# Letter from the Editors

Dear Reader,

As you know, the *Tennessee Counseling Association Journal* is now online! This is an exciting new format for *TCAJ* and we are happy to provide you with quick and easy access to *TCAJ*. Please share the website link http://www.tcajournal.org with your colleagues and peers. This transition may be accompanied with a few glitches during the learning process. We appreciate your patience and support.

This is the third publication year of the *Tennessee Counseling Association Journal* and the first year it is exclusively available online. The editors extend their appreciation to the Tennessee Counseling Association's (TCA) and Tennessee Association for Counselor Education and Supervision's (TACES) sponsorship and support in publishing *TCAJ.*

The purpose of the *Tennessee Counseling Association Journal* remains constant: to promote professional growth and creativity of TCA members, Tennessee counselors, counselors nation-wide, and other helping professionals. We hope the empirical research and expository ideas shared in this journal hearten readers to provide best practices to clients, expand notions of counseling, and share innovative counseling strategies with peers.

The target audience for this journal is counselors in all specialties, and we invite manuscripts of interest for professionals in all areas of counseling. We welcome manuscripts that: (a) integrate theory and practice, (b) delve into current issues, (c) provide research of interest to counselors in all areas, and (d) describe examples of creative techniques, innovations, and exemplary practices.

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Sincerely,

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# Essential Knowledge and Skills for Suicide Lethality Assessment

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Suicide is a leading cause of death among U.S. citizens, and it is certain that professional counselors in all specialty areas will work with suicidal counselees. Unfortunately, an unknown truth is that counseling professionals report lacking confidence in working with these individuals. Essential topics needed to prepare counselors to work with suicidal clients are presented, and suggestions are made for how to train oneself or others regarding suicide assessment and awareness.

Suicidal clients are part of every counselor's clientele, and suicide assessment is one of the most vital and stressful decisions individuals trained in the mental health professions will need to make (McAuliffe & Perry, 2007; Sánchez, 2001). In 2000, U.S. hospitals reported treating approximately 264,000 people for nonfatal self-inflicted injuries (Centers for Disease Control, 2002). Given these statistics, it is not surprising that suicide is the 11th leading cause of death among all U.S. citizens and the third leading cause of death among 10-19 year-olds (Hamilton et al., 2007). Among psychology interns, 11.3% worked with a suicidal client during their internship experience (Kleespies, 1993). In addition, 23% of professional counselors from across the nation experienced the death of a client, with some of these deaths occurring when they were training for the profession (McAdams & Foster, 2000). From these study results, it is certain that suicide will touch the lives of all counselors.

Counselors have an ethical and legal obligation to prevent suicide by understanding the signs and symptoms of suicidal ideation, assessing for lethality, and intervening with individuals who display these symptoms. Despite mandates issued in the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) as well as

resources from the American Counseling Association (ACA), and the American School Counseling Association (ASCA), the unfortunate reality is that most mental health professionals lack formal training on suicide assessment (Bromley, 2000; Debski, Spadafore, Jacob, Poole & Hixson, 2007; Feldman & Freedenthal, 2006; Neimeyer, 2000). In a study by Thomas and Leitner (2005), 16% of mental health professionals reported not receiving any training in suicide, and in a study by Allen et al. (2002), 58% of surveyed school psychologists considered themselves to be ill prepared to work with students in crisis. Although it is vital that counselors are well trained in identifying and assessing suicidal clients, these professionals frequently report a lack of confidence in their ability to assess suicide lethality (Debski et al., 2007), and school counselors have reported uncertainty in their ability to assess lethality in their students (King, Price, Telljohann & Wahl, 1999).

Training mental health professionals about the warning signs of suicidal ideation performs a gatekeeping role with the primary intent to identify individuals at risk for suicide in order to get them the appropriate assistance (Cross, Matthiew, Cerel, & Knox, 2007). Yet, despite the compelling reasons for providing this information, training programs for helping professionals often provide inadequate training for their students (U.S. Department of Health and Human Services, 2001), partially due to faculty who have not received training themselves (Bromley, 2000).

Despite the reluctance on the part of some counselor training programs, various counselor training methods have been created for understanding suicidal behaviors and assessment strategies (Sánchez, 2001). For example, a one-hour multimedia training was provided to doctoral-level mental health counselors, as a result of this training, participants' knowledge increased, as did their understanding and confidence in suicide intervention (Knox et al., 2006). Another standardized training program, that included role-play and open-ended questions, resulted in increased ability to resolve the discomfort of dealing with suicide (McAuliffe & Perry, 2007). Clearly, training programs on suicide assessment can be effective.

Unfortunately, when training for suicidal ideation assessment does occur, it tends to be fragmented and minimal, with inappropriate integration of theory and practice (Knox et al., 2006). Regardless of the type of suicide training that is provided, an awareness of risk factors may inform intervention. Knowledge of risk factors should be supplemented with an understanding of outreach, consultation (Neimeyer, 2000), and appropriate steps for prevention and postvention as well as the ethical and legal ramifications such as documentation (Bromley, 2000).

The purpose of this article is to describe the components needed for an appropriate level of training on suicide assessment. This training is based on *best practices* from the literature, and includes: a) the historical issues of suicide; b) personal reflections about suicidal behaviors; c) warning signs and assessment of lethality; and d) interventions. An individual seeking to learn more about suicide lethality assessment may access the resources presented below, or a professional counselor seeking a comprehensive program to train helping professionals about suicide may utilize the following training plan.

## Historical Foundation of Suicide

A brief review of the history of suicide helps counselors to recognize that, from a historical perspective, suicidal beliefs and attitudes of today are similar to those of the past. Too often people believe that suicide is a reflection of the issues surrounding 21st century society, without recognizing that the first reference to suicide was over 4,000 years ago, and that the same moral debates surrounding self-killing are repeated throughout history (Granello & Granello, 2007). Philosophical debates, beliefs, and attitudes surrounding the topic of suicide have been similar throughout the years. Stoicism, for example, is a philosophical belief that suicide is a personal, rational choice in which each individual has a right to choose when to die; another perception viewed suicide as a selfish act without regard to the impact on significant others (Patterson, 2005). Today, human service professionals have a legal and ethical responsibility to prevent suicide regardless of individual perspective about suicide.

Despite historical debates surrounding self-harm, religions have been mediators of suicidal viewpoints, and in the 1600's, some churches passed laws forbidding suicide. In the 1700's suicide began to be defined as a component of an emotional illness (Patterson, 2005). Even with the recognition that suicidal people were suffering from emotional issues, it was not until 1958 that the first local suicide prevention center was established (Suicide Prevention Resource Center, n.d.). Finally, in the mid-1980s, the U.S. government began significant funding for research, education, and treatment to prevent suicide (American Foundation for Suicide Prevention, n.d.). So, while suicide has been discussed for centuries, only recently have prevention efforts moved beyond conversations about moral decision-making surrounding the act of suicide.

## Personal Reflections on Suicide

Individual attitudes and beliefs surrounding suicide are essential training considerations as these attitudes may determine the practitioner's action. For instance, in a study examining differences in suicidal attitudes held by younger and older adults, results demonstrated that older adults believed suicide was more acceptable and related to a lack of religious ideology than did younger adults (Segal, Mincic, Coolidge & O'Riley, 2004). In addition, Neimeyer, Fortner, and Melby (2001) found that practitioners who believed suicide was a personal choice were less effective in assisting self-harming clients. Counselors should examine their personal views on suicide to ensure that they are putting safety and the needs of their clients first.

Many counseling practitioners report anxiety and fears of incompetence when they work with a suicidal client (Thomas & Leitner, 2005). When practitioners explore personal fears of life and death situations in a supportive environment, personal vulnerabilities that could negatively impact the counseling situation may be addressed. Thomas and Leitner examined styles of suicide intervention in which *fight* and *flight* were two common problematic responses displayed by mental health practitioners when working with a suicidal client. When a *fight* response was assumed to prevent the suicide from occurring, the client's feelings of hopelessness were exacerbated as the client's autonomy was lessened. When the practitioners assumed a *flight* response by not asking the client about suicidal intentions to avoid dealing with what might be a distressing situation, therapeutic rapport and trust was diminished. In either case, clients may suffer as a result of counselors' unexplored personal feelings about suicide.

Counselors should also reflect on the explanations given for suicidal behavior. In a study exploring beliefs about suicide (Zadravec, Grad & Socan, 2006), general practitioners, psychiatrists, and laypeople identified several different explanations for suicidal behavior. Laypeople and general practitioners explained suicide through the idea of a crisis model in which suicidal behavior was seen as a reaction to severe stress. Psychiatrists, on the other hand, promoted the medical model in which suicidal behavior was characterized as a changed mental state. All three groups recommended therapy for suicidal persons. In a study investigating teachers' opinions about suicide (Wastell & Shaw, 1999), mental illness and a cry for help or attention seeking were the highest rated explanations of suicidal behavior. Teachers were likely to explain suicide as an act of impulsiveness. It seems that views on suicide vary greatly amongst people in the helping fields and in the general population.

Counselors may identify their personal beliefs regarding suicide in a number of ways. *The Suicide Opinion Questionnaire* (Domino, Moore, Westlake & Gibson, 1982) and the *Questionnaire on Attitudes Toward Suicide* (Salander-Renberg & Jacobsson, 2003) are instruments that identify personal feelings related to those with suicidal behaviors. Counselors can self-administer these surveys to examine their personal beliefs about suicide; in a group training setting, counselors could take items from one of the surveys and discuss their thoughts and opinions with other group members. Counselors may also examine the personal effects of suicide in their own lives. Being personally affected by suicide can bring about profound feelings that could lead to transference issues with suicidal clients. Whichever method of introspection counselors engage in, taking time

to process personal feelings and beliefs associated with suicide is an essential part of any model used in suicide training (Neimeyer et al., 2001).

## Warning Signs and Assessment of Lethality

Suicide warning symptoms and methods to determine lethality are common components of training programs, because counselors must have a thorough understanding of verbal, behavioral, and physiological symptoms. The following section provides a brief overview of warning symptoms and a detailed exploration of assessment models that may be considered in determining suicidal risk.

### *Warning Signs of Suicide*

Often, the best way to learn about warning signs is simply to explore the literature and appropriate, research-based websites. For example, counselors are encouraged to read articles by Barrio (2007) and Capuzzi and Gross (2004) along with visiting websites sponsored by The National Strategy for Suicide Prevention (http://mentalhealth.samhsa.gov/suicideprevention/) and The Centers for Disease Control and Prevention (http://www.cdc.gov/). These articles and websites serve as examples of thorough descriptions of suicide warning signs along with information on how culture affects suicide warning signs. It is vital that helping professionals thoroughly learn all of the potential warning signs; they also must understand that no two suicidal clients are the same.

Warning signs of suicide may be verbal, behavioral, or physiological. Verbal signs may include both the specific mention of suicide and indirect comments about living. Indirect comments may include: "I hate this life," "Nothing matters anymore," and "Everyone would be better off without me" (suicide.org, n.d.). Indicators also may come in the form of journal entries or poems. Behavioral warning signs include feelings of hopelessness or worthlessness, changes in work or school behavior, reckless behavior, substance use, and social withdrawal (American Association of Suicidology, n.d.). Finally, examples of physiological warning signs include sleep pattern changes, loss of energy, and weight changes (suicide.org). It is important to note that other warning signs may be present as well and that not all of these warning signs will be exhibited by every suicidal person.

### *Assessment of Lethality*

Obviously, the best way to start a suicide assessment is to interview the client and ask, "Are you thinking of killing yourself?" Many counselors combine this questioning with a paper-and-pencil lethality instrument to confirm suicide intent (Westefeld, Range, Rogers, Maples, Bromley & Alcorn, 2000). Some agencies and school districts have required forms for this purpose. Unfortunately, there is no existing suicide instrument or single scale that provides a perfect assessment of suicide lethality (Kleespies, Deleppo, Gallagher & Niles, 1999, as cited in Rogers, Lewis & Subich, 2002; McAuliffe & Perry, 2007). In an investigation of the types of suicide assessment tools used by school psychologists (Debski et al., 2007), most respondents indicated that they did not use a standardized suicide risk assessment instrument, but instead relied on a student interview to determine suicide lethality. Therefore, three types of practical suicide lethality assessments that combine many suicide-related factors are presented. Counselors can then select the most appropriate assessment for their particular clientele.

The DIRT/SLAP model (source unknown) is an acronym-based assessment of suicide intent and immediate risk of suicide. This commonly used acronym (Granello & Granello, 2007) makes this model easy to remember and offers a quick way to assess suicidality. DIRT, stands for Dangerousness, Impression of degree of risk, Rescue, and Timing; the second acronym, SLAP, represents Specifics, Lethality, Availability, and Proximity. This acronym assists in determining immediate suicidal risk and an examination of past suicide attempts. For example, in determining *dangerousness*, the counselor is trying to identify the

level of danger or lethality in the attempt or plan. One negative to this model is its lack of other underlying aspects of suicidal behavior such as sexual orientation, substance use, and mental health history. After gaining this additional information through an interview, counselors can determine lethality and move toward intervention options (described later).

