects that mentoring has on students’ school commitment from both the perspective of mentors as well as mentees. Mentoring programs in schools have also had positive effects on mentees’ level of school commitment.

Using a longitudinal approach, Sanchez et al. (2006) found a strong school commitment in a sample of 128 high-school freshmen mentees that continued through to their senior year. Cavendish (2013) found similar results in a sample of high-school students. More specifically, African American mentees reported a higher level of school commitment than both Caucasian and Hispanic mentees. Overall, females showed higher commitment than males.

**Leadership.** With a paucity of research in leadership development within the population of high school adolescents, the discussion of student leadership has focused on the college population. Throughout in the 1990’s, a number of scholars addressed the need for the development of leadership skills in young, college-aged students (Astin, 1993; Freeman, Knott, & Schwartz, 1994; Komives, Lucas, & McMahon, 1998). In more recent studies, researchers have studied leadership skills through examining individual characteristics in the college students. For example, Posner (2004) found that fraternity chapter presidents who self-reported as a more effective leader consistently engaged in several leadership practices, including modeling, inspiring, challenging, enabling, and encouraging. In addition, in a study of attributes predicting leadership skills among college students, hope, self-efficacy, and optimism were found to be significant predictors of leadership skills (Wisner, 2011). While research of leadership skills is increasing in the college population, the study of such skills has yet to begin in the high-school population.

Prior research has shown mentoring programs to have positive effects on mentors’ sense of altruism in adult samples (Aryee, et al., 1996; Allen, 2003) and in adolescent samples with mixed results (Schwartz, et al., 2009). Research has yielded evidence of increased commitment to school among mentees (Sanchez et al., 2006; Cavendish, 2013), yet little definitive evidence of the effects on mentors’ commitment. The study of leadership is evident among college students (Posner, 2004; Wisner, 2011), yet has not been investigated with high-school students, including those students put into leadership positions.

The purpose of this study was to investigate the effects of mentoring on the mentor attributes of altruism, commitment to school, and leadership skills in a high-school sample. Three hypotheses were tested: 1) mentoring would produce an increase in mentors’ altruism, 2) mentoring would produce an increase in mentors’ commitment to school, and 3) mentoring would produce an increase in mentors’ perceptions of their leadership skills.

**Method**

**Participants**

Students from a Midwestern public high school were invited to participate in the B.I.O.N.I.C. school-based mentoring program. To fulfill the criteria for entry into the program, each student had to have the recommendation of two teachers from their high school and have a returned signed parental consent. A signature line for the high school students was included on the parental consent form to indicate participant’s assent for the program study. Seventy-four
11th and 12th grade students volunteered to participate as mentors for this study and completed both the pre- and post-test measures.

**Instrumentation**

Three questionnaires and a demographic survey were utilized in the present study. The questionnaires were used to measure leadership efficacy, altruistic behavior, and diligence (i.e., commitment to school), respectively.

**Student Leadership Practices Inventory (SLPI).** The SLPI was originally designed to mark the progress of an individual’s comfort level with a leadership position in college students (Kouzes & Posner, 1987), and was updated by Posner in 2004. The SLPI was modified in item content to better suit a high school sample. The inventory consisted of fourteen items to which participants responded using a Likert scale ranging from 1 (Definitely No) to 5 (Definitely Yes). Examples of items included: *One of my greatest desires is to become a leader, and I am comfortable implementing new techniques.* Internal consistency estimates have been reported in several college samples, including fraternity and sorority presidents, ranging from .60 to .75 (Posner & Brodsky, 1994); resident assistants, ranging from .69 to .83 (Posner & Brodsky, 1993); and orientation advisors, ranging from .56 to .66 (Posner & Rosenberger, 1997).

**Altruistic Behavior-Middle School questionnaire (AB-MS).** The AB-MS was designed to measure altruistic behaviors of others (Development Studies Center, 2000). The questionnaire consists of nine items, each using a Likert response scale ranging from 1 (Never) to 5 (More than 10 times). Sample items include: *Have you comforted someone who was hurt or feeling sad? and Have you helped a classmate with homework?* A Cronbach alpha reliability estimate of 0.80 has been reported.

**Diligence Scale for Teenagers (DST).** The DST consists of seven items, each using a Likert response scale ranging from 1 (None of the time) to 5 (All of the time), producing an overall diligence or commitment score. Examples of items include: *Do you finish the tasks you start? and Do you give up when things get difficult?* A reliability estimate of 0.79 has been reported for the DST (Child Trends, 2013).

**Procedures**

Prior to beginning their mentoring duties, students participating in this study completed a three-day training institute in July, 2013. Students began each day by participating in team-building exercises in which they developed relationships among fellow mentors. Students also participated in two learning modules each day for a total of six learning modules throughout the entire training institute. Topics of these modules included character building, effective communication skills, dedication, courage, empathy, and building a vision.

At the beginning of the fall semester in August, 2013, all student mentor participants were given the three pre-test measures of altruism, commitment to school, and leadership efficacy, along with a demographic questionnaire.

The intervention consisted of each participant serving as a mentor in the B.I.O.N.I.C. program, in which the student mentor assumed the role of leader within the local high school. The first phase of the program entailed mentors, who were paired with five freshman mentees, to participate in interpersonal and team building activities for approximately thirty minutes before
lunch every day in a classroom with their mentees that was overseen by a school teacher. The team building activities helped the students form relationships and get to know one another more quickly than would have likely occurred in a school setting. Spending time with the mentors also helped the mentees, all high school freshmen, better acclimate to their new high school environment. Following team building exercises, mentors and mentees would eat lunch together. Mentors were encouraged to engage the mentees in meaningful dialogue to get better acquainted and to foster a sense of community.

Initially, mentors and mentees met every day over the first two weeks of school during the fall semester. After which, mentors and mentees met together once a week for more interpersonal activities and lunch. Regular monthly meetings, between mentors and the researchers, were scheduled to help student mentors with any interpersonal issues they might be facing. The researchers meeting with the mentors were graduate students enrolled in a master’s level school counseling program. At the conclusion of the fall semester, student participants completed the three post-test measures.

**Results**

Data were analyzed using SPSS (IBM Corp.), performing paired-samples t-tests and calculating Pearson product-moment correlation coefficients among the experimental scale scores. Table 1 presents pre- and post-test within-groups Altruism, Commitment, and Leadership scale descriptive statistics, along with Cronbach alpha estimates for the pre- and post-test scales.

Test results showed no significant differences between the pre- and post-test means for either the Altruism ($t(73) = 0.762, p = .448$) or Commitment ($t(73) = -0.762, p = .115$) scale means. These findings did not support hypotheses #1 or #2, respectively. Results showed a significant difference between the pre- and post-test Leadership means ($t(73) = 1.91, p = .060$), not supporting hypothesis #3, evidenced by the decrease.

Table 1. Pre-test and Post-test, within-groups Leadership, Altruism, and Commitment Scales, along with Alpha estimates (N=74).

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-Test</th>
<th></th>
<th></th>
<th>Post-Test</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>SE$_{\text{mean}}$</td>
<td>Alpha</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Altruism</td>
<td>31.6</td>
<td>6.5</td>
<td>.76</td>
<td>.81</td>
<td>31.0</td>
<td>6.2</td>
</tr>
<tr>
<td>Commitment</td>
<td>30.1</td>
<td>4.5</td>
<td>.52</td>
<td>.79</td>
<td>30.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Leadership</td>
<td>61.0</td>
<td>6.5</td>
<td>.76</td>
<td>.85</td>
<td>59.6</td>
<td>8.3</td>
</tr>
</tbody>
</table>

Pearson product-moment correlations among the three measures (post-test) showed that all were positively intercorrelated: that is, the correlations between altruism and commitment ($r = .36, p = .002$), between altruism and leadership ($r = .33, p = .004$), and between commitment and leadership ($r = .42, p = .000$).
Discussion and Conclusions

The present study investigated three mentor attributes. The results showed no significant differences for altruism and commitment to school following participation in a high-school mentoring program. On the other hand, the findings showed a significant decrease in mentors’ perceptions of their leadership skills, a finding contrary to the stated hypothesis.

An important criterion for selection of mentors in this study was the requirement that each must be recommended by two of their teachers. The present findings suggest that the students teachers recommended already demonstrated an increase level of caring for others (altruism) and were known to be dedicated to their academic performance (commitment to school). As a result, selected mentors’ self-reported levels of both altruism and commitment to school were already elevated before participating in mentoring activities and not representative of scores which might be seen through a random sampling of high school students. These elevated levels were reflected in the mentors’ pre-test scores which were on the higher end of the Likert scale used to measure these characteristics. As a result, it was not surprising to find that their altruism and commitment to school scores were not influenced by their mentoring experience. Although mentoring did not yield significant increases in students’ altruism or commitment to school, administrators interested in implementing a mentoring program can screen for these attributes when selecting student mentors.

Beyond the characteristics of altruism and commitment, interesting results were found in the area of leadership. An unexpected result in this study was the significant decrease in mentors’ leadership scores. Mentor’s self-perception of leadership skills were relatively high prior to their mentoring activities. This increased view of leadership skills could have been due to inflated ego, lack of prior “real-life” leadership opportunities, an idealized view of leadership, or a lack of practical knowledge about what it means to be a leader within a group of individuals. Mentors apparently realized that their skills were not as strong as they thought once faced with real-world leadership demands. Participants reported, after completing their mentoring service, “Leading is harder than I thought it would be …”, “Now I know that leading takes a lot more than just a will to keep going …” and “I didn’t expect obstacles. When you lead, you struggle, but you grow.” Consequently, continued monitoring of leadership skills is important, particularly with adolescent mentors.