The *Suicide Assessment Checklist* (Rogers, Alexander & Subich, 1994) is used to assess suicidal risk from a list of related factors. These risk factors include the client's suicide plan, previous mental health issues, substance use, recent losses, and demographics, along with a section asking for clinical impressions of the client. The counselor uses the total score from the two parts of the assessment (i.e., risk factors and clinical impressions) to assist in determining suicide lethality. While this instrument is more comprehensive than the DIRT/SLAP model, it is necessary to use the actual assessment tool as a guide and may result in an uncomfortable, impersonal interview rather than one based on empathy and concern. Paying close attention to therapeutic rapport can help alleviate these issues.

The SAD PERSONS Scale (Patterson, Dohn, Bird & Patterson 1983) is a third option, and like the first model, uses an acronym in which each letter stands for a suicide-related factor. This scale includes demographics (Sex, Age), mental health status (Diagnosis), history of attempts (Previous attempts), substance use (Ethanol/drugs), current psychological state (Rational), support systems (Social support), suicide plan (Organized plan), and overall health status (No spouse, Sick) for determining suicide lethality. Similar to the DIRT/SLAP model, the acronym helps with remembering some critical aspects of suicide risk, but also excludes some suicide risk factors. Once again, counselors can use the information to determine lethality and move toward providing appropriate interventions.

Overall, counselors are to consider multiple risk factors in their suicide assessments such as previous suicide attempts, specifics of the current suicide plan including accessibility and lethality level, recent losses, a current event prompting suicidal thoughts, medical and mental health history, substance use, and access to support systems. In addition, the practitioner should have an awareness of the demographic risk factors that increase the likelihood of suicide (e.g., adolescence or older individuals, gender, marital status). In choosing a lethality assessment, counselors need to consider which approach best matches their population. Formal assessments can serve as a reminder of the factors that are associated with suicidal risk behaviors (Granello & Granello, 2007).

## Simulated Experiences

Information alone does not prepare counselors for the necessary steps that need to be taken with suicidal clients. Our experiences and those of other researchers (Fenwick, Vasillas, Carter & Haque, 2004; Kleespies, 1993) suggest that an essential part of the training process is to practice a suicide assessment through simulated exercises, which may occur in a number of ways. For example, psychology students being trained to respond to crisis calls were given feedback after answering calls from simulated suicidal clients. These students role played as the responsive counselor using actual cases of suicidal clients (Kleespies). Another study (Fenwick et al., 2004) compared two types of suicide training programs and the impact of these programs on skills and confidence in working with suicidal clients. In one program, lecture and small group discussion were combined with an experiential opportunity to observe and assess a professional actor who was given a brief "script" of a suicidal client. This format was compared to a lecture and large group discussion with opportunities for the participants to role-play either a suicidal client or a counselor assessing for suicide. Results indicated that both of these training methods were equally effective, in part because both used experiential activities.

Counselors who have never assessed suicide lethality may be uncomfortable with the process, and role-plays in a trusting, safe setting may help overcome these feelings. For example, we created the following scenarios to use as role-play situations in a recent suicide lethality training session.

> Tanya, age 11, is a 6th grader at Butterfield Middle School. She has difficulty in her courses and was held back a grade two years ago. Today, she received her report card, which has mostly C's and D's, and she knows her mother will take away her dance class, which is her favorite activity. Tanya decides to visit her school counselor and asks if her math grade can be changed to a B since she has been trying harder in the class. The counselor explains that she has spoken to the math teacher and knows that Tanya has neglected to turn in homework. Tanya becomes enraged and yells that no one understands her and that life is not worth it.

> Mark is a 45 year-old divorced male. He has walked into your agency because he is having a hard time dealing with his current divorce. Mark insists that he is fine and merely suffering from the 'blues.' He states that he has no desire to kill himself, although he does add: "If I were to kill myself, I know exactly how I would do it."

Counselors unfamiliar with suicide lethality assessment could role play these scenarios with a professional peer. An assessment model may be selected from those listed above or one from their place of employment, and then the lethality assessment process can be practiced. More importantly, after the role play, counselors should discuss with their partner: a) the difficult parts of the role play, b) the thoughts and feelings about the role play, and c) the thoroughness of their assessment. Alternatively, counselors can facilitate discussion of these factors when conducting a workshop for helping professionals.

## Interventions for Suicidal Clients

Finally, interventions commonly implemented in school and agency settings should be thoroughly examined. These may include: a) determining the client's support systems; b) contacting parents/guardians; c) creating no-harm contracts; d) consulting; e) providing counseling services, f) hospitalization and/or involuntary commitment; g) debriefing; and h) follow-up procedures. It is vital that counselors know about the support programs available in their local community as well as those that are available for people with and without insurance coverage.

Counselors should remember that interventions often are based on their employment settings and that interventions at a mental health agency differ greatly from those at a public or private school. For example, at a school where counselors are working with minors, contacting parents or guardians is typically required, even if suicidal lethality is considered to be very low. Additionally, best practice requires the school counselor to hold the student at school until a responsible adult arrives. It is possible that principals and teachers may be notified when a suicide assessment occurs. This practice differs greatly from the mental health setting, where the client is either an adult or accompanied by an adult at the time of the suicide assessment.

Mental health professionals need to understand office policy and make the appropriate contacts. Often, this may mean a follow-up appointment or insistence that the client goes immediately to the emergency room for possible inpatient care. In either case, counselors must familiarize themselves with required procedures for their workplace and create a list of community resources for suicidal clients.

An additional training component to consider is dealing with the emotional aftermath when a client does complete suicide. Knox et al. (2006) investigated mental health trainees who experienced the death of a client by suicide during their internship experiences. Trainees expressed a wide range of reactions that were exacerbated by their inexperience and vulnerability. Furthermore, study participants reported increased vigilance in attending to potentially suicidal clients and lingering reactions in response to the suicide. Based on this result, common therapist reactions following a suicide may be considerations for training sessions.

## Discussion and Conclusion

Counselors are responsible for knowing how to work with suicidal clients. In some states, such as Tennessee, suicide prevention training is required for all public educators each year (Suicide Prevention Resource Center, n.d.). As part of this process, several components of appropriate training are listed. Counselors may choose to learn this information on their own or find a workshop that covers the topics. As part of the mental health and school counseling programs at our university, for example, mandatory suicide lethality assessment training has been provided for the past three years and has addressed each of the listed sections. An opportunity to role-play a suicide lethality assessment is included in this training module in order to allow the students to practice their new skills. In the role-play exercises, students were asked to select one of the previously discussed assessments to use in completing a thorough lethality assessment.

Based on the evaluation results at the end of each workshop we present, participants found the workshop to be both useful and interesting. On a five-point Likert-type scale (1 = *poor*, 5 = *excellent*), the mean rating for the presenters was 4.73 and for the overall presentation was 4.64. The assessment of lethality and warning signs sections were rated by participants as the most helpful parts of the workshop, which affirms the importance of role-play experiences. In addition, many participants answered an open-ended question about the most beneficial part of the workshop, and indicated that the role-play exercises were the most valuable workshop component.

Suicide assessment is a necessary skill for counseling professionals. With the high rate of suicidal ideation in our society, counselor educators would be remiss if this skill and knowledge were not included in their curriculum. In fact, American School Counseling Association (ASCA), American Counseling Association (ACA), and Council for Accreditation of Counseling and Related Educational Programs (CACREP) promote training on issues that could negatively impact development and growth. Although many counselor education training programs incorporate a knowledge base of suicide theory and assessment in their curriculum, training is often inconsistent and randomly addressed. When counselors intentionally implement a training plan and reflect on their knowledge about suicide, they will feel less apprehensive and more prepared in their ability to work with a suicidal counselee.

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# Women, HIV, and Depression: A Review of the Literature

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With women representing 25% of all new AIDS cases in the United States (CDC, 2001) and a lifetime prevalence for depression occurring in 20% of women (Mazure, Keita, & Blehar, 2002), it is imperative to understand the adverse effects these two risk factors create for women. After reviewing the literature on women with HIV and depression, three themes emerged: effects on mental health, effects on physical health, and effects on special populations. When working with women with HIV, counselors should tailor counseling to reflect what the clients perceive as important, counselors may want to collaborate with clients' physicians to ensure quality care, counselors may want to include family members in counseling, and counselors may want to increase their multicultural competence.

The majority of the literature on HIV researches male populations; however, women are increasingly at risk of HIV infection. It is one of the leading causes of death for women aged 25-44 (Evans, Mason, Bauer, Leserman & Petitto, 2002). According to the Center for Disease Control and Prevention (2008), women represent over 25% of all AIDS cases. In addition, women are at an increased risk of developing depression, with Mazure, Keita and Blehar (2002) reporting that 20% of all women will experience depression at some point in their lifetime. Given these two risk factors, it is imperative to address how depression is impacting women who are HIV positive.

Depression is one of the frequently reported psychological responses to HIV (Hudson, Kirksey & Holzemer, 2004). Women with HIV are four times more likely to be depressed than women without HIV (Morrison et al., 2002). In addition, depression in HIV positive women is associated with lack of adherence to life prolonging medications (Catz, Kelly, Bogart, Bentsch, & McAuliffe, 2000; Schuman et al., 2001) and it advances the progression of the disease (Cook et al., 2004; Ikovics et al., 2001). Therefore, depression is not only burdensome, but life threatening as well. Depression does not, however, have to reduce the quality of life for individuals with HIV. For example, Laperriere and colleagues (2005) performed a ten-week group therapy intervention for women with HIV and depression utilizing cognitive behaviors techniques and other interventions. After

the intervention, the improvement in depression scores was still maintained at the one year follow up. Therefore, it is imperative that women with HIV and depression be treated for both conditions to reduce adverse effects.

Hadler, Smith, Moore, and Holmberg (2001) performed a comprehensive literature search and evaluation over HIV in women. Their research was a comprehensive review of the literature spanning from 1981 through 2000. Therefore, this present literature review chronologically extends the research commenced by Hadler and colleagues with a concentration on depression in women with HIV through 2008. This review will include the literature concerning women with HIV and depression. This research was conducted via a comprehensive search in the PsychInfo database. The terms searched included women, depression, and HIV. In addition, the researcher analyzed references included in published works. The intent of this paper is to gain a greater understanding of the impacts of HIV on women and on their mental health, specifically depressive mood status from 2000 to the present.

Several large cohorts throughout the United States were developed to increase knowledge about HIV infected women (Hadler et al., 2001). The majority of the current research reviewed is still coming from these large samples of cohorts such as the Family Health Project Research Group (Ball, Tannenbaum, Armistead & Maguen, 2002; Devine et al., 2000; Jones, Beach, & Forehand, 2001a, 2001b; Jones, O'Connell, Ground, Heller, & Forehand, 2004), the Women's Interagency HIV Study (Cook et al., 2007; Cook et al., 2006; Cook et al., 2004; Richardson et al., 2001; Schuman et al., 2001), the HIV Epidemiology research Study (Milan et al., 2005; Schuman et al., 2001), the HIV Cost and Services Utilization Study (Turner & Fleishman, 2006), and the Women and Family Project (Gurang, Taylor, Kemeny & Myers, 2004). Of the 35 total studies included in this review, 14 of the studies came from these five main sources. Based on an analysis of the literature related to depression and women with HIV, three themes emerged: 1. attention to mental health, 2. attention to physical health, and 3. attention to special populations. The majority of the research utilized quantitative research designs while a few utilized mixed method designs.

## Attention to Mental Health

Depression can be a pervasive problem for any individual. When this issue is compounded with HIV, women often notice other areas of their life being affected by the depression. Common areas, where a decline has been reported, include the quality of life and ability to deal with chronic burdens like socioeconomic status. However, one's ability to cope in a given situation or ability to rely on a social support system may result in lower rates of depression in women with HIV.

### Quality of life

With the ever-improving quality of medical interventions, HIV is becoming a chronic illness (Hudson et al., 2004). Given this information, it is important to assess women with HIV from a holistic perspective and learn how this disease affects individuals' quality of life. According to Hudson et al., quality of life was defined as being comprised of the well-being of three components: psychological, physiological, and social. Therefore, the intent of the research measuring quality of life was based on these three assessments.

To determine the impact on quality of life, Moneyham, Sowell, and Seals (2000) conducted a three-year longitudinal study assessing depression, among other variables, in African American, HIV positive women. The other studies related to quality of life (Hudson et al., 2004; Tostes, Chalub & Botega, 2004) were conducted through a one-time assessment. Each study measured depression through different instruments. All three studies reported higher means on these depression inventories than the normed means. Across the studies, higher depression scores were associated with poorer quality of life. Depression was also reported in epidemic levels. For example, Hudson et al. (2004) reported that 81% of their sample had clinical levels of depressive symptomalogy. When assessing the psychological side of quality of life, depression was associated with lower self-

esteem, higher anxiety levels, and difficulty concentrating (Moneyham et al., 2000; Tostes et al., 2004; Hudson et al., 2004). Even with the psychological health concerns, Tostes et al. found very few individuals from their sample sought help for these negative mental health symptoms.

Physical health also significantly influenced the depression and quality of life results (Hudson et al., 2004; Moneyham et al., 2000; Hudson et al., 2004; Tostes et al., 2004). Tostes et al., when assessing quality of life in women in Brazil with HIV, created three subgroups: those individuals that were asymptomatic, individuals with physical symptoms of HIV, and individuals with AIDS. Of these three groups, the individuals with physical symptoms of HIV had the lowest quality of life, where 30.3% of the sample was considered depressed. The final component encompassing quality of life was social health (Hudson et al., 2004). Hudson et al. found that of the three components of quality of life, social quality of life was the least impacted from the virus, but this does not mean that social quality of life may not be affected. Hudson and colleagues did report that the physical symptoms of HIV were noted for disturbing functional roles. Moneyham et al. reported depression was associated with less family support and family cohesion. This suggests that increasing social resources will decrease depression in HIV positive women.

## Coping

Lazarus and Folkman (1984) defined coping as a process in which individuals utilize behaviors and cognitions to manage perceived difficult situations. They divided coping into two categories: emotion- or problem-focused coping. Emotion-focused coping was defined as coping strategies that target the emotions to achieve emotional equilibrium such as prayer, optimism, and social support. Problem-focused coping is defined as task-oriented behaviors. Utilizing coping behaviors may help with levels of depression. For example, Catz, Gore-Felton, and McClure (2002) and Moneyham et al. (2000) found that individuals who infrequently utilized coping strategies had greater amounts of depression.

While coping is traditionally viewed as a positive behavior, both types of coping (emotion- or problem-focused) do not necessarily produce beneficial effects on the individual. Ball et al. (2002), when assessing coping in African American women with HIV, divided the sample into two groups: those experiencing physiological symptoms of the virus and those who were asymptomatic. Of the individuals who were experiencing physical symptoms, fewer depressive symptoms were reported if problem-focused coping was utilized less frequently. This was not true, however, for asymptomatic women; these women experienced less depressive symptoms when they utilized problem-focused coping. Ball and colleagues further reported that emotion-focused coping strategies positively impacted depressive symptoms in both groups. Simoni and Ng (2000) explored the impacts of coping with predominately African American (46%) and Latina (47%) women with HIV living in New York City who had a history of physical or sexual abuse. Avoidant coping, a type of emotion-focused coping that ignores cues associated with the traumatic event or isolating oneself, was associated with increased depressive symptoms. Within this study, how easily one adapts to circumstances, the utilization of avoidant coping strategies, and history of childhood abuse explained 41% of the variance in depressive scores. Other research studies support the association between avoidant coping strategies and increased depression (Catz et al., 2002; Gurang et al., 2004; & Moneyham et al., 2005). Catz et al. also reported failure to plan as a coping strategy associated with depression.

Devine et al. (2000) explored the emotion-focused coping strategy of optimism in women living with and without HIV. The relationship between depression and optimism was not a simple linear relationship for those women with HIV. In the infected sample, extremely high and extremely low levels of optimism correlated with fewer depressive symptoms; yet, individuals with moderate levels of optimism had the most depressive symptoms. However, Jones et al. (2004), when assessing optimism in African American women with and without HIV, only found that less optimism was associated with depression in women with

HIV. Gurang et al. (2004) reported similar results with Latina women; higher optimism scores were associated with lower depression scores.

## Social Support

Multiple studies assessed social support for women infected with HIV and predominately reported that a lack of social support was positively associated with depression (Catz et al., 2002; Gurang, et al., 2004; Milan et al., 2005; Moneyham et al., 2005; Richardson et al., 2001; Schrimshaw, 2002b; Schrimshaw, 2003; Simoni & Cooperman, 2000). Furthermore, Gurang et al. as well as Richardson et al., found that lack of social support was one of the greatest predictors of depression. When assessing for clinical depression in these samples, prevalence of clinical depression ranged from 58-61% (Milan et al., 2005; Schrimshaw, 2003; Simoni & Cooperman, 2000). However, in Milan et al., if physiological responses to depression (e.g., changes in sleep patterns or weight change) were not included, the rates of depression dropped to where only 44% of the women were considered to be clinically depressed. Milan et al. conducted their research over a five-year period and were able to also demonstrate that depression was stable over time.

When Simoni and Cooperman (2000) examined social support among other variables (abuse and individual strengths) in mostly Latina and African American women living in New York City, they found that social support was beneficial and was positively associated with psychological adaptation to HIV. In addition, increased social support and spirituality were associated with fewer depressive symptoms and better perceived physical health. Schrimshaw (2003) assessed the impact that perceived social support, conceptualized by type of social support (spouse/partner, family member, friend), affected depression in women with HIV. They reported that in their sample, fewer unsupportive events occurred with friends compared to family or spouse/partner. When unsupportive acts by friends, families, and partners increased depressive symptoms also increased. However, unsupportive interactions by family were the acts that were the most detrimental to depression. Unsupportive interactions between friends and a spouse/partner and high levels of unsupport from either system increased levels of depressive symptoms. It is important to note that unsupportive interactions by friends only impacted depressive symptoms, if they were paired with unsupportive acts by a partner. Therefore, only when an individual is experiencing unsupportive acts by a partner will the unsupportive acts by a friend be associated with depression scores.

Schrimshaw (2002b) assessed depression, perceived social support, social integration, and social conflict in African American, Puerto Rican, and European American women with HIV living in New York City. No relationship was found between depression and the availability of individuals for social support. However, depressive symptoms were associated with decreased social integration and increased social conflict. Milan et al. (2005) also assessed social conflict in HIV positive women and comparable to Schrimshaw (2002b), partner conflict predicted depression in this sample. However, depression did not predict partner conflict.

### *Chronic Burden*

Chronic burden, defined as anything contributing to incessant stress in an individual's life such as socioeconomic status, illness, violence, or familial difficulties, negatively impacted women with HIV (Catz et al., 2002; Gurang et al., 2004; Moneyham et al., 2000; Richardson et al., 2001; Schrimshaw, 2003; Simoni & Ng, 2000). Catz et al. found chronically elevated stress levels and more life stressors were associated with more depressive symptoms. Richardson et al. found, in their sample of predominately Latina and African American women living with and without HIV, chronic burdens such as poverty and domestic abuse seemed to predict depression in women infected with HIV. This difference in depression rates could not be attributed to demographic differences, because regardless of HIV status, both groups were demographically equal. Gurang et al. also

examined how chronic burden impacts depression in women (Latina, African American, and European American) with and without HIV. Therefore, both Gurang et al. and Richardson et al. were able to compare the impact HIV may have on women. However, researchers only surveyed a population of HIV positive women (Moneyham et al.; Simoni and Ng; and Schrimshaw). Gurang et al. found that in both the HIV positive and HIV negative groups, chronic burden was associated with less optimism, less social support, increased utilization of avoidant coping strategies. However, depression scores were higher in the HIV positive sample when compared to the HIV negative population. In opposition to Gurang et al., Richardson et al. found that within their sample, there were no significant differences in depression by HIV status. It is important to note that in Richardson et al. both those with and without HIV had comparable depression diagnoses (57.7% for those who were HIV positive and 55% for those who were HIV negative). In both populations, the greatest predictors of depression were low socioeconomic status, domestic violence, and substance abuse. Of these three, the strongest predictor of depression was abuse by an intimate partner. However, Simoni and Ng (2000) reported childhood abuse (physical and sexual) had a greater impact on current depressive symptoms than abuse that occurred as an adult.

Gurang et al. (2004) additionally assessed differences divided by ethnicity. In their sample, African American women had the highest levels of depression. For the African American women, chronic burden was one of the greatest predictors of depression and this variable was more influential than HIV status. Across races, depression was associated with chronic burden, lower education, decreased optimism, and decreased social support. In Schrimshaw (2003), several factors correlated with increased depressive symptoms including race. Schrimshaw found that Puerto Rican women with HIV had more depressive symptoms than Caucasian and African American women with HIV.

Moneyham et al. (2000) found that depression was associated with environmental (economic-tangible, social, and family) resources. Similarly, Gurang et al. (2004) found that lower socioeconomic status was also associated with depressed mood. Catz et al. (2002), when examining psychological distress in minority women with HIV living in poverty, found three fourths of their sample reported scores from at least mild, and up to severe, depression symptomalogy. In Schrimshaw (2003) several factors correlated with increased depressive symptoms including increased HIV physiological symptoms, income less than $20,000, and educational attainment less than high school.

## Summary

Morrison et al. (2002) reported that women with HIV are four times more likely to experience depression than the general population. Both the depression and HIV status may influence and be influenced by other psychological factors such as quality of life, chronic burden, and social support. Hudson et al. (2004) reported that mental and physical quality of life are impacted the greatest by depression and HIV and social health was moderately impacted by HIV and depression. However, social health was mostly influenced by physical health, which is obviously impacted by the virus. Therefore, it is imperative that counselors be thorough in their assessment of the psychological health of the client. Counselors may also want to examine what support systems these women have and how compassionate these support systems are for the women with HIV. Schrimshaw (2003) reported that negative interactions by family members are the most harmful for women with HIV and that it is associated with increased depressive symptoms. How women cope with difficult situations may increase depression; for example, avoidant coping strategies are associated with increased depression (Catz et al., 2000; Gurang et al., 2004; Moneyham et al., 2005). Therefore, counselors should explore what coping skills women with HIV are utilizing and how these coping strategies are impacting potential depression. Finally, understanding what chronic burdens these women face, such as socioeconomic status, may help counselors to conceptualize stressors that are contributing to depression.

## Attention to Physical Health

While the focus of this review is on depression in women with HIV, the physical component of the illness cannot be ignored. The influence depression may have on the progression of the illness is prevalent throughout the literature. Even though it cannot be determined that depression is the cause of the progression of illness, it does make one wonder if traditional depressive symptoms like feelings of hopelessness or lack of energy to engage in normal activity may influence one's adherence to treatment. Therefore, the illness may progress more rapidly with individuals who are depressed and lead to higher mortality rates.

### Immunology and HIV

Traditionally, discussion concerning progression of HIV revolves around CD4 counts, natural killer cell activity, viral loads, and CD8 T lymphocytes (Cruess et al., 2005; Evans et al., 2002; Jones et al., 2001a). While the scope of this paper is not intended to be an in depth understanding of the immunology of HIV, a brief description is provided. CD4 counts are an indication of the strength of the immune system; as HIV progresses CD4 counts decrease, with counts less than 200 typically indicating an AIDS diagnosis (Evans et al., 2002; Jones et al., 2001a). Natural killer cell activity also decreases as HIV progresses (Cruess et al., 2005; Evans et al., 2002). In addition, HIV is associated with higher CD8 counts and activation of the CD8 cells (Evans et al., 2002). CD8 cells recognize the viral infected cells. Viral loads indicate how the disease is progressing (Evans et al., 2002; Cruess et al., 2005).

Three longitudinal studies assessed the immunology of HIV and depression (Cruess et al., 2005; Evans et al., 2002; Jones et al., 2001a); each utilized the same depression inventory; thus, there is consistency among the findings. Jones et al. (2001a) performed a longitudinal study assessing depression, physical symptoms, and CD4 counts in HIV positive African American women, with the time between the initial and second assessment being twelve to fourteen months. Within this sample, depression was positively associated with physical symptoms at the second assessment. Interestingly, depressive symptoms at the first assessment were not associated with CD4 counts at the final assessment. However, correlations were not run to see if there was an association between depressive symptoms and CD4 counts at the initial assessment.

Both Cruess et al. (2005) and Evans et al. (2002) were concerned with the impact depression has on the disease progression of HIV, specifically the cellular activity of the natural killer (NK) cells. Evans et al. also investigated the effects of depression on CD8 T lymphocytes. HIV is known for decreases in immune activity, specifically NK cells. Cruess and colleagues reported that depressive symptomology was associated with the NK cellular activity within the immune system. Evans et al., through their examination of the effects of depression on NK cells and CD8 T lymphocytes in women with HIV, found that HIV positive women had higher rates of depression than HIV negative women. In addition, HIV positive women had higher CD8 counts and activation of the CD8 cells, surprisingly, there were no differences reported with NK cellular activity (Evans et al., 2002). When factoring in depression, HIV positive women had significantly higher viral loads, higher CD 8 T lymphocytes counts, and lower NK cellular activity. This suggests that progression of the virus could be linked to depression and thus depression may impair the immune system. It appears reducing depressive symptoms is key in improving the mental and physical health of HIV positive women.

#### *Treatment*

Cook et al. (2006) examined utilization of highly active antiretroviral therapy (HAART) and depression. HAART is currently one of the prominent and highly effective series of medications for HIV. In the study sample, 67% of the participants were considered to have probable depression. Women were less likely to be on a HAART regimen, if they were African

American and reported drug use (heroin, cocaine, and crack). The authors stated that the best practices for treatment of depression were mental health counseling and utilizing antidepressant medications. Although, counseling alone, also produced auspicious results. Women who were on this best practice for improving depression were more likely to also be on a HAART regimen (the considered best practice for the treatment of HIV). Thus, indicating a consistency across the quality of care in this population.