Peer mentoring is seen as a compelling approach as the peer-group influences adolescents the most (Erikson, 1968). The principal of this high school, based on her 30 years of teaching and administration, recognized the need for a mentoring program to help freshman adjust to high school. Mentees receiving the peer interventions can produce positive benefits, such as improved attendance, increased grades, development of healthy coping skills, social support, decrease of discipline referrals, enhanced school connectedness, and a rise in self-esteem (Cary, et al., 2000; Karcher, 2009, Tobias & Myrick, 1999). Furthermore, mentoring programs can be effective interventions that lead to improved behaviors, attitudes, and academic performances of students (Durlak, 2011). Recognizing how beneficial a mentoring program can be to adolescents inspired us to not only create an effective mentoring program, but one that focused on the needs and leadership of the mentors; junior and seniors, who are in essence implementing the program. With these exciting possibilities for high school students, school programs, and schools in general, this research examined the characteristics of altruism, commitment to school, and leadership among high school adolescents to see if these components are part of the “formula” to creating effective peer mentoring. It was clear from these preliminary results that cultivating and
developing leadership skills in dedicated adolescents is imperative in order to help them prepare to be effective leaders. While altruism, commitment and leadership skills were present and believed to have contributed to this peer mentoring program, due to the self-reported nature of the research, future study is needed to clarify to what extent these attributes effect mentors and a peer mentoring program.

References


**Author Note**

Rob McKinney, MS, LPC, NCC, is a doctoral student at Kent State University in Ohio.

Heidi A. Larson, Ph.D., is an Associate Professor at Eastern Illinois University in Charleston, IL. She can be contacted at halarson@eiu.edu.

J. Adriane Moody, MS, LPC, NCC, PEL, is a doctoral student Northern Illinois University in DeKalb, IL.

Margaret F. Schwartzkopf, MS, PEL, is a school counselor in Illinois.

Aaron D. Hale, MS, PEL, is a school counselor in Illinois.

Steven R. Conn, Ph.D., is an Associate Professor at Eastern Illinois University in Charleston, IL.

This research was supported in part by grants from the College of Education and Professional Studies at Eastern Illinois University.
Sensation Seeking and Alcohol Use among GBT Male Adolescents in the Midwest

Hector L. Torres  
*The Chicago School of Professional Psychology*

Nayeli Y. Chavez-Dueñas  
*The Chicago School of Professional Psychology*

David W. Seal  
*Tulane University School of Public Health and Tropical Medicine*

Abstract

This study explored associations among personality, social, and behavioral variables among gay, bisexual, and transgender adolescent males. Positive correlations were found between (1) sensation seeking and impulsivity, societal stigma, and drug use; (2) drug use and impulsivity; and (3) drug use and loneliness. Negative correlations were found between (4) sensation seeking and internalized homophobia; and (5) drug use and self-esteem. Regression analyses indicated that sensation seeking was predictive of drug use. Implications for prevention and clinical interventions are discussed.

The use of drugs and alcohol among youth in the United States (U.S.) is high (Bryan, Ray, & Cooper, 2007; Wong, Kipke, & Weiss, 2008). According to the Youth Risk Behavior Survey (YRBS), more than 70% of 9th to 12th grade students reported that they drank alcohol in their lifetime and 42% of them said they had at least one drink of alcohol within the previous 30 days (Centers for Disease Control, 2010). The same survey reported that 37% of students had used marijuana at least once during their lifetime, and 21% had used marijuana at least once within the previous 30 days. High percentages also were reported for the consumption of other illicit substances, including cocaine, inhalants, and methamphetamines (Centers for Disease Control, 2010).

Concerns regarding high prevalence rates for the consumption of drugs and alcohol among U.S. American youth arise from the fact that they often lead to negative health consequences (National Institute on Alcohol Abuse and Alcoholism, 2000). In addition to the physical health consequences associated with consuming alcohol and drug use at a young age, the use of these substances also has been linked to an increase in the likelihood youth will engage in other high risk behaviors, including unprotected sex (Gullette & Lyons, 2005; Henderson et al., 2002; Martins, Storr, Alexandre, & Chilcoat, 2008) and driving under the influence (Zakletkskaia, Mundt, Balousek, Wilson, & Fleming, 2009).

Gaining an understanding of the factors that contribute to the participation in risky behaviors among lesbian, gay, bisexual, and transgender (LGBT) youth is particularly important due to the higher incidence of these behaviors among this population. For instance, national data...
show that compared to their heterosexual counterparts, rates of alcohol and substance use tend to be significantly higher among LGBT individuals (Haldeman, Pantalone, & Martell, 2007). In particular, gay and bisexual men report high rates of lifetime alcohol, marijuana, and cocaine/crack use (Haldeman et al., 2007; Peregoy, Bartosz, & Hendricks, 2006). These high rates of alcohol and substance use among LGBT adolescents has been attributed to the challenges they face due to the stigma, discrimination, and rejection that they experience as a result of their sexual orientation (Elze, 2002; Perrin & Sack, 1998; Ryan & Futterman, 1998). Nonetheless, there continues to be a dearth in the literature examining existing models and theories that help to explain high-risk behaviors among this population.

One of the theories that was created to help us understand the development of problem behaviors such as alcohol and drug abuse is the Problem-Behavior Theory. This theory works from a psychosocial framework and defines problem behaviors as those that depart from the norm of the larger society (Jessor, 1992). Based on the idea that problematic behaviors are purposeful, functional, and instrumental towards attaining specific goals, Problem-Behavior Theory proposes that problematic behaviors are a result of the influence and interaction of three psychosocial systems: (a) the personality system; (b) perceived environment system; and (c) the behavior system (Jessor, 1992).

The personality system encompasses variables at the social cognitive level and reflects social meaning and developmental experiences. Personality proneness to problem behavior includes variables such as low self-esteem, impulsivity, and sensation seeking. The perceived environment system includes environmental characteristics that can be perceived and given meaning. Perceived environment proneness to problem behaviors includes variables such as lack of community support and societal stigma. Lastly, the behavioral system includes behaviors outside conventional norms. Proneness to problem behavior in the behavior system includes higher involvement in problematic externalizing behaviors, such as engaging in risky sexual behaviors while using a substance. Hence, these three systems can be seen as risk factors that can increase the probability of engaging in problematic behavior (Jessor, 1987; Jessor, 1992).

For more than 40 years, numerous studies based on the Problem-Behavior Theory have been conducted to address a variety of problem behaviors such as drug use, sexual risk behavior, and drinking. However, research on the practicality of using this model to understand gay, bisexual, and transgender youth is lacking. Dudley, Scales Rostosky, Kofhage, and Zimmerman (2004) published the first study to attempt to understand sexual risk behavior among sexual minority youth through the Problem-Behavior Theory. Data from this study showed that impulsive decision making, sensation seeking, anxiety/depression, internalized homophobia (personality variables) predicted unprotected anal sex more so than other high-risk behaviors (behavioral variables). Therefore, results from this study supported a strong link among sensation seeking, impulsivity, and sexual risk in sexual minority adolescents.

Sensation seeking is one of the most widely studied personality traits in the area of substance use and addictions. Individuals who engage in sensation seeking generally prefer exciting and novel stimulation (Kalichman, Johnson, Adair, Rompa, Multhauf & Kelly, 1994; Ostrow, DiFranceisco, & Kalichman, 1997). Research on this area reveals a consistent strong relation between this personality trait and substance use (Donohew et al., 1999; Donohew et al., 2000; Dubey & Arora, 2008; Hays et al., 1997; Hoyle, Fejfar, & Miller, 2000; Martins et al., 2008; Yanavitzky, 2005; Zakletskaia et al., 2009; Zuckerman & Kuhlman, 2000). In addition, sensation seeking has been associated with other problematic behaviors including higher sexual risk, as measured by lower condom use and higher number of sexual partners (Bryan, Ray, &
Cooper, 2007; Gullette & Lyons, 2005; Henderson et al., 2002). This is particularly. Men who score higher on sensation seeking report having more sexual partners and drinking more alcohol than females (Brown & Vanable, 2007). When looking at the behavior of gay males in particular, research has found that they tend to report higher sexual sensation seeking when they also reported low self-esteem, high-internalized homophobia, and low community acceptance (Preston, D’Augelli, Kassab & Starks, 2007).

To address gaps in the literature of high risk behaviors among gay, bisexual, and transgender adolescent males, we explored the relationship between several of the variables that fit into the three original systems addressed by the Problem-Behavior Theory: the personality system, perceived environment, and behavioral system. Based this theory, we hypothesized that each of the variables that represent the personality system (sensation seeking, impulsivity, loneliness, self-esteem, and internalized homophobia) and the perceived environment system (societal stigma) would be statistically correlated with the variable representing the behavioral system (drug use). We further hypothesized that the personality and perceived environment systems would be predictors of the behavioral system variable, drug use. This study contributes to the limited literature regarding drug use and the sexually risky behaviors of gay, bisexual, and transgender adolescent males. This information is crucial to the development of more effective interventions and prevention strategies that serve the needs of those in the LGBT population at high risk for problematic risk behaviors.

Method

Participants

Participants were recruited through a youth development program at a Lesbian, Gay, Bisexual, and Transgender Community Center in the Midwest. A total of 63 adolescents completed baseline surveys.

Procedure

Flyers were posted at the Lesbian, Gay, Bisexual, and Transgender Community Center to recruit adolescent males between the ages of 14 and 19 who identified as gay, bisexual, transgender, or unsure. Parental consent was waived to protect the privacy of participants who had not openly disclosed their sexual orientation. Each participant provided informed consent and completed an anonymous survey in a private office. Each participant received a $30 stipend for the completion of the survey. The study was approved by two Institutional Review Boards, Children’s Hospital of Wisconsin and the Medical College of Wisconsin.

Measures

The survey assessed demographic data including age, ethnicity, grade in school, sexual orientation, and living situation. We also assessed loneliness, self-esteem, internalized homophobia, societal stigma, sensation seeking, and impulsive decision-making using the following measures:

*Short-Form UCLA Loneliness Scale* (ULS-8) (Hays & DiMatteo, 1987) was developed by using 8 items from the revised UCLA Loneliness Scale (Hays & DiMatteo, 1987).
Participants were asked to indicate the response option that best described the way they felt about the statement on a 4-point Likert-type scale ranging from 1 “Never” to 4 “Often.” Items included, “I lack companionship,” “I feel left out,” and “People are around me but not with me.” Items 3 and 6 were reversed scored, and then all items were summed to obtain an overall loneliness score for each participant. The instrument demonstrated a moderate reliability, alpha = .70.