Quality of care across racial ethnic backgrounds is a concern. Turner and Fleishman (2006) reported that Latina and African American women with dysthymia were the least likely to be using a HAART regimen. This discrepancy equated to 50% less chance of using HAART when compared to Caucasian men without a history of dysthymia. Furthermore, women were more likely to have dysthymia and Hispanic women had the highest rates of dysthymia across all ethnicities.

Not all studies are grim about the amount of people in minority groups that have access to the HAART regimen. Remien et al. (2006) in their study across four major U.S. cities in a predominately African American sample (61%) with Latinas representing the next largest ethnic group (20%) found that almost three-fourths of their sample was using HAART. This was the rate despite the fact that 41% of the sample had severe or moderate depression.

Sleep may also play a role in the relationship between depression, sleep disturbance, and medication adherence. Phillips et al. (2005), in their study with HIV positive, low income women in the southeastern U. S., reported that two thirds of their sample experienced sleep disturbances and scored high in depressive symptoms. While sleep disturbance was associated with lack of medication adherence, depression was the greatest predicator of lack of adherence to medication. The results for sleep disturbance and adherence became insignificant when depression was factored into the equation. Therefore, suggesting the influence depression may play in adherence to medication.

*Mortality*

Research continues to explore the impact depression may have on mortality (Cook et al., 2004; Ikovics et al., 2001). Both studies included in this review assessing HIV disease progression in women with depression were seven-year longitudinal studies with similar methodical designs and demographic compositions (Cook et al., 2004; Ikovics et al., 2001). For example, in the Ikovics et al. study, racial composition from the 765 women was 62% African American, 21% Euro Americans, and 18% Latina. In addition in the study by Cook et al. their sample size of 1716, had a racial makeup of 55% African American, 23% Latina, and 22% other. Not surprisingly, given the resemblance of both studies, results were also comparable. Ikovics et al. reported that 42% of their sample was classified as chronically depressed, i.e. clinically depressed for a minimum of 75% of the visits with researchers. Cook et al. reported that 32% of their sample had probable depression during a minimum of 75% of the visits. Furthermore, Cook et al. found an additional 37% of their sample had probable depression intermittently.

Ikovics et al. (2001) reported women with chronic depression were twice as likely to die during the seven years compared to those women with limited or no reported depressive symptoms. Cook et al. (2004) reported that those with chronic depression, who did not suffer from depression during their initial visit, were nearly twice as likely to die during the study as those with intermittent depression. Furthermore, in the Ikovics and associates study, 54% of the women with chronic depression died and 48% with intermittent depression died during the duration of the study, compared to only 21% of the women with limited or no reported depression. Cook et al. reported that of those who died during their study, 66% would have qualified for depression and 52% had probable depression at their final two visits. In addition, Ikovics et al. reported that women with depression were more vulnerable to high viral loads (more than 10,000 virus copies) and low CD4 counts. CD4 counts are a measure used to

determine the status of the immune system by assessing for T-helper lymphocytes that have the surface CD4 cell markers. These results were reported even after controlling for clinical characteristics, substance use, and demographic characteristics.

There are reasons for women with HIV and depression to remain hopeful in regards to their disease progression. Cook et al. (2004) found that individuals receiving mental health services significantly decreased their mortality risk. In addition, Cook and colleagues further reported that depressive symptoms were the lowest in individuals taking the HAART treatment regimen. These findings suggest the importance of specific medication utilization and mental health treatment for women with HIV.

### Summary

When counseling women with HIV, it is important for counselors to keep in mind that higher rates of depression are associated with faster disease progression. Counselors also should be knowledgeable about the best medical interventions for HIV in order to ensure quality treatment for all clients. Taking the HAART regimen is considered to be the best quality treatment for HIV. African American women and individuals who had abused substances, women with dysthymia, and women with depression were less likely to be taking the HAART regimen (Cook et al., 2006; Phillips et al., 2005; Turner and Fleishman, 2006). Therefore, counselors working with women with HIV should inquire about HIV medication, in order to be an advocate the client. Despite treatments, HIV is a terminal illness. Ikovics et al. (2001) and Cook et al. (2004) found depression was associated with increased mortality rates in women with HIV. Therefore, reducing depressive symptoms should be addressed in counseling.

## Special Populations

*African American Women*

African Americans women, as reflected in the research, represent 64% of all new AIDS cases in women in the United States (CDC, 2001). Almost all of the research included in this review had samples that were compositionally representative, except those studies that were specifically focused on another population. Some examples of this composition include the studies by: Eller and Mahat (2003), Simoni and Ortiz (2003), and Tostes et al. (2004). Therefore, when considering how the results of the research studies could be generalized, all of the literature in this review should be considered applicable to African American women with HIV and depression.

*Nepali and Puerto Rican Women*

Eller and Mahat (2003) found in a sample of 98 Nepali former sex workers that 18% were depressed when the somatic symptoms of depression were included. However, only 6% overall were considered depressed, when not including somatic symptoms. The authors noted that in the Asian population, psychological symptoms manifest in somatic manners. Still, depression rates were lower than expected. The authors attributed this to the eastern philosophy of acceptance, as well as when these women were diagnosed with HIV, they were given housing, an education, and no longer had to be sex workers. This change in lifestyle, for many in the sample, was considered a step up from their past situations. In addition, there was little education about HIV in Nepal and therefore some women may not fully understand what having this virus means. Other findings from Eller and Mahat included that increased amounts of perceived stress was positively associated with depressive symptoms. Additionally, they reported two factors predicted the variance in depression: perceived stress and, the emotion-focused coping strategy, escape avoidance.

While Eller and Mahat (2003) found that avoidance as a coping strategy predicted depression in the Asian population, Simoni and Ortiz (2003) reported that spiritually based coping with Latinas was associated with less depressive symptoms. According to the Center for Disease Control and Prevention (2001), Latina women represent 17% of all new AIDS diagnoses in the U.S. In order to learn more about this population, Simoni and Ortiz (2003) assessed spirituality and depression among HIV

positive individuals who were self identified as Puerto Rican and living in New York City. They reported an inverse relationship between spirituality and depressive symptoms. Therefore, if a person in this population was spiritual, then less depressive symptoms would be expected. It is important to note, that in their sample, 66% of the women could be considered clinically depressed, thus suggesting the effects the illness had on mental health.

### Social Supports in Relationships

Motherhood poses many challenges for women with HIV. Jones et al. (2001b) examined differences in depression using two assessments: a self-report scale and clinician ratings. Single mothers with HIV were more likely to be depressed than single mothers without HIV. These measures eliminated somatic depressive symptoms to decrease the confounding factor of the illness on the body. Therefore, affective and cognitive factors were the only factors utilized to determine depression.

Miles, Gillespie, and Holditch-Davis (2001) assessed depression, physical health, and the stigma of having HIV in mothers infected with the disease. These women had passed on their HIV to their children. Depression and physical symptoms were high among these women and physical health and mental health were significantly positively correlated. In a similar study, Murphy et al. (2006) assessed depression, physical health, social functioning, and the stigma of having HIV in mothers. Murphy and colleagues reported that the stigma of having HIV was positively associated with depression.

The parent-child relationship may help explain the differences in depression. McKee et al. (2007) examined the relationship between depressive symptoms and protective factors (quality of mother-child relationship and coping skills) among African American women with and without HIV/AIDS. They found that for the women infected with HIV, the quality of the relationship between parent-child was associated with less depression. Therefore, having a warm, supportive relationship between mother and child was protective of depressive symptoms. Cho, Holditch-Davis, and Miles (2008) were also able to confirm the implications for the quality of the mother child relationship. They reported that HIV positive women with more depressive symptoms were not as attentive to the needs of the infant. While cause and effect cannot be determined, the correlation between the quality of the parent-child relationship and depression cannot be ignored.

Similar results, concerning the relationship between depression and the quality of the relationship and perceived social support from the immediate family, were reported by lesbian women with HIV. Prado et al. (2002) assessed differences between lesbian and heterosexual HIV positive African American women. They found that within their sample, 50% of the lesbian sample displayed major depression, while only 7.9% from the heterosexual sample displayed major depression. However, the sample size of both heterosexual and lesbian women was only 48, with only ten from the lesbian cohort. In addition, with all demographic characteristics being equal, the main difference with the lesbian population compared to the heterosexual population was a significantly less amount of perceived social support from their immediate family. Therefore, when interpreting these results, it is important to keep in mind this difference in social support. When working with HIV positive lesbians, assessing social support would be imperative.

### Summary

Special populations may have additional needs in counseling. The majority of the research utilized predominately African American samples, which is representative of women with HIV in the U.S. (CDC, 2001). Other populations represented in the literature include Nepali women, Puerto Rican women, and lesbians. How depression impacted these women should be considered when working with these populations. For example, lesbian women reported more depression than heterosexual women (Prado et al., 2002) and spirituality may help reduce depression in Puerto Rican woman (Simoni & Ortiz, 2003). Finally, many of these women with HIV are mothers. For some the HIV infection has been passed on to their children. Special

considerations such as childcare, parent-child relationship, and the physical and mental health of the family should be explored in counseling.

## Implications for Counselors

As the rates of new HIV cases increases and the quality of medical treatment for HIV improves, counselors can expect to see an increased caseload of clients with this illness. While clients have been known to attend counseling for terminal illnesses, counseling may need to be tailored to work with clients with HIV. Women with HIV have been reported to have high rates of depression. While cause and effect cannot be determined between having this illness and the impact on mood, what can be determined are the challenges many women with HIV face. As was reported in the attention to mental health section, women with HIV may have been the victim of domestic violence or abuse as a child, the quality of the relationship and social support received from family members may be poor, they may live in poverty, or have a poor quality of life. Even without the HIV status, all of these reasons bring women into counseling. Therefore, it is important for counselors to keep in mind that the impetus for counseling by these women may not be their HIV status, and HIV may not be the greatest concern for these individuals. Addressing the HIV status may not be the focus of counseling, if the clients are struggling with a variety of mental health concerns. Counselors then need to address in counseling what the clients view as the most important topic for sessions. As with all counseling, addressing coping skills is necessary. Counselors should take the time in sessions in order to address what the client is currently doing to help cope with the situation, inquire if the current coping skills are helpful, and perhaps work with the client to develop new coping skills.

Upon reviewing the literature, one of the most cited predictors of depression was lack of social support. This may be reflected in the stigma of being HIV positive, the cultural perspective of HIV, or that women with HIV may be in same sex relationships that are not supported by family members. While the reasons for lack of social support may vary, it cannot be denied that relationships may help improve depression. As such, counselors need to address the social networks of the clients. Counselors should inquire about individuals who provide social support for the clients and encourage clients to seek out support from others, if the quality of the relationship is such that these interactions could be supported. If relationships are in need of repair, this could also be addressed in counseling. Counselors may want to include family members in counseling sessions. Not only could this be used to help repair relationships, but, even if the relationships are intact, it may be beneficial for the client to have someone there who supports her.

HIV significantly impacts physical health so, counselors may want to consider communicating with the client's physicians. The collaboration between the counselor and physician could help ensure that the clients are receiving quality care for their health. For example, these two professionals could work together to increase adherence to medications. One concern counselors may want to keep in mind, if they chose to communicate with a physician about a client's health, is confidentiality of medical records. Therefore, clients would need to sign the proper release form before any communication with a physician is made.

All counselors should be multiculturally competent. If counselors are working with clients with a different cultural background, the counselors should educate themselves about that culture. When reviewing the literature, there are high rates of Latina and African American women with HIV. If counselors expect to work with clients with HIV, they would benefit from seeking out more information about counseling clients from these cultures. It will also be important for counselors to keep in mind that the stigma of having HIV may vary between cultures, and some cultures may have a more negative perception about having HIV

than others. Therefore, counselors should address cultural stigma and allow the clients to discuss how their HIV status personally affects them.

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# A Thematic Analysis of an Adolescent's Journey in Art Therapy

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Recognizing person-centered art therapy as a therapeutic intervention for at-risk adolescents, the researcher examined the first, second and tenth sessions of an 11-session work with a female adolescent client. The researcher used a thematic analysis of the recorded transcripts of the art therapy sessions, the art produced by the client, and researcher notes on client behavior made in-session to describe the intervention. From sessions one and two, two clusters emerged: client attributes and client deficits. Themes included family life, emotions, personal goals, client needs, lack of assertiveness, and self deficits. For the later session, the same two clusters emerged representing themes of assertiveness, emotions, empowerment, lack of assertiveness and undeserving. The findings support the effectiveness of the person-centered art therapy intervention to help adolescents explore personal problems and development issues, assume responsibility and control for growth and change, and decrease resistance to therapeutic intervention.

Adolescence, by its nature, represents a challenging and sometimes turbulent transition in life span development. Whether encountering normative or non-normative life experiences during this developmental period, adolescents may benefit from counseling; yet, they often present resistance to traditional psychotherapy techniques (Riley, 1999). The purpose of this study is to describe a person-centered art therapy intervention with an adolescent female through a thematic analysis of several art therapy sessions and the client-produced art.