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) is a 10-item scale that has been used among the adolescent population samples and has demonstrated high reliability (alpha=0.82; Savin-Williams & Ream, 2003). Responses and levels of intensity were measured on a 4-point Likert scale ranging from “strongly agree” to “strongly disagree.”

Internalized Homophobia Scale (IHP) (Meyer, 1995) is a 9-item measure using responses with a 5-point Likert-type scale, ranging from 1 “strongly agree” to 5 “strongly to disagree.” Example of items include: “I often feel it best to avoid personal or social involvement with other gay/bisexual men,” I feel that being gay/bisexual is a personal shortcoming for me,” and “I feel alienated from myself because of being gay/bisexual.” We summed across all items to obtain an overall score for each participant. To ease data interpretation, all scale items were reversed scored so that higher scores indicated greater internalized homophobia. The scale demonstrated excellent reliability with alpha = .92.

Herek and Glunt (1995) developed a 7-item measure of Perceived Stigma. The original instrument assessed individual’s perceptions of stigma. This scale was administered using a 5-point response scale, ranging from agree strongly to disagree strongly.

The scale selected to measure degree of sensation seeking was the Brief Sensation Seeking Scale (BSSS). This 8-item scale had good reliability among a sample of adolescents (alpha=.74; Hoyle, Stephenson, Palmgreen, Pugzles, Lorch & Donohew, 2002). Items’ responses were on a five-point scale ranging from “strongly disagree” to “strongly agree.”

The Impulsive Decision Making Scale is an 11-item decision making style scale that was used to measure the participant’s decision making tendencies. This scale has shown good internal consistency (alpha = .71) and good validity among adolescents (Donohew et al., 2000).

Finally, alcohol and drug use were assessed by self-report measures using a standardized retrospective assessment (Center for Disease Control, 2010). Past alcohol and drug use was assessed on a 5-point scale anchored at 1 (Never used it) and 5 (Every day).

Data Analysis

The internalized homophobia scale had a bimodal distribution. Therefore, we created two groups, low homophobia and high homophobia at logical thresholds. Descriptive statistics were computed (i.e., means, standard deviations, ranges, and frequencies). Pearson chi-square tests were conducted to compare categorical variables and t-tests were used to compare continuous variables. Participants with missing incomplete data were dropped from the analyses. Compared to those with missing data, individuals retained in the analyses were, on average, significantly older by approximately one year (d = .98, SE d = .34, t = 2.89, p <.01). A point biserial correlation test was calculated when one variable was dichotomous. Negative binomial regression was conducted using the GENLIN command in SPSS 17.0 to examine the associations between the constructs of interest (i.e., loneliness, self-esteem, and internalized homophobia) and drug use in the past year. We used the covb = robust option in order to obtain
robust standard errors for the regression coefficients, which corrects for an underestimation of the standard errors.

**Results**

**Participants**

The analytic sample consisted of 63 gay, bisexual, and transgender adolescent males. Participants ranged in age from 14 to 19 years ($X = 17.7$). The majority of respondents were African-American (68.3%). Mean level of education was 11 years. About half of the participants (52.4%) reported being employed either full time (22.2%) or half time (30.2). Over half of the participants (56%) identified themselves as gay/homosexual, 36% self-identified as bisexual, 6.1% identified as transgender/transsexual, and 1.6% as other. More than half of the respondents (63.5%) reported having disclosed their sexual orientation to “many people” or “everyone they knew.” However, less than half (41.3%) said they have disclosed their sexual orientation to one or both of their parents.

**Pearson Product Moment Correlational Analyses**

*Sensation Seeking:* Pearson product moment correlations conducted on variables of interest revealed a strong statistically significant positive association between sensation seeking and impulsivity ($r = .52; p < .01$). A positive correlation also was found between sensation seeking and society stigma ($r = .28; p < .05$). Furthermore, a statistically positive link between sensation seeking and drug use was observed ($r = .31; p < .01$). Analyses further revealed a statistically significant negative association between sensation seeking and internalized homophobia ($r = -.22 p < .05$).

*Drug Use:* There was a negative correlation between drug use and self-esteem ($r = -.34$), indicating that participants who reported higher levels of substance abuse described themselves as having lower self-esteem. Finally, statistically significant positive associations were found between drug use and impulsivity ($r = .34$), and drug use and loneliness ($r = .22$).

**Regression Analysis**

Our second hypothesis proposed that sensation seeking (personality system) and societal stigma (perceived environment system) would predict the behavioral system variable (drug use). Thus, regression analyses including the full model were conducted. The results indicated that together, sensation seeking and societal stigma did not significantly predict drug use. Additional regression analyses were conducted to further examine the relationship between sensation seeking and drug use. The results of the analyses indicated that sensation seeking significantly predicted drug use, $B = .095, \beta = .310, t(59) = 2.5, p < .05$. Sensation seeking explained a significant proportion of variance in self-reported drug use, $R^2 = .96, F(1, 225) = XX, p < .01$. These findings suggest that participants’ self-reported level of sensation seeking is predictive of their use of drugs.

**Discussion**

The Problem-Behavior Theory has been useful to explain problem behavior among adolescents in general. However, it is important to acknowledge that gay, bisexual, and
transgender males face unique challenges not experienced by their heterosexual counterparts. Therefore, it is essential that these challenges are acknowledged and incorporated into existing theories that attempt to explain behaviors among this particular group. Although fully testing the problem behavior theory among gay, bisexual and transgender youth was beyond the scope of our study, the preliminary results seem to support the relevance of some key variables in this theory to understand problem behaviors among LGBT youth.

The personality system, specifically sensation seeking, was associated with drug use among our sample, a relationship that as has been found in other studies (Donohew et al., 2000; Hays et al., 1997; Hoyle et al., 2000; Zakletksaia et al., 2009; Zuckerman & Kuhlman, 2000). With regards to sensation seeking and impulsivity, a strong statistically significant positive association was found, suggesting that individuals who scored high on sensation seeking were more likely to also report impulsiveness. Previous research also has found an association between higher sensation seeking and risky behaviors (Bryan, Ray, & Cooper, 2007; Gullette & Lyons, 2005).

In the current study, sensation seeking was positively correlated with society stigma, which can be considered a component of the perceived environment system of the Problem-Behavior Theory. In other words, participants who perceived higher discrimination from society also tended to report higher sensation seeking. These results are consistent with previous the literature which has consistently identified societal stigma as one of the psychological stressors experienced by this population (Remafedi, 2007; Peregoy, Bartosz, & Hendricks, 2006) and has linked high levels of perceived stigma with risk behaviors, including sexual risk behaviors (Kooyman, 2008).

Internalized homophobia can be a major developmental challenge among gay and bisexual men (Rowen & Malcolm, 2002). The current study found a statistically significant negative association between sensation seeking and internalized homophobia. These findings suggested that males in our sample that scored high on sensation seeking tended to report less internalized homophobia. These results present a challenge given the fact that high sensation seeking was positively correlated with societal stigma but negatively correlated with internalized homophobia. Sensation seeking has been typically seen as a risk factor and a negative attribute. However, for our sample, sensation seeking appeared to be a protective factor shielding participants from the internalization of societal stigma. Generalizations about these results cannot be made at this point, given the study sample size and other limitations discussed below, but this result should be further explored. Futures studies should also analyze the nature and direction of the relationship between sensation seeking and internalized homophobia.

Consistent with other research (Lock & Steiner, 1999), drug use was negatively correlated with self-esteem. For instance, previous studies have found that gay males who report higher sexual sensation seeking tend to have lower self-esteem, more internalized homophobia, and less community acceptance (Preston et al., 2007), which can increase drug use in this population. Several studies have suggested that internalized heterosexism is positively correlated with higher substance use (Brubaker, Garrett, & Drew, 2009). Furthermore, the results of this study demonstrated a link between sensation seeking and drug use, suggesting adolescents in the sample that scored high on sensation seeking were more likely to report drug use, a finding that has been supported by previous research (Kashuneck-West & Syzmanski, 2008; Martins et al., 2008). In our regression analyses, sensation seeking was correlated with drug use and impulsiveness. Moreover, drug use was also positively correlated with loneliness and impulsivity, indicating that these variables also influence the use of drugs.
Implications for Counseling and Prevention Strategies

The results of the present study can be helpful in the development of drug prevention interventions and counseling service strategies provided to gay, bisexual, and transgender adolescent males. For instance, researchers have proposed that participating in novel and exciting activities could help high sensation seekers, given that the reward experienced after engaging in those activities may be comparable to the rewarding effects experienced with drug use (D’Silva, Harrington, Palmgreen, Donohew, & Lorch, 2001). Therefore, D’Silva et al. (2001) recommended that when working with high sensation seekers, it is important to provide them with a wide variety of options that include participation in novel and exciting activities; these activities can be positive and healthy alternatives to the use of drug and alcohol use. Moreover, therapists working with gay, bisexual, and transgender youth should be familiar with the literature on sensation seeking and the Problem-Behavior Theory, and be able to assess and address the complexities delineated by this model. In addition, both prevention and counseling should address the connection between sensation seeking and impulsivity, societal stigma, internalized homophobia, and drug use.

Limitations

This study has a number of limitations including the sample size and the fact that a convenience sample was used. Future studies that use a randomized, larger, more representative sample are necessary. The second limitation of the current study is the use of a convenience sample of recruited youth from an LGBT organization. Thus, our sample may not be representative of gay, bisexual, and transgender male adolescents who are not involved in these type of organizations.

Despite the above-described limitations, our study provides important information for the understanding of problem behaviors among gay, bisexual, and transgender adolescent males. Our data provides insight into the relationship between selected variables involved in drug use, which can be useful when providing counseling and developing future drug prevention interventions. Finally, our findings contribute to the scientific literature on risk behavior among gay, bisexual, and transgender male adolescents.

References


**Author Note**

Héctor L. Torres, Psy.D., is an Associate Professor at The Chicago School of Professional Psychology in Chicago, IL. He can be contacted at htorres@thechicagoschool.edu.

Nayeli Y. Chavez-Dueñas, Ph.D., is an Associate Professor at The Chicago School of Professional Psychology in Chicago, IL.

David W. Seal, Ph.D., is a Professor at Tulane University School of Public Health and Tropical Medicine in New Orleans, LA.

The authors wish to acknowledge that this research was funded by the National Institute of Mental Health (NIMH) Center Grant #P30-MH52776 (PI: Jeffrey A. Kelly, Ph.D.). We would also like to acknowledge the Milwaukee Lesbian, Gay, Bisexual, and Transgender Community Center for their collaboration.
Playing the Hurt Away: Play Therapy as a Technique for Working with School-Age Children having Attachment Difficulties

Olamojiba O. Bamgbose  
*Northern Illinois University*

Charles E. Myers  
*Northern Illinois University*

Abstract

Bowlby’s attachment theory offers a deeper understanding of the effect that early childhood relationships between children, their main caregivers, the environment, and significant others can have on children’s mental, social, behavioral, and emotional development. This paper provides a summary of attachment development and considers the implications of insecure attachment patterns as children move from childhood into adolescence. It explores the efficacy of play therapy as a technique for working with children on a range of issues and then presents examples from the literature on two models integrating attachment theory concepts with play therapy and one example of practice.

Early attachment relationships between children and their main caregivers, environment, and significant others has implications for children’s development in the immediate and across a lifespan. From these relationships, children form internal working models (Hardy, 2007) and develop a mental sense of their own worth, lovability, and right to protection. Children’s internal working models derive from attachment patterns that develop in reaction to children’s perception of their caregivers’ responsiveness to attachment-activated behaviors. These attachment patterns can be secure, avoidant, resistant-ambivalent, or disorganized.

Securely attached children perceive the self as loved and autonomous and significant others as available, cooperative, and dependable. This view influences their interaction in future relationships. Children with avoidant attachment patterns see the self as unloved but self-reliant and others as rejecting and intrusive. Children with resistant-ambivalent attachment patterns have a low sense of self, and perceive others as neglecting, insensitive, unpredictable, and unreliable. Children with disorganized attachment patterns view the self as confused and bad and others as frightening and unavailable (Howe, Brandon, Hinings, & Schofield, 1999).

A comprehensive understanding of attachment theory provides therapists with a theoretical framework in which to assess children’s needs and development, assist their access to services, and evaluate the effectiveness of interventions. Attachment theory provides another forum for understanding children’s behaviors in context of their attachment patterns and interactions with significant others, informing therapists when selecting and implementing interventions that are effective in breaking cycles of unhealthy functioning. By exploring play therapy as a developmentally responsive and effective intervention for working with children having attachment difficulties, we gain a better understanding on how to use play, a natural
childhood behavior, to assist in the healing and repairing of fractured internal working models (Mills & Allan, 1992). Using attachment-based play therapy, children could receive support to experience healing at their own pace. They also have opportunity to resolve issues or traumas from earlier attachment relationships and to test out more healthy ways of negotiating their world in a safe and trusting environment.

The Theory of Attachment

Understanding Attachment

Attachment theory describes the emotional relationship or connection between a baby and “some other differentiated and preferred individual, who is usually conceived [by the infant] as stronger and/or wiser” (Bowlby, cited in Benedict & Mongoven, 1997, p. 277). Children use attachment behaviors to initiate protective relationships with their primary caregivers (usually the mother) during periods of stress and anxiety, and the child is able to experience the caregiver as physically, emotionally, and psychologically present in their responses and interaction. These interactions operate on a continuum of sensitivity-insensitivity, acceptance-rejection, cooperation-interference, and accessibility-ignoring (Howe et al., 1999). Securely attached children have most likely experienced parental interactions along a continuum of sensitivity, acceptance, cooperation, and accessibility. In contrast, children with insecure attachment styles (i.e., avoidant, resistant-ambivalent, disorganized) may have experienced the mother-child relationship along a continuum of insensitivity, rejection, interference, and ignorance. Children with disorganized attachment patterns might have experienced maltreatment; therefore, these children’s reactions to their main caregivers are one of conflict and uncertainty because they recognize their caregiver as the source of both their pain and comfort (Hardy, 2007). Cornell and Hamrin (2008) identified an overlap between the clinical definition of Reactive Attachment Disorder as provided by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) and disorganized attachment behaviors. However, assessing a child as having attachment difficulties is not a diagnosis of Reactive Attachment Disorder.

Infant attachment develops in four stages (Berk, 2009); preattachment (0-6 weeks) - babies engage in innate social interactions that draw caregivers to them; however, there is no preference for the main caregiver. Attachment in the making (6 weeks to 6-8 months) - infants demonstrate preference for the main caregivers and other familiar faces and they develop a sense of trust. At this stage, there is no clear defined attachment or distress during separation, even though infants expect caregivers to come during periods of distress or when signaled. Clear-cut attachment (6-8 months to 18 months-2 years) - children display clear signs of separation anxiety, present as deliberate in gaining close proximity with main caregivers, and use them as a secure base from which to explore. Formation of reciprocal relationship/goal corrected partnership (18 months-2 years and on) –children can prepare for the caregivers’ absence and mentally represent them when they are gone, allowing for the development of autonomy and exploration in securely attached children.

Hughes (1999) characterized the first three years of infancy as a time of attunement. In the first year, mother and child attune to each other, learning to share affect, which supports infant brain stimulation, develops positive emotions of interest and joy, and helps the child to feel special. In the second year, mothers teach the child how to socialize with significant family
members. In addition, infants learn the importance of limits and boundary setting, a process that can result in shame for the child and necessitate reassurance from the mother, through comfort and re-attunement. The second into the third year is one of integration for securely attached children; here they learn to accept the ‘good’ and ‘bad’ aspects of the self and the main caregiver, and from this secure base, they can continue with other developmental tasks.

Children’s earlier relationships and interactions lead them to develop a mental sense of their own worth, lovability, and right to protection, described as internal working models. The model “consist[s] of representational structures that define one’s perception of self and others and contribute to the internal processes that define one’s selective experience of the external world” (Hardy, 2007, p. 28). Pietromonaco and Barrett (2000) reflected that these mental representations are made up of “expectations about the self, significant others, and the relationship between the two” (p. 156). Once developed, these models provide the foundation on which children learn to adhere to social normative behaviors, regulate feelings and emotions, respond to the larger world, and negotiate other social interactions.

**Implications of Attachment Difficulties on Children & Adolescents**

Longitudinal studies, exploring the association between early attachment difficulties and later functioning in school-age children and adolescents have identified a number of potential challenges for insecurely attached children. Dallaire and Weinraub (2007) researched early infant-mother attachment security as a protective factor against anxious and aggressive behaviors in first graders during periods of family stress and significant life events. They identified that children with insecure attachment patterns showed increased aggressive behaviors in the classroom and a specific risk factor for the development of anxious behaviors. Sroufe (2005) studied the role of infant attachment patterns and representations on developmental functioning across the different stages of pre-school, middle childhood, and late adolescence, in a sample of two hundred children. He found that nursery-age children with insecure attachments (avoidant and resistant) were less self-reliant in their interaction with teachers and other adults, than their secure counterparts. These findings remained consistent at age 10. Children with resistant patterns of attachment showed fewer competencies in new situations and problem-solving tasks, and presented as ineffective in peer relationships. Children with avoidant patterns showed difficulty forming relationships and a preference for solitary play.

Allen, Porter, McFarland, McElhaney, & Marsh (2007) considered the connection between adolescent attachment behaviors and their functioning in several areas of social interaction. They found that securely attached adolescents were able to maintain father-child relationships even during periods of conflict and show autonomy within these relationships. In peer group interactions, securely attached children showed capacity to form emotionally supportive and socially rich relationships, while maintaining autonomy and resisting peer pressure. Allen and colleagues also noted links between insecure attachment patterns and increased symptoms of depression (especially among females) and the higher risk of externalizing behaviors at age 13, which steadily increased over the period of adolescence.

Hoeve and colleagues (2012), in their meta-analysis of 74 unpublished/published manuscripts (55,537 subjects), found that young people with poor attachment patterns rated higher for delinquent behaviors, especially in younger age children. The attachment-delinquency link was stronger in the mother-child relationship and significantly stronger for same sex parent and child. Hoeve et al. concluded that insecure attachments in the father-son relationship
presented an increased risk for delinquency and suggested the involvement of fathers as part of the intervention process.

Fonagy and associates (as cited in Hardy, 2007) identified a relationship between affective disorders and unresolved attachment status. Hardy reviewed 13 meta-analytic studies, and found strong associations between insecure attachments and borderline personality disorders. Allen, Hauser, & Borman-Spurrell (1996) identified relationships between insecure attachment, depression and behavioral difficulties in childhood and adolescents. Infant insecure attachments were associated with hostility and conduct disorders. Remkus (1991) identified that insecure attachment relationships limit children’s emotional, cognitive, and social development. There is a direct correlation between the stimulation a child receives, the attachment relationship, their language and cognitive development, and environmental curiosity. These studies highlight the significance of early attachment relationships on children’s mental, emotional, social, and behavioral development, and support the importance of working with this population early on in their development, in order to minimize the effects of early attachment relationships on current and later functioning.