Person-centered art therapy differs from traditional, psychoanalytically based art therapy interventions in which the therapist interprets artistic expression to gain insight into unconscious psychic conflicts (Natale, 1996). In contrast, person-centered art therapy allows the client to direct the therapeutic process, is generally non-directive, and employs no interpretation on the part of the therapist. The approach is supported as an effective counseling intervention in school counseling, as well as agency, settings (Kahn, 1999; Landreth, 2002; Riley, 1999; Rogers, 1993).

## Review of the Literature

Art therapy evolved as an intervention due to its non-threatening nature, lack of verbal demands, and reported efficacy as an outlet for cognitive and emotional expression (Riley, 1999). Riley described art as providing communicative qualities when verbal responses to questions may be avoided and supported art therapy as an intervention with adolescent populations to stimulate creativity, provide a sense of control for the client, and decrease resistance frequently encountered with traditional talk therapies. Numerous studies have documented the effectiveness of non-directive, expressive play therapy with children, but fewer studies have examined the formal application of such treatment modalities with adolescent populations (Kahn, 1999; Landreth, 2002).

Art therapy, rooted theoretically in psychoanalytic theory, emerged as a component of play therapy. Both represented relationship based treatment techniques for working with individuals experiencing emotional disturbance (Landreth, 2002). From a philosophical perspective, the process of art stood for a series of discrete acts, based on intuitive biological processes that together constituted communication of emotional experiences, (Julliard & Heuvel, 1999; Langer, 1953). From a biological perspective and with the use of brain imaging techniques, researchers have posited that artistic and brain function are connected through visual information processing, particularly in terms of memory, cognition, and emotional expression (Lusebrink, 2004). These findings suggested that sensory stimulation could be used as a basic psychotherapeutic intervention that included art media (Lusebrink). In other words, the apparent interconnectedness of mind and body, as well as emotion and cognition, warranted the consideration of art therapy as a psychotherapeutic intervention.

Reports of positive benefits of art therapy have included enhanced self-expression, insight into problem issues, goal setting, and identity development (Kahn, 1999). Authors have provided positive anecdotal reports to support the effectiveness of art therapy with adolescent populations in various settings and/or conditions: school environments (Kahn, 1999; Natale, 1996); group counseling (Vick, 1999), physical infirmity (Appleton, 2001; Baerg, 2003; Favara-Scacco, Smirne, Schiliro & Di Cataldo, 2001; Councill, 1993; Sourkes, 1991; Bradding & Horstman, 1999), situational stress (Backos & Pagon, 1999; Pifalo, 2002) , family instability (Haeseler, 1996) , and behavioral disorders (Cernero, 1991). For the most part, however, empirical studies, focused on art therapy through formal research design, appeared limited.

Art therapy has been integrated into the treatment methodology of cognitive-behavioral therapy (Kahn, 1999), solution-focused brief therapy (Riley, 1999), and person-centered therapy (Landreth, 2002). The person-centered theory provided the theoretical framework for the current study. This approach, introduced by Carl Rogers (1942, 1951), represented a nondirective, client-centered therapy and viewed the counselor-client relationship as the focal part of the therapeutic process. This powerful relationship empowered the client to resolve issues in an accepting and safe environment, and led the client toward reconciliation between the real self and the perceived self. Present day clinical and school counseling professionals use person-centered art therapy to work with individuals with a range of developmental, academic, social, and emotional needs. This study describes the experience of client-centered art therapy for an adolescent female in a residential setting.

## Methodology

The methodology includes a description of the participant, the role of the researcher, the procedure and the trustworthiness of the data, and the method of analysis used. Included in the procedure is a description of the person-centered art therapy used in this study.

### Participant

After obtaining approval from the Institutional Review Board of the university, in addition to consent from the administrative staff at the residential treatment center, the researcher initiated the participant selection process. Eligibility criteria included the following: an adolescent between the ages of 13 and 17; enrollment as a full-time residential student at the treatment center; a psychiatric diagnosis of mood disorder either singly or in combination with other psychiatric disorders; and expressed interest for participation on the part of the student. Each adolescent and his or her parent(s)/guardian(s) that met eligibility criteria for participation in the research project was informed of the art therapy project and provided the opportunity to be considered a candidate. Selection was based on a first come first served basis.

The first student candidate and selected participant was Susie (fictitious name), a mildly mentally handicapped 16-year-old with a history of abandonment, neglect, and severe abuse. Susie had received special education services while enrolled in public school systems, but had experienced a number of alternative placements in more restrictive settings due to behavioral difficulties at home and school.

### Researcher

The researcher in this study was a doctoral student in counselor education at a southeastern university who had received graduate level training in expressive therapy. While not a certified art therapist, per se, she applied art therapy techniques based on person-centered theory and recommended for use by school counselors in academic settings (Kahn, 1999; Riley, 1999; Landreth, 2002).

The researcher served as the principle investigator and primary instrument for data collection. The role of the researcher as an instrument for collecting data is in keeping with recommendations for qualitative, case study research (Merriam, 1998; Schloss & Smith, 1999; and Wolcott, 1994).

### Procedure and Trustworthiness of the Data

In order to explore the themes developed in art therapy with an adolescent client, the researcher conducted a total of 11 weekly art therapy counseling sessions, approximately one hour in length, beginning shortly after Susie's admission and terminating at the time of her discharge from the treatment center. The qualitative case study design was selected for this investigation due to its applicability with extremely small sample sizes and its appropriateness for an in-depth understanding of the research subject (Merriam, 1998).

Art therapy sessions were conducted from a person- or child-centered perspective. Upon entering the art therapy session, Susie was greeted warmly and invited to verbally express her thoughts, feelings, and/or experiences from the past week. A variety of art materials were provided at each session for self-expression. The researcher informed the client that she could use any or all of the materials to express her thoughts and feelings in any way she wished. Art media provided at each session included: drawing paper, colored construction paper, pencils, colored pencils, crayons, markers, water-based paints with brushes, modeling clay, play-dough (which is softer and easier to manipulate than the clay) in a variety of colors, glue sticks, liquid glue, scissors, and pipe cleaners.

Trustworthiness of the data was derived through triangulation of multiple data sources. Sources for triangulation included transcribed audio-taped sessions in art therapy, copies of art products created by the student participant, and observations by the researcher during art therapy sessions.

## Analysis

Qualitative analysis of the data was considered "concrete" and "case-focused", according to Weiss (1994). The analysis was considered "case-focused" since the interpretation of data focused directly upon the behavior (including spoken utterances) and art products made by the single subject participant during art therapy sessions. The analysis was conducted from "the level of the concrete" since the focus remained on the subject's behavior, as opposed to generalizations that could be drawn in regard to other populations with similar profiles. Typed transcripts from audio-taped art therapy sessions, behavioral observations, and art products were selected for data analysis. Data were analyzed from the first two sessions and from session ten, near the end of the project intervention, for comparison purposes. The typed transcripts and the behavioral observation notes were read and re-read several times and were coded for meaning units that, based on the researcher's discretion, appeared to emanate from the data. Meaning units for the transcripts were defined as instances in which the participant appeared to change her focus from one thought or meaning to another (Thomas & Pollio, 2002). Meaning units for the behavioral observation notes were defined as new information about the participant's behavior. The researcher analyzed the art products three times and developed meaning units from the art work. For each meaning unit, the researcher wrote a rationale based upon concrete renderings in the art product. Meaning units from the three data sources were segmented by cutting them into paper strips to facilitate the comparative process.

Meaning units were categorized by similarity and renamed as themes. The themes were derived, using the constant comparative method, from the three data sources. Dye, Schatz, Rosenberg, and Coleman (2000) suggested the constant comparison method, initially proposed by Lincoln and Guba (1985), as an appropriate means of analyzing qualitative data. Using the constant comparative method, information is recorded, analyzed and coded for meaning, and continually compared and refined until new relationships or meanings are discovered within the data (Goetz & LeCompte, 1981; Merriam, 1998). Once themes were identified, data were further organized by preparing written summaries of the meaning units constituting each theme. This process was used to analyze the data from the first two art therapy sessions. An identical process was employed in analysis of the tenth session.

# Results

This section outlines the results of the two analyses, those of sessions one and two and session ten. For each analysis, clusters were client attributes and client deficits. Themes are described within each cluster.

## Art Therapy Sessions One and Two

The following themes were identified from the two initial sessions: family life, emotions, personal goals, client needs, lack of assertiveness, and self deficits. The themes were then grouped into clusters, based on similarity of content. Clusters were labeled client attributes and client deficits. The following narrative provides a review of the client attributes and client deficits clusters and themes.

*Cluster I: Client Attributes.* Client attributes are defined as information provided by the client to describe herself. Themes in this cluster included family life, emotions, and personal goals.

*Family Life.* The family life theme consisted of the following meaning units: present family structure, family leisure activities, and power struggles within the home. Susie lived in a blended family headed by an adoptive parent she referred to as "Mamaw". Although Mamaw is a title typically applied to a grandparent, the adoptive female head of the household, age unknown, appeared to serve a parental role. Susie reported two biological sisters, a step-sister (all sisters younger than herself), a 5-year-old nephew, biologically unrelated, and a 45-year-old adopted brother. She described leisure activities at home

consisting of watching television and outdoor play with her sisters. Power struggles within the family were alluded to in the following excerpt:

> Susie: "My Mamaw. She's the boss. But sometimes my sisters try to be the boss."
>
> Researcher: "All of them, or just one?"
>
> Susie: "All of them." (coughs)
>
> Researcher: "And you, sometimes you want to be the boss?"
>
> Susie: "It's hard not to be the boss at my age."

Susie also indicated that, at times, her Mamaw needed her help in "handling the younger girls," providing further information as to the client's role as co-caregiver within the family system.

*Emotions.* Susie revealed a number of emotions during the initial intake and art therapy sessions, providing a bird's eye view into her present emotional health. Meaning units included: feelings of abandonment, embarrassment, anger, worry, victimization, dislike, and loss. She expressed feelings of anger at the abandonment by her mother, subsequent sexual abuse by her biological father, and later abuse by an adult friend of the family, all at the age of six. She worried about pregnancy following the abuse, and embarrassment in communicating these events to her therapists. The following excerpts vividly revealed her emotional reaction to the trauma experienced during early life:

> Susie: "My mom ran off with another guy….She ran off and left me and my sisters when we were little…..She left us right after she had ____, my little sister…My dad took care of me. When I was about 5 or 6, that's when it happened. You don't know what I'm talking about, do you? ……I was sexually abused by him. It was thundering one night, and I didn't know what he was going to do. I thought he was going to protect me. But instead…(silence)… he didn't. And, it's a good thing I was that little, because if I wasn't then I could be pregnant."

Later in the session, the therapist encouraged Susie to express her feelings through her drawings:

> Researcher: "Could you please make a drawing to show exactly how you felt when that happened to you." (The client drew an angry torso, with mouth open and teeth showing, eyes slanted to the right.) (See Figure 1).

Susie also expressed emotions typical of students whose lives have not been traumatized by abandonment or abuse. They included her likes and dislikes, as well as feelings of loss. The following passage demonstrated her feelings of grief in leaving friends and counselors:

> Susie: "I didn't live there, I just went to stay for a week. It was like a church thing. It was hard saying good-bye to everybody at the end…and I didn't get to say good-bye to my counselor at my last placement….This is making me cry…I always think about it."

*Personal Goals*. During the first art therapy session, Susie expressed several goals, including obtaining a driver's license. When asked if given three wishes, what she would wish for, she replied:

> Susie: "Well, to be back home with my real family; and to go to Georgia and get married".

Susie also spoke of having children:

> Susie: "I was the first one that was born. The first baby I want to be a daughter and the second baby a son."
>
> Researcher: "So you do want children someday?"
>
> Susie: "Like in my 20's…cause I'm not gonna get married until I'm like 21-year-old or something like that…yeah, I want to get married in Georgia…..(pensive)…close to the ocean, and have three bridesmaids…."

Following the disclosure regarding her early abuse, the client stated she still worries about being pregnant, yet denied any further sexual contact since the age of six.

*Cluster II: Client Deficits*

The second cluster, client deficits, represented a collection of themes indicating what appeared to be lacking. The themes were client needs, lack of assertiveness, and self-deficits.

*Client Needs.* During the initial art therapy sessions, Susie indirectly implied a need for social support. Transcripts from these sessions revealed the client's perceived friendships at the treatment center as consisting primarily of staff rather than peers, as was demonstrated in the following passage:

Researcher: "Do you have a best friend?"

Susie: "I've got plenty now."

Researcher: "Tell me about some of your friends here at _____."

(Susie talks only of staff members)…. "They don't make fun of me….."

Researcher: "If you could be friends with any student here, who would you choose to be your friend?"

Susie: "Probably _____ or _____…."

Researcher: "What would you do if you would like to start a conversation with those two girls? It could be at different times. What would you say?"

Susie: "Uh, I don't know."