**Play Therapy**

Play Therapy

Play is the natural medium through which children speak, interact, or socialize with their world. Children’s play reflects their subjective view of the world, supporting their social, emotional, cognitive, behavioral, and physical development. Landreth (2002) identified that:

Play is the key way in which children learn about the world around them as they attempt to organize and understand their experiences. Play also provides children with an opportunity to gain a sense of control and mastery over their world as they explore and experiment with toys and other play media. In play, the child can create a world that is the way he or she wants it to be. Through play, the child can experience being in control of life experiences in ways that are not possible in the world of reality outside of play. (p. 529)

Play therapy provides a counseling experience for children by tapping into these natural play behaviors. Using play as a therapeutic conduit, children can safely relive and resolve traumas from previous experiences, identify and attend to their fears and anxieties, and/or act out (within safe limits) those behaviors that negatively affect their functioning in the real world, and learn more acceptable ways to be. Hall, Kaduson, and Schaefer (2002) described play therapy as “an interpersonal process wherein a trained therapist systematically applies the curative powers of play (e.g., relationship enhancement, role-playing, abreaction, communication, mastery, catharsis, attachment formation, etc.) to help children resolve their current psychological difficulties and help prevent future ones” (p. 515). Landreth (2002) viewed play therapy as a relationship “in which the child plays out feelings, thus bringing them to the surface, getting them out in the open, facing them, and either learning to control them or abandoning them when appropriate”(p. 530).

**Play Therapy & Research**

Studies have identified play therapy as an effective technique for working with children across all ages (Ray, Bratton, Rhine, & Jones, 2001) and on a number of externalizing and internalizing behaviors, some of which are closely associated with insecure attachment patterns.
Dougherty and Ray (2007), in their review of studies looking at the validity of play therapy with children, identified improvements in verbal and social interactions, off-task behavior, and aggressive acts of children aged 4-6 years old, after 11 weeks of play therapy sessions. They noted improvements in self-concept and play behaviors of children aged 5-6 years old, who had witnessed domestic violence, and a reduction in behavioral problems (externalizing and otherwise) following 12 sessions of intensive play therapy over a two-week period. They also identified improvements in learning skills, assertive and peer social skills, and task orientation in children aged 5-9 years old after weekly play therapy sessions.

Bratton & Ray (2000) reviewed 82 play therapy studies, based on experimental research, from 1942 to 1999, where participants received either individual or group client-centered, non-directive play therapy. They identified the efficacy of play therapy in a range of behaviors such as self-concept, behavioral change, cognitive ability, social skills, and anxiety. The authors also reviewed over 100 case studies and found play therapy was effective in working with a range of concerns such as schizophrenia, enuresis/encopresis, anxiety disorders, trichotillomania, selective mutism, withdrawn behavior, acting out behaviors, sexual abuse, trauma and neglect, learning/academic problems, and various life adjustment problems.

Play Therapy & Attachment Difficulties

Despite the above successes, a review of the literature identified few therapeutic interventions associated with attachment theory, although concepts from the theory, including elements of Bowlby’s (Benedict & Mongoven, 1997) five tasks (see thematic play therapy), have informed clinical interventions and treatments in work with adult clients. Furthermore, therapists have taken into account clients’ attachment patterns and behaviors when developing clinical interventions. They use attachment measurements to enhance therapeutic understanding of clients’ relationships and overall functioning in a range of settings. Therapists may serve as attachment figures and provide clients a secure base from which to explore and change their unhealthy internal working model (Eagle, 2006). Finally, therapists have focused interventions on assisting clients to build new attachment relationships, improve existing attachment figures, and minimize attachment symptoms and behaviors (Hardy, 2007).

The literature integrating attachment theory with play therapy for work with insecurely attached children is sparse and somewhat divided between play therapy with children showing attachment disorders as defined by the DSM-5 (APA, 2013) and children with attachment difficulties. I have referenced three examples here. Both Mills and Allan’s (1992) attachment-sensitive play therapy and Benedict and Mongoven’s (1997) thematic play therapy provide frameworks or models of practice that therapists can employ in play therapy work with children. Anderson and Gedo (2013) integrated attachment theory and play therapy to treat a three-year-old with insecure attachment and aggressive behaviors. Although their work was with a preschooler, their case study provides a basis for understanding case conceptualization and intervention using attachment theory concepts.

Attachment-sensitive play therapy. Mills & Allan (1992) explored the use of attachment-sensitive play therapy with insecurely attached, maltreated children who exhibited aggressive and withdrawn behaviors. The authors identified that therapists using this approach must understand certain concepts significant to the change process: internal working models involving children’s need to discard previously held internal working models and develop new models of self and the self in relation to others. Ego defense mechanisms - through play, children
explore wishes, repressed feelings, and trauma using projection and symbolization. Transference—children project and replicate feelings for significant others onto the therapist, but receive responses that are accepting, affirming, and non-punitive.

Mills & Allan’s (1992) therapeutic model has four stages. In stage one, therapists create a secure base built on a trusting and supportive relationship with age-appropriate limit setting so that children can explore their inner worlds. Children lead the pace and direction of play and therapists cautiously reflect their observations back to the children, thus increasing their sense of acceptance and feeling of safety. Two themes arise at this stage; first, children engage in symbolic enactment of their pain, and second, they display regressive behavior back to when the damage first occurred. Stage two is characterized by changes in the child’s attitude towards the therapist (Mills & Allan, 1992). Previously compliant children begin to test boundaries, display behaviors that replicate their functioning with other adults, and test the therapist’s claim of unconditional acceptance. The therapist role remains one of acceptance and gentle reflection of the child’s ambivalent feelings; this alleviates the child’s anxieties, weakens defenses, and promotes an environment where the child can begin to explore repressed feelings.

Stage three is the working stage, where children begin to interact with the therapist on an interpersonal level in order to explore and work through their pain (Mills & Allan, 1992). Transference is the main theme at this stage, as the child’s interaction with the therapist fluctuates between positive interaction at the start of session to negative behaviors of “anger, negative attention seeking, manipulation, or other unresolved feelings” (Mills & Allan, 1992, p.13) as the session progresses. The therapist role is to affirm, accept, and manage the child’s feelings and behaviors through non-punitive strategies. The therapist also interprets the child’s play and behaviors and encourages active dialogue and reciprocal play.

Stage four is the “consolidation and termination stage” (Mills & Allan, 1992). Children engage in play or dialogue about their lives outside of therapy, demonstrate improved interpersonal skills, and interact with the therapist purposefully. Therapists become more directive in their work with children to support growth and development in social skills. Termination is gradual and begins once reports from school indicate that the child has begun to form positive peer relationships. The model encourages collaborative working with school and teachers to compliment the therapeutic process and support the child’s social development acquisition and adoption of new working models.

**Thematic play therapy.** Benedict and Mongoven (1997) discussed the use of thematic play therapy with children presenting five categories of attachment disorders, as defined by Zeanah, Mammen, and Lieberman. The model combines Bowlby’s attachment theory and object relations, and it employs some of Schaefer’s (1999) curative factors (e.g., metaphorical insight, fantasy compensation, sublimation, creative problem solving catharsis, and abreaction). The model interprets Bowlby’s five therapeutic tasks into the therapeutic process; therefore, through play, therapists provide a secure base from which children can explore past experiences and pain. As a secure base, therapists sensitively provide children with structure, challenge, intrusion, and nurture. Children receive support to change their internal working model through the therapist-child relationship. Therapists assist children in understanding the influence of past experiences on current relationships and supports them to explore their expectations, feelings, and behaviors in these relationships. Finally, therapists help children understand the inaccuracy of previous internal working models in order to develop healthy ones.
In thematic play therapy, the therapist demonstrates acceptance, affirmation, and warmth towards the child. The therapeutic approach is child responsive, consistent, and sensitive to the child. These attributes, combined with a safe (physical and psychological) environment, are the perquisites for a trusting relationship. As the therapist-child relationship develops, therapists observe, interpret, and reflect on the themes emerging from the child’s play in order to understand their current functioning and support the development of new internal working models. Benedict and Mongoven (1997) identified five predominate themes for children assessed as attachment disordered - safety, anger, nurturance, constancy, and loss. The authors proposed that children might not necessarily play out all the themes; however, as they arise, therapists respond to them on a needs-led basis using their understanding of the individual child and an array of appropriate techniques/responses. Benedict and Mongoven identified termination as the most important stage of the therapeutic process. They suggested that therapists gradually prepare children for termination and attempt to minimize the effect through tangible representations as a symbol of the therapeutic relationship. In this model, clinical work with caregivers is significant to the therapeutic process and increases the effectiveness of any work with the child.

**Attachment theory and play therapy intervention.** Anderson and Gedo (2013) proposed that individual therapeutic interventions such as play therapy could repair disrupted attachment patterns and support children to develop healthy internal working models. They identified that therapy should be child led. Therapists should show empathy, be genuine, warm, and positive in their interactions with the child, attuned to the child’s thoughts and feelings, predictable in their responses, encourage the child’s freedom of expression, and use fantasy play to assist the child in regaining control. The authors demonstrated this approach by integrating attachment theory and play therapy in their work with three-year-old Adam. Using attachment theory, the authors conceptualized Adam as insecure ambivalent with periodic bouts of aggression, and intense distress (aggression and anxiety) when separated from significant attachment figures or during transitions. Following assessments and observations at the initial stage and over the course of treatment, Anderson, the first author, further assessed Adam’s internal working model as the self is unworthy and adults as inconsistent and unreliable. Anderson and Gedo also identified delayed expressive language and echolalia.

The treatment consisted of three phases, in the initial treatment phase; Adam demonstrated ambivalence and distrust towards the therapist as a reliable attachment figure (Anderson & Gedo, 2013). Anderson managed Adam’s ambivalence by being attuned to and tolerant of his anger. In the middle treatment phase, Anderson employed reflective interventions, and modeled self-soothing skills as a way of helping Adam understand and accept his “affective experiences” (p. 258) while learning to develop self-soothing capacities. As the work progressed, Adam’s play evidenced themes that were both anxiety provoking, while attempting to convey strength. Anderson came to understand the function served by Adam’s aggressive behaviors as “an attempt to turn his passive, anxious suffering into an active sense of control over his life” (p. 259). Anderson was unable to complete the termination phase and she noted a slight change in relationship between her and Adam during this stage, as he tried to prepare for the work ending. However, during the middle phase, Anderson noted significant therapeutic gains and changes in Adam’s behavior. He showed decreased ambivalence towards Anderson, signs of developing a secure attachment towards her, and increased ability to manage separation. He internalized self-soothing skills, developed better affect and behavior regulation, and learned to verbalize feelings instead of acting them out aggressively. He also demonstrated improved tolerance and social interaction in sessions and with classroom peers.
Conclusion

Attachment theory provides a basis to understand the effects of early childhood relationships on children’s overall functioning and negotiation of significant relationships as they move from childhood through to adolescence. The theory provides a theoretical framework to accurately understand and assess children’s needs, assist their access to services, develop interventions that take account of attachment tasks, and evaluate the effectiveness of interventions. Attachment patterns have implications for a child’s overall functioning. Children with insecure attachments are at risk of increased aggressive behaviors and the development of anxious behaviors (Dallaire & Weinraub, 2007). At school age, children present as being more reliant on adults, less confident in their interactions, have low self-esteem and experience difficulty forming, maintaining, and coordinating groups of friendship (Sroufe, 2005), and rate higher for delinquent behaviors (Hoeye et al., 2012). Insecure attachment relationships also affect children’s emotional, cognitive, and social development (Remkus, 1991).

Play therapy is an effective technique for working with children exhibiting a range of externalizing and internalizing behaviors characteristic of children with insecure attachment patterns (Bratton & Ray, 2000; Dougherty & Ray, 2007). Currently, there is a dearth of research connecting attachment theory and play therapy; however, Mills and Allan’s (1992) attachment-sensitive play therapy and Benedict and Mongoven’s (1997) thematic play therapy, provide frameworks or models of practice that demonstrate such an integration can occur. Anderson and Gedo (2013) provided an example of direct practice using attachment theory for case conceptualization and intervention in play therapy work with a three-year-old boy. These pieces of work demonstrate how the integration of attachment theory and play therapy would provide therapists with greater insight assessing and treating children with attachment difficulties.

References


**Author Note**

Olamojiba O. Bamgbose, M.A., PEL with School Counselor Endorsement – Illinois and Wisconsin, is a doctoral student at Northern Illinois University in DeKalb IL. She can be contacted at obamgbose1@niu.edu.

Charles E. Myers, LPC, LCPC, NCC, LMHC, RPT-S, ACS, is an Associate Professor at Northern Illinois University in DeKalb, IL. He can be contacted at cemyers@niu.edu.
Neglected Child Refugees: Undiscovered Issues and Suggestions for Services

Mi-Hee Jeon  
St. Lawrence University

Charles E. Myers  
Northern Illinois University

Abstract
Refugees make up 10% of annual immigrants to the United States. Researchers have neglected child refugees in refugee studies. Child refugees experience multiple dimensions of difficulties including traumatic experiences from their countries, cultural shock during resettlement, and issues from their family dynamic resulting from migration to a new country. This article is a review of existent mental health concerns of child refugees, an overview of current mental health services available to them, and a call for the awareness and social action of mental health professionals to increase the availability and quality of those services.

Among the 150 refugee host nations, the United States, along with Canada, accepts the highest number of refugees in the world (United Nations High Commissioner for Refugees [UNHCR], 2012), with about 2.5 million resettling in the United States since 1975 (Singer & Wilson, 2007). The UNHCR (2011) identified refugees in the following way:

[A person who,] owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country. (para. 3)

Refugees currently comprise 10% of annual immigrants to the United States, forming distinct foreign-born groups, especially in many U.S. metropolitan areas, such as New York, Los Angeles, and Chicago (Singer & Wilson, 2007). Children and their mothers make up a significant portion in the refugee population. In mid-1995, the United Nations (UN) assessed that three-fourths of all refugees were women and their dependent children, and the United Nations Population Fund (UNFPA) stated that women and children comprise 80% of refugees (Population Information Program [PIP], 1996, para. 4). This demographic feature highlights the need for increased attention on refugee research regarding children and their parents, particularly mothers.

Child refugees represent a significant portion of U.S. immigrants; however, mental health professional organizations and literature have overlooked this vulnerable population. The refugee population and child refugees should be a continuation of multicultural counseling. The mental health profession needs to take steps to provide the attention and proper services that these children require and deserve.

Researchers of refugee populations have overly focused on physiological and psychological consequences of pre-migration traumatic experiences. Child refugees often arrive in the United States following traumatic experiences in their home country and during their
escape and relocation. While their traumatic experiences might affect their lives, the most prominent issues from their resettlement processes have yet to be illuminated. Korkut (2010) noted that the unsolved problems of refugees, such as displacement from their original context and experiences of tragic personal loss, remain and even worsen over time. Korkut’s claim applies to the child refugee population, suggesting the neglect of other significant and extant issues, such as acculturation and resettlement experiences, regarding the living situation of child refugees.

Both the neglect of the child refugee population and the research emphasis on trauma could result in a failure to provide practical help for this population. With efforts to incorporate child refugees under the multicultural counseling umbrella and to draw public attention to this population, this paper focuses on reviewing a research trend on child refugees and its critique, addressing ongoing but less highlighted issues they face, interventions in current use, and suggestions for continued research on the treatment of child refugees.

**Overweighed Emphasis on Pre-Migration Experiences in Research**

For two decades, a significant amount of research has started addressing the traumatic experiences of child and adolescent refugees whose countries have undergone war, famine, and political conflict (Almqvist & Brandell-Forsberg, 1997; Mollica, Poole, Son, Murray, & Tor, 1997; Rothe, 2008). Many child refugees suffer from severe psychiatric disorders (i.e., posttraumatic stress disorder [PTSD], depression, anxiety, and conduct disorder) and symptoms (i.e., somatic complaints, over-dependency, and restlessness), social life disruptions, and loss of family and friends (Almqvist & Brandell-Forsberg, 1997; Heptinstall, Sethna, & Taylor, 2004; Wiese & Burhorst, 2007). Unfortunately, their symptoms endure and persist over years (Ehntholt & Yule, 2006). Hodes (2000) extrapolated that up to 40% of child and adolescent refugees living in the United Kingdom may have psychiatric disorders. Similarly, Summerfield (2000) identified that 40-50% of child refugees living in the US actually do suffer from severe psychiatric disorders.

Refugee experiences of trauma may occur pre-, mid-, and post-migration. When counselors consider a child refugee’s trauma symptomatology solely on the child’s pre-migration experiences, they limit their ability to understand the child’s experiences, which may negatively affect their ability to provide adequate services. There has been a critique regarding child refugee research, asserting that researchers place too much emphasis on PTSD as the main consequence of traumatic experience. Berman (2001) argued that PTSD symptoms represent only one category of symptoms exhibited by child refugees resulting from their traumatic experiences. Researchers have found that PTSD symptoms of refugees significantly correlated to previous traumatic experiences in the home country, while children’s levels of depression were significantly associated with their family’s stress from the post-migration experiences (Almqvist & Brandell-Forsberg, 1997; Heptinstall et al., 2004). Therefore, counselors need to look beyond assumed labels when evaluating a child refugee’s symptoms.

**An Under-Researched Area**

A great deal of research has illuminated both physical and psychological consequences of child refugees’ trauma (Almqvist & Brandell-Forsberg, 1997; Heptinstall et al., 2004; Mollica et al., 1997; Sack, Clarke, & Seeley, 1995), overlooking the effect of their resettlement experience
on their lives in their host country. This blindness towards the post-migration experience may indicate the perception that the source of child refugees’ agonies link only to the traumatic experiences in their home countries and that their suffering ends after migrating to a new country. However, the attribution of their traumatization solely to previous traumatic experiences could generate additional trauma.

This section will cover post-migration experiences that child refugees might have after their resettlement to the United States in relation to mental health of refugee children. In addition, the role of family, particularly the relationship between parents and children and its effect on children’s mental health will be shed light on.

**Unreported Children**

Even though the focus of this article is on post-migration experiences of child refugees, this emphasis does not discount traumatic experiences that children might have gone through in their countries of origin. In fact, child refugees have often been subjected to traumatic events such as direct exposure to war, violent death of a family member, people being injured, tortured, and/or raped, combat, displacement, separation from caregivers, dead bodies, serious food deprivation (Birman et al., 2008; Dybdahl, 2001; Lustig et al., 2004), or exposure to any combination of the above. Of course, these experiences violate child refugees’ intra-psychic world, and result in a variety of mental health symptoms, chiefly PTSD.

Unfortunately, traumatic symptoms of child refugees is underreported due to their parents’ efforts in “protecting” their children. Parents’ denial may cause them to pretend that “nothing happened” in order to relieve their children’s worries. However, considering the severity and profundity of experiencing war, violence, and social chaos, the effectiveness of this parental strategy is dubious. To make matters worse, parents may overlook their children’s traumatic experiences, keeping their children silent. This silence can be a barrier to both parties; parents may miss the chance to offer their children proper treatment, and children may not obtain parental support (Almqvist & Broberg, 1997). Given that unresolved issues from pre-migration trauma closely relate to psychosocial maladjustment (Benmark, Chung, & Pedersen, 2003), efforts to detect whether child refugees are traumatized by their previous experiences must be accessed.