Susie also indicated needs for approval, affection, nurture, and attention. In responding to a question designed to elicit an understanding of her potential to self-harm, the client's reply was as follows:

Researcher: "Have you ever tried to hurt yourself?"

Susie: "Not that I know of."

Researcher: "Have you ever thought about hurting yourself?"

Susie: "Well, I hit my head on the bed one time."

Researcher: "On purpose or by accident?"

Susie: "I was just playin'….Just to see what one of the staff would do. I would go bang and 'ou' and bang/'ou', bang/'ou', over and over again."

Researcher: "…Well, why were you doing that?"

Susie: "Just tryin' to get attention. I like to get attention from the staff. Ms. _____ made a growly sound at me yesterday, and I made one back at her. I like the staff to give me hugs. Yeah, it feels good. I guess I don't get too much attention."

*Lack of Assertiveness.* During the second art therapy session, Susie was shown a variety of art media with which to work, and from these she made two paper and pencil drawings (Figures 1 & 2). When offered the opportunity to continue, she smiled sheepishly and said she did not know what other items she would like to use. Susie also demonstrated a lack of assertiveness in asking for what she needs. Examples included her report that she had not asked the doctor for more water in taking her medicine (a need she had discussed with the researcher) and her expressed difficulty in raising her hand to ask for help in the classroom, as is demonstrated in the following excerpt:

Susie: "I need some tutoring in some of my classes".

Researcher: "…Well, if you needed extra help, how would you get it? Who would you tell?"

Susie: "I would ask Ms. _____, but I'm too bashful to ask for help in front of the boys…..I mean… (thinking)…it's just hard to raise my hand in front of the boys. I sit beside one and in front of one".

Researcher: "…Tell me what makes it hard with the boys being there".

Susie: "It's just so embarrassing…I don't know about the other girls, but me, I think it's embarrassing."

Researcher: "So, if there were a classroom full of girls, you could probably raise your hand and ask a question if you needed to?"

Susie: "Yeah, I used to be in a class with all girls in middle school and that was easier…."

Susie expressed additional examples of lack of assertiveness that included activities with both males and females.

*Self- Deficits.* Susie's verbalizations during the first two sessions reflected deficits in self-image and self-esteem. At one point, the client referred to herself as "crazy" upon forgetting the tree in a picture, and then said, "I'm not good at drawing". Additionally, the average sized girl described herself as "overweight" and "mean" at other times during the interview. When asked to tell some things she liked *about herself*, Susie described things she or her sisters liked to do. When redirected to what she liked about herself, she was silent.

Although assessment was not a component of this study, Susie's lack of self-esteem and poor self-image may be interpreted in her self-portrait, illustrated in Figure 1. While no directions were provided in creating the drawing, the drawing's composition of only a head and upper shoulders was noteworthy. It was noted that while Susie was unable to describe or draw positive qualities, she experienced no difficulty in identifying a negative quality, being "mean", when asked what she would like to change about herself. The two examples seemed to represent similar lines of reasoning.

*Art Therapy Session Ten*

Transcript analysis from the tenth session, 13 days prior to the client's discharge, revealed five themes within the clusters of client attributes and client deficits. Client attributes represented assertiveness, emotions, and empowerment. The cluster of client deficits included lack of assertiveness and undeserving. The following narrative provides a review of the client attributes and client deficit clusters and themes.

*Cluster I: Client Attributes*

*Assertiveness.* Throughout the tenth session, Susie assertively employed behaviors that resulted in meaning units in decision making and emotional expression, either through her verbalizations or spontaneous use of art materials in creating products. The researcher noted that, on several occasions, the client independently selected materials, colors, and added details to her work without requesting input from the researcher. During this session she also was able to change the subject and begin to create a list of specific individuals to whom she would bid farewell.

*Emotions.* Susie approached the session stating, "I guess…(silence)…I'm happy" in response to an inquiry as to how she felt about her upcoming discharge. Following the researcher's reflection of her expressed emotion, she spontaneously continued to describe a range of emotions: sadness at leaving the treatment center staff, anxiety that she might cry in saying good-bye, and the embarrassment she believed she would feel. Following the client's initial disclosure that she "guessed" she was happy, she voluntarily asserted that she did not want to leave, followed by artistic expression of her anxiety and sadness. When provided a choice of three art activities, Susie independently selected the bridge drawing/marker activity (Figure 3). The researcher noted the client drew stick figures representing herself as happy at her time of admittance at the left of the bridge, and sad at the time of discharge at the right side of the bridge.

*Empowerment.* In regard to the empowerment theme, when asked to describe herself, Susie used the words, "caring", "awesome", and "smiles". These descriptors revealed an increase in the client's self-esteem as well as a positive image of the self. Such represented a sharp contrast to the timid, withdrawn girl who described herself as "crazy", "overweight", and "mean" at the beginning of the art therapy sessions. Further analysis indicated Susie's feelings of empowerment were developing characteristics, since she also continued to demonstrate deficits in related areas, described in the following section.

*Cluster II: Client Deficits*

The researcher chose "lack of assertiveness" and "undeserving" to represent themes within the client deficits cluster. While Susie demonstrated assertiveness and improved self-image within the client attributes cluster, during the same session, the researcher also noted instances in which these qualities appeared under-developed.

*Lack of Assertiveness.* During this session, Susie also demonstrated a lack of assertiveness. For instance, when asked to express her sadness in her art, she replied, "I don't know what to do." Later in the session, she assertively decided not to complete an activity because she lacked confidence in spelling the staff members' names as well as words she wished to include in the product. The therapist noted and appreciated Susie's expressed ability to set a boundary in saying "no," but also realized her lack of effort in attempting a task when she was told she could use any spelling and keep the product private if she so desired.

*Undeserving.* Near the end of this session, Susie revealed her concerns that she is undeserving of the compliments and positive statements received from fellow students and staff.

For instance, she said, "People are gonna be saying nice, positive things about me and they don't really know [me]". However, when asked to express the part of herself she did not want others to know, Susie replied, "I don't know if I can". These verbalizations as well as behaviors supported the contention that, although Susie appeared to have made substantial gains during her treatment, her development was ongoing, with continued deficits demonstrated periodically.

## Implications for Counseling

Qualitative research is an interpretive endeavor. The findings represented the researcher's understanding of the client's experience within the art therapy process. The findings are representations of reality, rather than reality itself. In this study the researcher is both the therapist and the researcher. This type of investigation is referred to by Pressick-Kilborn and Sainsbury (2002) as "research in your own backyard", where the researcher has more than one Identity in the research process. The researcher continually reflected and considered this dual relationship while analyzing the data. The researcher used multiple data sources and created a concrete data base from which to base the findings. The data generated from the study depended on the art therapy skills of the researcher and the researcher's interpretive skills. Throughout the investigation, the researcher remained cognizant of matters of trustworthiness mentioned previously.

This study described the experience of an adolescent client receiving art therapy in a residential treatment setting. Results of the study support the following implications for using art therapy to counsel adolescents.

1. Art therapy allows the counselor to explore personal problems with the adolescent (Kahn, 1999). The client used her art to share issues about her family, self esteem, and lack of friends. Within the clusters of client attributes and client deficits, the client expressed verbally and through her art, personal issues that troubled her. Adolescents are often described as reluctant clients (Backos & Pagon, 1999; Riley, 1999), but during the first and second art therapy sessions, within the theme of *emotion*, Susie disclosed powerful negative emotions that included expressions of abandonment, anger, embarrassment, and focused on what others had done to her. Susie expressed positive emotions during session ten, again within the theme of *emotions*, stating

that she "guesses" she is happy and expressing her negative emotions, sadness, anxiety, and embarrassment. She also focused on leaving the residential setting and saying goodbye, circumstantial rather than personal.

2. Counselor can use art therapy as a way to introduce and talk about developmental adolescent issues (Backos & Pagon, 1999). In this particular case, Susie shared her animosity toward her family and indicated the importance of goals such as getting married and having children. She also introduced developmental challenges common to adolescents. For example, Susie talked about social support, in terms of meaningful adult and peer relationships important to the developing adolescent (Baerg, 2003; Riley, 1999). In the first two sessions, within the themes of *family life*, *personal goals*, and *client needs*, she indicated, verbally and through her art, the notion of her role as a caregiver in her family, a desire to be "with my real family", a hope to marry and have children, and perceived friendships at the treatment center. In session ten, within the theme of *assertiveness*, she described the friends that she has at the treatment center by making a list of those she wished to bid goodbye. She also expressed anxiety about interactions with peers when she says goodbye.

3. Counseling using art empowers adolescents to assume responsibility for growth and change (Backos & Pagon; Riley, 1999). Here the client is able to talk about personal goals separate from her family. She ascribed position attributions to herself. In addition, she owned her negative feelings about herself. Art therapy also helped the counselor pinpoint areas of low self-esteem and other deficits. Developmentally, one of the focuses of counseling adolescents is helping them take responsibility for or control of their own behavior (Thompson & Henderson, 2007). Proponents of art therapy suggest {delete space} this as a positive outcome of the approach (Baerg, 2003; Riley, 1999; Backos & Pagon, 1999).

As described in the first two sessions, the theme *lack of assertiveness* captured the client's unwillingness to choose art material in session, asking for water to take medicine, or raise her hand in class. In session ten, within the theme of *assertiveness*, Susie chose art therapy materials and activities and suggested an avenue of discussion and possible solutions. Regardless, she was still dependent upon the art therapist for some guidance and direction. Stoltenberg, McNeil, and Delworth (1998) described skill development as building sequentially over time through a stage-like process best illustrated by a continuum leading from one level to the next. In consideration of these authors' contentions, the client's demonstrated skills in assertiveness and decision-making could be described as developing.

Embedded in Susie's increased responsibility and control of her behavior was a change in the way that she viewed herself. In sessions one and two, within the theme of *self-deficits*, she described herself as "crazy", not talented in drawing, "overweight", and "mean." Her self-portrait reinforced these negative images. Even though, in session ten, within the themes of *undeserving* and *lack of assertiveness*, she still indicated a negative view of herself, reflecting her continued perception of herself, to some degree, as helpless or lacking in ability, such was in contrast to evidence of her growth in other areas related to the self, within the theme of *empowerment*, indicating a positive caring person.

4. Art therapy decreases the resistance to the helping process (Landreth, 2002). Susie revealed personal concerns related to friends, leaving the residential facility, and earlier abuse. Those working with adolescents noted that, at times, talk therapy is not effective with adolescents (Kahn, 1999; Landreth, 2002; Riley, 1999). The results of this study suggested that through her art, Susie was able to "talk" about salient issues, as well as "talk" about issues related to her art. In fact, in this study, the client is willing to talk about sexual abuse in session two, expressing her emotions both verbally and through her drawing. Her strong negative emotions are congruent in both. Early powerful expressions are consistent in the literature focused on art therapy and adolescents. Baerg (2003) described sessions with adolescents living with cancer who are able to express their

sadness and rage in early sessions; Riley suggested using art therapy as a form of brief therapy, indicating emotions and thoughts can be expressed fairly quickly.

Resistance still occurred during the counseling sessions. It was noted primarily during times in which the researcher found it necessary to employ verbal strategies within the sessions, thus supporting the effectiveness of art therapy in lowering client resistance and eliciting information that potentially may have been concealed during traditional talk therapy. These were noted in sessions one and two, within the themes of *client needs* and *self-deficits*. When asked to talk about friends, the researcher tried to explore, without success, how to begin a conversation with classmates at the treatment center. Susie also could not "say" what she liked about herself. In session ten, there were no indications of resistance, and the client chose her own materials and activities. She also initiated the tasks she wanted to talk about after she drew the "bridge", representing her discharge from the treatment center.

## Conclusions

This study suggested that the 11-session duration of art therapy for cognitively impaired adolescents with severe issues and behavioral difficulties provided opportunity to identify and express emotions, address personal issues, and increase self-image. The number of art therapy sessions could be reduced for students of average cognitive abilities with less severe behavioral difficulties. Client-centered art therapy appears to allow clients to explore salient issues, develop a sense of control of the therapeutic process, and use therapy as a way of thinking about issues outside the therapeutic environment. Suggested opportunities for future research regarding client centered art therapy include expanding the description of the therapeutic process to school and agency settings. The findings of this study were supportive of an effective intervention that may be employed with adolescents in both clinical and educational settings.

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Figure 1

The adolescent client illustrated her anger at the perpetrators of her abuse then spontaneously drew her self-portrait expressing happiness and stated, "This is how I want to feel." (Figure is smaller than actual size.)

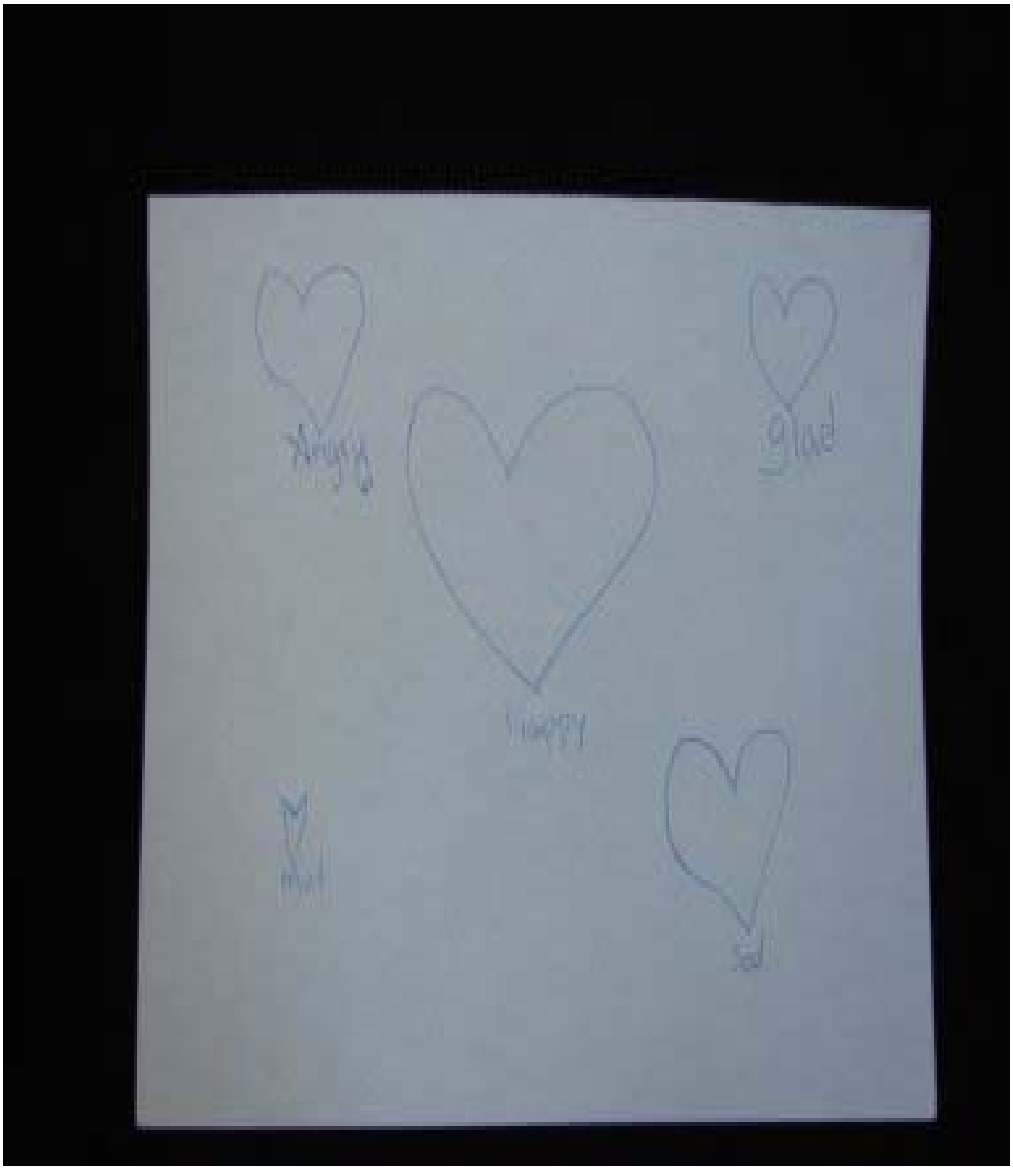



Figure 2

Susie illustrated her emotions as a series of hearts, varying in size and shape. (Figure is smaller than actual size.)

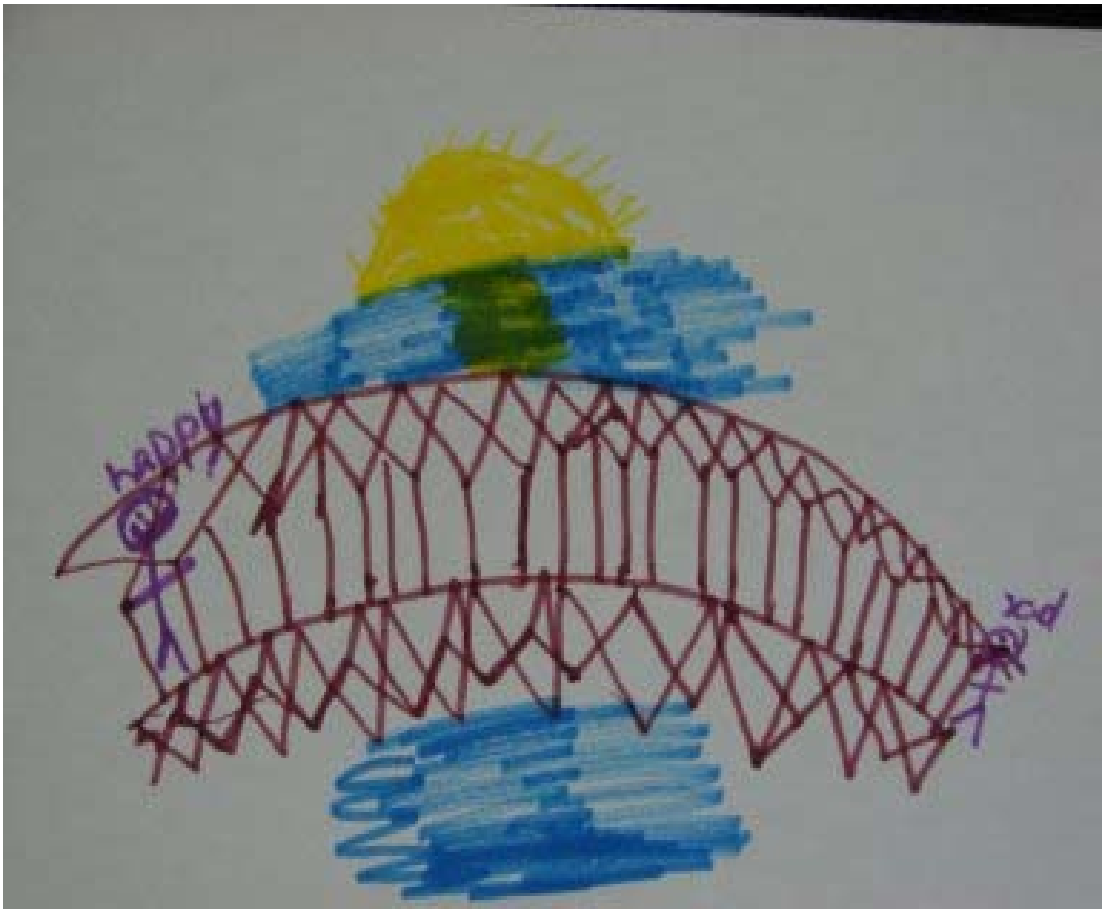
.) 


Figure 3

The bridge illustrated Susie's feelings at the time of her admittance to the treatment center (left) and at the time of her discharge (right).

# Understanding, Assessing, and Addressing Career Indecision: Applications of Developmental Counseling and Therapy (DCT)

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The purpose of this article is to introduce Developmental Counseling and Therapy (DCT; Ivey, Ivey, Myers, & Sweeney, 2005) as a model for understanding the career indecision of college students from a developmental perspective. The authors describe DCT as an assessment process and an approach to intervention planning that facilitates the growth of undecided college students. Counseling implications are illustrated and discussed via a case example.

When called upon to choose a major, many college students accomplish this task with relatively little difficulty and little to no guidance. Other students, however, become overwhelmed with the task and experience indecision both cognitively and emotionally (Gordon, 1995). Literature focusing on career indecision dates back over seventy years and is extensive, indicating the centrality of this issue within the career counseling and vocational psychology professions (Betz, 1992; Jurgens, 2000). Research findings give credence to the attention the issue has garnered, especially given that career indecision is associated

with psychological distress and anxiety (Constantine & Flores, 2006; Rochlen, Milburn & Hill, 2004) and is negatively related to academic performance and persistence (Leppel, 2001). Contrarily, the stated presence of a career decision is positively related to coping and overall psychological well-being (Creed, Prideaux & Patton, 2005; Saunders, Peterson, Sampson, & Reardon, 2000).

Much of the research on career indecision has examined specific psychological and personality factors that are associated with indecision and that differentiate undecided students from those who have made decisions about a major (Newman, Gray & Fuqua, 1999). Within this body of literature, it is not uncommon for indecision to be referred to as a psychological problem and interventions as treatments (Kelly & Lee, 2002). More recently, scholars have begun to frame career indecision within a holistic, developmental perspective (Gordon, 1995) that is more closely aligned with the philosophical tenets of the counseling profession (Sweeney, 2001). By using this approach, indecision is framed as a normal and expected phenomenon that can be addressed from a facilitative position within the counseling process. Therefore, the purpose of this article is to introduce Developmental Counseling and Therapy (DCT; Ivey, 1993, 2000; Ivey, Ivey, Myers, & Sweeney, 2005) as a model for understanding, assessing, and addressing the career indecision of college students from a developmental perspective. A case example based on a compilation of student experiences with indecision will illustrate how this model may be applied in career counseling.

## Developmental Counseling and Therapy

DCT is an integrative, metatheoretical approach to counseling that was developed to help practitioners connect the developmental theories that serve as a foundation for the counseling profession to daily counseling practice (Ivey, 1993, 2000; Ivey, Ivey, Myers et al., 2005). Differing from a developmental life-span perspective, DCT emphasizes the specific processes of growth and development, rather than outcomes that occur at different life stages. Thus, DCT can be used in conjunction with life-span, career development, and student development theories to understand developmental abilities and preferences and guide developmentally appropriate intervention.

Ivey (2000) developed DCT using a metaphorical interpretation of Piaget's theory of cognitive development. Like Piaget, Ivey postulated that there are four cognitive/emotional styles (i.e., sensorimotor/elemental, concrete/situational, formal/reflective, and dialectic/systemic) that individuals may develop and utilize throughout the life-span. Contrary to Piaget, however, Ivey contended that DCT cognitive/emotional styles are not hierarchical or mutually exclusive. Rather, development and functioning within all styles is necessary for optimal growth and development. Thus, all cognitive/emotional styles may be active simultaneously as individuals interact with the world and face developmental demands. One particular cognitive/emotional style may be more developed and thus evoked more heavily to process experience, and individuals may rely more heavily on a specific cognitive/emotional style in a specific situation. Moreover, Ivey, Ivey, Myers et al. (2005) recognized that not all individuals are able to function in all of the cognitive/emotional styles. Further, they proposed that counselors facilitate growth by intentionally matching or mismatching interventions to cognitive/emotional style preferences and abilities.

To date, DCT has been applied to a number of counseling populations and presenting concerns including children (Myers, Shoffner & Briggs, 2002), adolescents (Crespi & Generali, 1995), college students with learning disabilities (Strehorn, 1999), adults in career transition (Kenney & Law, 1991), women with eating disorders (Weinstein, 1994), and counseling supervisees (Rigazio-DiGilio, Daniels & Ivey, 1997). Authors have discussed uses of DCT with bibliotherapy (Myers, 1998), spiritual bypass (Cashwell, Myers & Shurts, 2004), and sexual identity development (Marszalek & Cashwell, 1998). Researchers

have reported empirical support for the existence of the cognitive/emotional styles (Rigazio-DiGilio & Ivey, 1990), links between counselors' cognitive/emotional style preferences and use of counseling interventions (Barrio Minton & Myers, 2008), and emerging evidence of a link between counselor-client cognitive/emotional style match and perceptions of empathy (Barrio Minton, 2008). Because an understanding of these styles is essential for assessment, conceptualization, and intervention within the DCT framework, each style is discussed in depth below.

### Sensorimotor/Elemental

The sensorimotor/elemental style is characterized as making meaning of current experiences through bodily sensation and emotion (Ivey, Ivey, Myers et al., 2005). Individuals who operate within the sensorimotor/elemental style rely on immediate sensory experiences (e.g., what is seen, heard, and felt) and may present as highly emotive with disorganized thought processes, short attention spans, and frequent physical movements. Sensorimotor functioning, which Ivey (2000) compared to Piaget's preoperational stage, is often characterized by illogical and magical thinking such as "I should be perfect," and "she made me act this way." Students are processing indecision from a sensorimotor orientation when they experience affective distress (e.g., bodily feelings of irritability, lack of concentration, inward tension, and displaced fear) related to career indecision.

### Concrete/Situational

Use of the concrete/situational style involves linear and sequential processing of experiences (Ivey, Ivey, Myers et al., 2005). Individuals who utilize this cognitive style communicate in a concrete manner, and rely on specific examples to describe situations and events (e.g., "I said this, and then he said that, and then we did this."). Others may demonstrate causal, if/then thinking (e.g., "When I got the letter that I had to pick a major soon, I just left my room and went to the store."). Moreover, clients who are functioning in a concrete style are able to recognize and label emotions, but they have difficulty reflecting upon these emotions and may find it difficult to identify patterns of thoughts, feelings and behaviors. For example, a second year student may describe her indecision and experiences that led to the indecision with an endless array of details. This student may have difficulty, however, identifying a pattern between the stories or understanding contextual factors influencing career decisions and the feelings that result from indecision.