**Cultural Shock**

Anthropologist Kalervo Oberg defined a cultural shock as a state in which people in a new culture lose a sense of meaningfulness, feel a sense of loss, have lowered self-esteem, and feel depressed (as cited in Zapf, 1991). Cultural shock is an initial stage in acculturation, where the experience in a new culture is depicted as a negative, emotional down. Even though child refugees are more likely to adapt to a new environment than adult refugees (Hyman, Vu, & Beiser, 2000), child refugees are not exempt from cultural shock. Child refugees may pay a high toll in the acculturation process, such as adapting to U.S. schools. In school, child refugees experience stress because when other school personnel and other students treat them as foreigners. Differences in language, dress, cultural codes in interactions, and so forth exemplify these stresses (Benmark et al., 2003). Unfortunately, child refugees may be subjects of “physical and emotional abuse, harassment, and robbery” (Benmark et al., 2003, p. 41). Counselors need to give the effect of cultural shock serious consideration when working with these children.
Barwick, Beiser, and Edwards mentioned that during the first year’s resettlement of child refugees the negative post-migratory experiences might threaten the child's future adjustment (as cited in Yohani, 2010).

**Family in Relation to Mental Health of Refugee Children**

The family itself can act as a shield for all family members from the chaotic environment of resettlement and as a hub to center the family in their transition period. Berman (2001) asserted that psychiatric effects on the children could not be separated from the presence of family. However, if the family does not function well enough to meet the needs of child refugees, then the family can conversely become a source of their symptoms. Liebkind’s (1996) study on the Southeast Asian Refugee youth population found a correlation between the dissociation of the family bond and anxiety and depression. In addition, child refugees living with families manifested a significantly higher frequency of relationship disorders than did children with no family present (Wiese & Burhorst, 2007). Many refugee families suffer from issues related to reversed-role functioning, conflict between couples, and challenge to previous family structure (Benmark et al., 2003, p. 39). These issues could ultimately affect family dissociation. Considering how vulnerable child refugees can be to changes in family-society dynamics, and the effect those changes can have on a wide range of issues in their mental health, a new approach focusing on family-focused theories (Wiene et al., 2004), family dynamics, and relationships during their post-migration stage will bring meaningful and practical results.

**Marital conflicts.** Child refugees might be affected by marital conflicts that result from a new family structure. The family structure of most refugees is patriarchy (Center for Applied Linguistics [CAL], 1982, p. 14), placing significant responsibility on fathers for supporting their family. However, resettlement into their host country result in a drastic change to the fathers' position. In terms of role performance, conflict begins with reversed roles. In their original countries where patriarchy is more pervasive, husbands are the primary source of family income. However, in their adopted society, wives often have an easier time finding employment than their husbands. As a result, wives have greater exposure to the cultural practices of their new country than their husbands are and might start to question their traditional roles (Benmark et al., 2003); meanwhile their husbands take care of the children and house chores. This reversed position has enabled wives to have a voice equal to their husbands within their family, which they may not have had in their old country. Eventually, the reversed-role dynamic between couples may bring about marital conflict and even domestic violence. Husbands who lost their status might become psychologically withdrawn and might abuse their spouses and other family members (CAL, 1982; Fozdar, 2009). Children exposed to marital conflict and domestic violence might be the direct victims of these battles.

**Value conflicts between parents and children.** Value conflicts can arise between parents and their children during their resettlement. Usually, children are more adaptive in acquiring a new language and adopting new cultural norms while their parents could insist on keeping their cultural customs and language (Hyman et al., 2000). Children may prefer the values of their host nation against their parents’ wishes, such as preferring to use the language of the host nation instead of the language of their native countries. Different expectations about value systems could bring conflict between the two generations (CAL, 1982; Fozdar, 2009; Wiene et al., 2004). Moreover, parents who have stronger ties with their home countries may refuse to adapt to the new value system. Regarding parental issues related to adaptation, Brower
(1980) mentioned that adults who are less successful at adapting are more likely to live in the past, preferring their old lives. They may prefer to keep their old lifestyles in the new land while children are eager to copy the ways of their host country.

Parenting conflict. Conflicts between parents and their children due to cultural differences can be an issue that would compromise their relationship. The children may oppose their parents’ disciplinary style. For example, children could view their parents’ disciplinary style as a restriction of their autonomy and freedom, comparing their own experiences to those of their peers in host country (Hyman et al., 2000). As children resist, parents may feel less respected and feel a loss of control over their children (CAL, 1982). Parents might fault the social system for their children's disobedience, feeling that the society is harming their relationship with their children. They see the social system “encouraging children to disrespect their parents by paying welfare allowances directly to children or through encouraging them to ‘tell on’ their parents over issues of domestic violence or corporal punishment” (Fozdar, 2009, p. 1,346). In extreme cases, the breakdown in the relationship might lead to child abuse and parental substance abuse (CAL, 1982).

Reversed roles between parents and children. The reversed roles between parents and their children may be an influencing aspect in their relationship. Children fluent in English mediate the interaction between their parents and their school and other institutions (Björn, 2005; CAL, 1982), placing children in a dominant role over their parents. Rather than feeling protected by their parents, these children take on the responsibility of caring for their family. On the other hand, parents may feel overwhelmed during resettlement process, becoming dependent upon their children (Benmark et al., 2003). In addition, child refugees are under significant pressure from their parents to attain successful academic achievement. DuongTran, Lee, and Khoi (1996) studied Southeast Asian refugee adolescents in their transcultural transition. They found that parents’ expectations for high academic performance caused adolescent refugees’ stress. Young refugees from the diverse range of ethnicities suffer from this stress because parents often believe education will open the door for the possibility of a better life.

Influences of parental mental health status on their children. Parental factors need more attention when discussing current issues of child refugees. As previously mentioned, 75% of refugees are comprised of mothers and their children (PIP, 1996). This demographic feature suggests that mental health studies of child refugees need to consider the parental aspect, particularly the dynamic between parents’ roles and their children’s mental health. Wiese and Burhorst (2007) asserted how susceptible child refugees may be to parents’ psychological issues. Research has revealed correlations between parental psychological distress and their children’s psychiatric symptoms (Dybdahl, 2001; Hodes, 2000). Heptinstall et al. (2004) found a significant correlation between family post-migration stress and child depression. In particular, mothers’ psychological wellbeing was directly associated with their children’s symptoms. Similarly, Dybdahl pointed out the significant role mothers play in their children’s healing process. These findings demonstrate how parents’ traditional role acts as a buffer between their children’s symptomatology and how parental mental health status can positively affect their children’s well-being (Lustig et al., 2004). Conversely, the reality of the parents’ exacerbated symptomatology closely relates to psychological issues of their children. Winship and Knowles (1996) presented the close relationship between mothers’ psychological problems and children's mental health. Their research demonstrated the transmission of unresolved grief and anxiety to even third generation survivors of Holocaust victims; second generation’s repression of interiorized survival guilt intensified these symptoms. Counselors need to remediate the
oversight of prior physical or psychological consequences of refugees’ traumatic experiences by shifting the frontline of research to shed light on the parental sector and its dynamic with child refugees’ mental status.

Benmark et al. (2003) posited that children’s self-regulation ability is dependent upon the emotional stability of their caregivers. When parents are still under the influence of traumatic symptoms from their original countries, their children could be vulnerable to their symptoms. Benmark et al. (2003) asserted that parents traumatized from pre-migration experience adversely affect the parent-child interaction and relationship. To make things worse, traumatic symptoms of parents might cause ‘secondary trauma’ to their children (Wiese, 2010). Considering the critical period for children’s emotional and relational development (Wiese, 2010; Wiese & Burhorst, 2007), the nature of the relationship between parents and children and the emphasis on parents’ mental health needs to be highlighted to prevent children from developing psychopathologies.

**Interventions in Current Use**

While the number of children who are refugees is high across the world and the United States, the body of literature on the treatment of this vulnerable population is surprisingly sparse. The following section is a brief overview of the interventions currently in use.

Hinton et al. (2004) utilized culturally adapted Cognitive-Behavioral Therapy in treating 12 Vietnamese refugees. Treatment involved 11 individual weekly sessions stressing eight core elements. These elements consisted of providing information on the nature of PTSD and panic, training in muscle relaxation and diaphragmatic breathing procedures, culturally appropriate visualization instruction, framing relaxation techniques in terms of mindfulness, cognitive restructuring of fear networks, conducting interoceptive exposure to anxiety-related sensations to treat panic attacks, providing emotional processing protocol to use during times of trauma recall, and exploring headache and orthostatic panic. Hinton and colleagues reported that participants received the CBT interventions well and that the outcomes were efficacious. Participants of the experimental group, as compared to the control group, demonstrated statistically significant reduction in anxiety ($p < .0001$), depression ($p < .05$), PTSD ($p < .01$), as well as large effect sizes.

Doran-Myers & Davies (2011) described Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) as an in-school, 10-session group format for the treatment of children who are refugees and have experienced trauma. In CBITS, students learn about common trauma symptoms, undergo relaxation training and CBT, learn how to face trauma, and begin to develop pro-social peer skills.

Onyut et al. (2005) developed KIDNET, a child-friendly version of Narrative Exposure Treatment. KIDNET as a constructivist-based approach centered on the construction of a detailed chronological account of a child’s life, with particular attention given to any traumatic experiences. The goal of KIDNET is for children to transform the generally fragmented reports of traumatic experiences into a coherent narrative. Children are encouraged to relive emotions while narrating. This process continues until elimination of related fear reactions. KIDNET has been used with six Somali children an African refugee settlement (Onyut et al., 2005), with 16 child survivors of war and Tsunami in North-East Sri Lanka (Catani et al., 2009), and with six children in schools who are refugees and trauma survivors (Doran-Myers & Davies, 2011).

Onyut and associates (2005) reported remission of clinically significant depression for all participants and remission of PTSD symptomology for one third of participants at the 9-month follow up. Catani et al. (2009) described meditation-relaxation training as centered on the
development of mediation and relaxation techniques and exercises. Each session started and ended with 15 minutes of breathing exercise. Catani et al. found that meditation-relaxation training significantly \((p < .0001)\) decreased PTSD symptoms and impairment of 15 child survivors of war and Tsunami in North-East Sri Lanka at one-month post-test.

Each of the above approaches has been demonstrated to be effective with working with children who are refugee survivors. Unfortunately, there is little in literature of the use of these approaches in other settings. Additionally, each of above studies is limited by low sample sizes. A strong need exists for more research in the treatment of children who are refugees survivors.

The National Child Traumatic Stress Network (NCTSN) recommended the use of comprehensive service models in the treatment of children who are refugees and trauma survivors (Doran-Myers & Davies, 2011). A comprehensive service model includes the use of trauma-informed treatment strategies for providing access for child refugees to mental health services, providing culturally competent services, and strategies for helping children who are refugees and the families cope with the stresses of resettlement.

**Discussion**

In reviewing the literature on refugee research trends in child refugee studies, a number of themes surfaced. Post-migration experiences of child refugees are an under-researched area. Family dynamics during resettlement affects child refugees’ mental health. Counselors need to consider these factors when working with child refugees. Through examining the literature, some questions still exist.

When counselors access children’s psychiatric spectrum, they need to consider multi-dimensional aspects. Reactions to child refugees’ traumatic experience are so intertwined with several factors, such as acculturation and resettlement process, that the instruments designed to measure PTSD may fail to discover the variety of symptoms (Berman, 2001). Given the significant role parents play in providing support and care to and serving as momentous influence on their children (Benmark et al., 2003; Wiese & Burhorst, 2007), attempts to understand children’s symptoms and interventions need to be grounded on involving the parents.

In addition, dominant researchers have used a Western-biased lens when portraying and identifying refugees’ symptoms and issues,. The question remains on how well egocentric-based, Western models interpret the symptoms of refugees in their original cultural context, where refugees’ experiences may have different meaning and importance (Bracken, Giller, & Summerfield, 1995). For example, for “Africans” and “ex-Yugoslavs,” “terms for ‘abnormal mental state’ were translatable simply as ‘madness’ or ‘craziness’—mental disorder was seen as an ‘illness’ if it was extreme, and the appropriate response was commitment to mental asylum” (Fozdar, 2009, p. 1,340). Therefore, refugees with similar notions of mental illness might not report their symptoms, nor seek help.

Next, counselors and therapists must attempt to understand the meaning of the traumatic experiences refugees have had, how they construct them in their host nations, and how they adopt them in a rational way to strive for resettlement (Berman, 2001). Further, additional research needs to be done to highlight their resilience and to portray their strength. According to Ingleby (as cited in Fozdar, 2009), researchers on refugees have focused mostly on the trauma approach since the 1980s. The considerable attention to refugee trauma and PTSD indicates a lack of understanding of the positive aspects of refugee adaptation (Schweitzer, Greenslade, & Kagee, 2007). Even though previous scholarly effort was aimed at revealing refugees’
difficulties in order to help them, this excessive focus on refugee trauma played a role in shaping negative stereotypes of this population. In order to depict refugees' resilience and strength beyond their difficulties, a new approach needs to be introduced. This strength-based approach will contribute to creating positive images of the refugee population instead of degrading them as a “less fortunate group.”

In addition, the need for a more practical study is called for. Clearly, in terms of interest in refugee issues, there is a gap between refugees and researchers. To solve their own issues, refugees approach researchers in a social and cultural context (Fozdar, 2009). Conversely, researchers approach refugees in a strictly psychological context, as evidenced by research trends so far. Much quantitative research has identified that social support is strongly associated with the psychological health of refugees (Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006; Jensen, 1996; Schweitzer, Melville, Steel, & Lacherez, 2006). However, despite this research, most refugee therapy has focused on the psychological component at the exclusion of the social paradigm, leaving the refugee without any actual psychological support. Given that most refugees’ concerns are related to work, schooling, and family reunification (Fozdar, 2009), there is a need to implement a more practical study that reflects their needs, providing them with psychological support relative to their needs.

Finally, counselors and researchers need to offer accessible services to refugees. Refugee parents might be concerned about the impact of pre- or post-migration experiences on their children while not knowing how to seek professional help (Heptinstall et al., 2004). Worst-case scenario is that parents and children keep silent about their symptoms and traumatic experiences for mutual protection. This silence might cause them to miss opportunities to obtain professional support and treatment for their emotional needs (Almqvist & Broberg, 1997). As a result, refugees are kept in the darkness without the light of positive mental health services. Counselors and researchers need to take a more aggressive approach to engage this population in the mental health services.

References


**Author Note**

Mi-Hee Jeon, Ed.D., NCC, is a visiting Assistant Professor at St. Lawrence University in Canton, New York. She can be contacted at mjeon@stlawu.edu.

Charles E. Myers, LPC, LCPC, NCC, LMHC, RPT-S, ACS, is an Associate Professor at Northern Illinois University in DeKalb, IL. He can be contacted at cemyers@niu.edu.
Examing Illinois School Counseling as a Social Imperative

Ken Oliver, PhD  
Quincy University

Abstract
Critical self-examination is a difficult process whether occurring at the individual or the systems-level. Self-examination and reflection, while difficult, can provide a wealth of information regarding deficits and often provides clarity in the quest for meaningful change. This article critically examines key issues related to the state of school counseling in Illinois such as school counselor-to-student ratios, professional identity, and school counselor impact, and provides recommendations for meaningful change.

Discussions surrounding the impact of school counselors have persisted for years within the counseling profession (Carey & Demmitt, 2012; Lapan, Gysbers, & Petroski, 2001). In Illinois, distribution of scarce resources has often been a source of contentious debate among policy-makers both at the state and local level. This paucity of funding is often cited as the reason for current school counselor-to-student ratios that far eclipse the recommended ratios suggested by the American School Counselor Association (ASCA) as part of the ASCA National Model (ASCA, 2011; 2012). According to the latest available data (ASCA, 2011), Illinois school counselor-to-student ratios hover around 655-to-one while ASCA recommends a ratio closer to 250-to-one to promote minimally-adequate service delivery.

The ramifications of this lack of adherence to ASCA’s recommendations are not clear. It should be noted that Illinois, however, was recently cited as having the highest rate of high school (i.e., grades 9-12) non-completers in the country (Stillwell, Sable, & Plotts, 2011). Additionally, when this 11.5 percent dropout rate data is disaggregated, it becomes obvious that Illinois has the highest dropout rate in the nation for each visible racial/ethnic group respectively (Stillwell et al., 2011). Black students have a non-completion rate of 20 percent; nearly double that of Arizona at approximately 10 percent, the next closest state. While proponents of increased school counselor presence in Illinois may see this data as both troubling and as cause for change, one major hurdle still exists. Specifically, a significant dearth exists in research to support the impact of school counseling on student performance. In today’s evidence-focused world, calls to improve counselor-to-student ratios, without supporting data, will likely be seen as meritless wishes to stakeholders in charge of funding-related decisions.

Unintended Consequences

While consequences of disproportionate school counselor-to-student ratios may seem obvious to the school counseling advocate, there are also other less obvious, often profound consequences to the lack of mandated school counseling. Illinois stands as one of 19 states that do not, in some capacity, require school counselors at some level within each school (ASCA,
This factor, combined with the opportunity for trained school counselors to secure mental health counseling licensure with minimal additional coursework, allows school counselors who may not secure employment in the schools to seek out employment as clinical counselors. For many, this “stopgap” experience as a clinical counselor may fulfill a specific need, yet fails to promote professional identity as a either a school counselor or clinical mental health counselor, fostering a potential professional identity crisis. This transient practice may also flood clinical mental health counseling with individuals who fail to identify with the profession (Oliver, 2012).

**Strategies for Exploring Counselor Impact**

General “calls to action” notwithstanding (Oliver, 2012), additional strategies need to be employed to effectively examine the impact of school counseling on issues related to student success. While empirical evidence supports the beneficial impact of school counselors on indicators of student success (Carey & Demmitt, 2012; Lapan et al., 2001), more research is needed. Illinois, with its wealth of scholars and practicing clinicians invested in improving the condition of professional counseling within the state, is poised to serve as a model for research on the impact of school counseling. Several strategies intended to promote the study of school counseling impact are suggested below:

1. **Identify relevant stakeholders**
   Illinois universities interested in supporting employment of counseling graduates, school districts, members of professional organizations, parents, administrators, legislators, and other relevant community constituents all benefit with the improvement of student success-related outcomes. Thus, they must all be included in initial conversations and ongoing dialogue regarding findings associated with Illinois school counselor impact.

2. **Utilize existing mechanisms of support**
   Professional organizations (e.g., Illinois Counseling Association and Illinois School Counseling Association) may wish to create a task force (i.e., ad hoc) to deal with this specific, yet wide-reaching dilemma. Strategic planning initiatives which include research, dissemination, and advocacy timelines may be appropriate. Sources of professional literature may wish to dedicate issues to the quantitative and qualitative study of counselor impact throughout Illinois.

3. ** Employ a comprehensive plan of action to explore impact**
   Varied research methods (e.g., qualitative, quantitative, mixed methods, outcome research, action research, secondary analyses, and use of direct and indirect measures) promote a more robust understanding of the phenomenon being questioned. Therefore, no single methodology is ideal for the study of school counselor impact.

4. **Disseminate, disseminate, disseminate**
   The Journal of Counseling in Illinois, Contact Newsletter, and Illinois Counselor Magazine all represent wonderful opportunities to promote, support, and disseminate research on school counselor impact.
5. **Advocate for best practice**
   Once determined, and in accordance with pre-determined strategic planning initiatives, it is appropriate to engage in the advocacy process—particularly at the levels of community, systems, public information, and social/political advocacy (Lewis, Arnold, House, & Toporek, 2003).

   Meant to serve as a point of commencement rather than an exhaustive list, these strategies, if implemented, will assist Illinois school counselors in meeting ASCA’s standard of accountability (ASCA, 2012). Evidence of school counselor impact not only supports the need for additional counseling services, it also strengthens the argument for increased school counselor funding. Furthermore, the implementation of a comprehensive school counseling program is essential to more fully meet the needs of all students in Illinois.

**References**


Author Note

Ken Oliver, PhD, is an Associate Professor of School & Community Counseling at Quincy University in Quincy, IL. He can be contacted at oliveke@quincy.edu.