### Formal/Reflective

Use of the formal/reflective style is contingent on an ability to think abstractly and is characterized by reflective thinking and identification of patterns of thought, feeling and behavior (Ivey, Ivey, Myers et al., 2005). Some individuals who operate within the formal/reflective modality may also be able to recognize patterns within patterns. A student who processes his indecision from a formal/reflective style might say something like, "every time I think about choosing a major, I feel afraid and decide to focus my energy elsewhere." Moreover, he may also link this fear to the pressure he feels from his parents to choose the right major.

### Dialectic/Systemic

Dialectic/systemic functioning is characterized by the ability to see oneself and situations from multiple perspectives (Ivey, Ivey, Myers et al., 2005). Like formal thinking, dialectic functioning requires abstract thought; however, it also requires the ability to step outside of oneself and recognize how patterns connect to greater systems (e.g., families, communities, and cultures). Individuals who function in a dialectic style understand that their situations and perspectives are influenced by their environment and are able to understand the concern from multiple perspectives. A student who processes her indecision dialectically may come to understand her indecision as being part of her overall fear of disappointing her parents given their

struggle to send her to college; furthermore, she may come to understand that this indecision has affected other aspects of her college experience such as her decisions regarding who to date and who not to date.

## Assessment and Intervention Planning

Counselors who work within the DCT perspective must identify a client's cognitive/affective style preference prior to selecting developmentally appropriate interventions (Ivey, Ivey, Myers, et al., 2005). The Standard Cognitive/Emotional Development Interview (SCDI; Ivey, Ivey, & Rigazio-DiGilio, 2005) was developed to assess a client's cognitive/emotional style preferences and blocks for one specific issue. The SCDI utilizes a sequence of specific questions oriented toward each developmental level. In essence, a counselor assesses sensorimotor functioning by asking a client to visualize herself in a specific situation and to relay what it is she hears, sees, and feels in her body. Concrete functioning is assessed by asking a client to provide specific, linear examples of a time during which the concern was present. Further, clients are asked to demonstrate formal thinking by noting patterns of thoughts, feelings, and behaviors present in the examples provided earlier in the interview. Finally, the interviewer assesses dialectic functioning by inquiring about the source and meaning of the rules or patterns identified during the interview. Standardized interview questions can be adapted to the context of the counseling situation, and with practice, the sequence becomes more fluid and less clinical in style. Experienced clinicians can prompt clients to share their issues informally and can assess developmental levels by listening to how clients describe their issues (Ivey, Ivey, & Rigazio-DiGilio, 2005). This latter method seems more likely in the context of career counseling and thus will be illustrated in the case example.

Each of the hundreds of proposed counseling theories and techniques is more or less consistent with each of the four DCT styles, and counselors use their assessment of the client's cognitive/emotional style needs and preferences to select appropriate counseling interventions (Ivey, Ivey, Myers, et al., 2005). Ivey and colleagues suggest use of Gestalt therapy, guided imagery, and relaxation and mindfulness techniques to promote or match sensorimotor/elemental development; more concrete approaches such as Reality therapy, behavioral techniques, narratives, and solution-focused counseling match the concrete cognitive/situational style. Adlerian, Person-centered, Cognitive, and Existential therapies are well-matched to the abstract, pattern-oriented thinking characteristics of the formal/reflective style, and Multicultural Counseling and Therapy, family systems approaches, and Feminist theories facilitate dialectic/systemic development.

Counselors may choose to facilitate horizontal development by matching interventions to clients' preferred cognitive/emotional styles (Ivey, Ivey, Myers et al., 2005), or they may facilitate vertical development (i.e. development of functioning in non-preferred styles) by intentionally mismatching interventions to preferences. For example, a counselor may engage a concrete client in a contracting process grounded in Reality Therapy. The same counselor may also use a more humanistic approach to challenge the client to identify patterns of thoughts, feelings, and behaviors related to career decision-making. In order to illustrate both the process and utility of DCT for assessing and addressing career indecision, we next provide a case illustration of a DCT intervention.

## Case Illustration

Trudy, a 20-year-old sophomore, was approaching the end of her second year at a large public university when she sought counseling at the university career center for assistance choosing a major. During the first session, the counselor engaged in rapport-building conversation while attempting to facilitate broad exploration of Trudy's reasons for coming to career counseling. Trudy stated that she was an English major with long-held aspirations of going to law school. Trudy appeared fidgety and preoccupied as she explained that she was having doubts about law school and that she wanted to explore other majors

since she believed English would be useless as for anything outside of a pre-law degree. During this conversation, several seemingly important issues arose. First, Trudy stated that her career indecision was the source of a lot of stress. Second, Trudy's mother and father were attorneys. Thus, she was reasonably familiar with the occupational path she needed to take to become a lawyer, and she was well-aware of her parents' excitement regarding her intention of going to law school.

Trudy's presenting issue lent itself to a variety of career interventions that would be helpful and appropriate in helping her explore possible majors. Thus, the counselor began shaping the experience to focus on the presenting issue: exploring possible majors. The counselor administered an interest inventory as one such intervention intended to help Trudy gain self-knowledge and a structured introduction to possible occupational areas. The counselor also gave Trudy a life values inventory as a take home assignment.

At the beginning of the second session Trudy again appeared sad, preoccupied, and uneasy, and she reported that she failed to complete her homework assignment. She did, however, begin talking about her desire to find a major that was meaningful to her, yet perhaps as respectable as law. Thus, the ancillary issues Trudy presented during the first session began to inform the counselor of the possible benefit of conducting a developmental assessment interview. As the session with Trudy continued, the counselor focused on a specific issue to begin the informal developmental assessment interview (Ivey, Ivey, & Rigazio-DiGilio, 2005).

Counselor: Trudy, you have mentioned that lately there have been events that have given you reason to doubt your future career plans. Can you describe a recent time when you were reflecting about your career choice?

Trudy: (Trudy began to mention that she had just learned that her cousin had been denied admittance to several law schools). Well, I was in my kitchen with my mom last Saturday; I was doing some homework for my math class. I've never been that great at math and pre-calculus is really hard for me; my mom always helps me when I am home. Anyway, we were talking about stuff, and she told me that my cousin had been denied admission, and that she was very upset about it.

Counselor: Can you remember exactly what you were feeling during that moment?

Trudy: Very scared. I was shocked because I thought my cousin was so smart and would have no trouble getting into law school. My mom said she couldn't understand what had happened, and she said that it was terrible news. I kind of panicked, thinking that I'll never get into law school because my grades are not good. I haven't been taking school very seriously. (Tears began to swell up in Trudy's eyes, as she started to fidget).

Counselor: It seems like you're still experiencing that feeling.

Trudy: My stomach feels like it's in knots all the time. (Trudy put her hand on her stomach and rubbed it). It's always on my mind.

Counselor: (Attempting to transition to a concrete style) When you were sitting there in the kitchen, thinking about your cousin and your own situations and feeling those panicky feelings, what did you do?

Trudy: I was upset for my cousin, but mostly I was scared about not getting in to law school myself. I just sat there questioning everything about my future. I was getting more and more scared about it. What am I going to do? What will happen to me if I don't go to law school? What will my parents

think? I'm not even sure it's what I want to do. I just keep thinking about this stuff, and I just got more and more overwhelmed.

Counselor: These feelings seem to consume you when you think of this. In fact, it seems like you're feeling it right now.

Trudy: I am. I can't stop feeling, I don't know, lost I guess.

Trudy's emotional reactions were present throughout the session and seemed to be consuming her thought processes. At this point, Trudy was exhibiting a strong sensorimotor orientation. Trudy was able to give some details about her experience; however, because she was experiencing her situation from such a strong sensorimotor orientation, she was not able to clearly focus on specific details. Her concrete description of the event was vague even after prompting, which is indicative of someone with a sensorimotor orientation (Ivey, Ivey, Myers, et al., 2005).

Counselor: Ok, let me review to make sure I'm with you so far. You were sitting in the kitchen doing your math homework and your mom was cooking dinner. She tells you that your cousin was denied admittance to law school. You were shocked about your cousin and you were scared that you might not get into law school either. You were feeling a lot of fear about your own future, and your stomach tied up in knots.

Trudy: That's right.

Counselor: (Attempting to assess extent to which Trudy utilizes a concrete style) What specifically do you think triggered this fearful feeling?

Trudy: I just feel like I'm failing and that if I don't go to law school, what will I do? I mean, I'll really let my parents down.

Counselor: Can you think of another time when you were feeling this way—a time other than this confusion about your career?

Trudy: Well, (long pause) I remember when I wanted to quit gymnastics, I felt like I was really letting my parents down, cause they really wanted me to continue into college, but, I don't know, I just didn't want to keep doing it.

Counselor: Can you describe this situation specifically?

Trudy described this instance much the same way as she described her current situation: with emotional responses and vague details of the examples.

Counselor: (Attempting to transition to the formal/reflective style) Do you notice any similarities in these situations?

Trudy: Well, yeah, both times I felt like my parents would be mad at me and really disappointed. I felt really, I don't know, afraid of what they would say.

Counselor: Afraid?

Trudy: Well, yeah, I didn't want to let my parents down. I feel a lot of pressure.

Counselor: So in both situations you feel like you are letting your parents down, and you have a lot of pressure on you.

Counselor: Any other similarities?

Trudy: Just feeling really stuck I guess.

Counselor: You are describing a lot of anxiety, Trudy, and I wonder what you're saying to yourself in your mind during these periods in your life when these feelings take over.

Trudy: I don't know. I guess I'm just telling myself that I'm letting people down, and I should just try harder.

At this point, Trudy was able to identify similarities between two situations in terms of her thoughts and feelings. Moreover, she is able to reflect upon herself easily and engage in causal reasoning indicative of a formal/reflective style; however, she was not able to recognize that the pressure that she perceives her parents place on her results in feelings of being stuck.

Counselor: (Attempting to transition to the dialectic/systematic style) Trudy, you've identified a pattern here where you feel very anxious about important decisions you make in your life regarding your future, and in which you feel your parents hold expectations for you. Is there one thing you've said that stands out for you?

Trudy: I don't know; I guess that I always feel overwhelmed and don't want to let my parents down.

Counselor: How might your parents describe this situation?

Trudy: (Long pause). I'm not really sure what they would say.

Upon further discussion, Trudy only mildly recognizes that her feelings of anxiety result from her perceptions of her parents' expectations of her and the pressure she experiences from these perceptions. Although she can clearly see that these perceptions relate to her feelings of anxiety, she is not adept at fully recognizing others' viewpoints in this situation. Moreover, she is not quite able to recognize the influence that these perceptions, and the feelings that result from them, have on her ability to engage in career exploration.

In this case illustration, the counselor assessed the specific modes of cognitive/emotional functioning Trudy was utilizing within this situation. Trudy was experiencing and processing her situation affectively as physical feelings of anxiety and fear. She had difficulty focusing or communicating many specifics of her situation; however, she was able to formulate patterns between her past and present experiences and the resulting thoughts and feelings associated with these experiences. Moreover, she found difficulty in perceiving her situation from multiple perspectives. In summary, Trudy was operating primarily in the sensorimotor/elemental and formal/reflective modalities, and seemed to lack strong concrete/situational and dialectic/systemic functioning within this specific situation.

Armed with an understanding of Trudy's developmental perceptions, the counselor can choose career counseling strategies that can address Trudy's issues more effectively. Trudy's difficulty functioning within the concrete style could hinder her ability to focus on early career exploration interventions such as completing interest and values inventories or engaging in occupational research. Thus, the counselor might decide to include interventions that match her sensorimotor functioning such as stress management and relaxation techniques. As Trudy develops the ability to manage her sensorimotor response, the counselor may begin integrating interventions that call for her to develop functioning within her non-preferred cognitive/emotional styles. For example Trudy could engage in role plays designed to help her explore her parents' perceptions and to practice responding in alternative ways to her parents' actual expectations. In so doing, Trudy could practice cause/effect thinking and perspective-taking and thus expand her development vertically within the concrete and dialectic modalities. In turn, Trudy may be more able to engage in more traditional exploration if she chooses.

## Conclusions

With roots in a positivistic approach to problem solving, career counseling is often a practice that focuses on cognitive and concrete operations. The DCT process allows career clients the opportunity to process their career concerns from a more developmental, cognitive and emotional perspective. This developmental understanding of career indecision allows counselors to promote overall growth and development and is essential because college students are typically fully engaged in the exploration and development of various dimensions of themselves (i.e., Chickering & Reiser, 1993; Kohlberg, 1981; Perry, 1981; Super, 1990). Additionally, a key component of career counseling is enhancement of the student's competence in this self-exploration process (Blustein, 1992). The DCT assessment and intervention process enhances self-exploration skills through examination of assumptions and consequences of behaviors that may go unnoticed by students (Ivey, Ivey, Myers et al., 2005).

The previous case illustration demonstrates how DCT can be used as an effective assessment and self-exploration strategy for career counseling. For career counselors it is important that developmental assessments are fairly brief and informal, as typical career clients may not readily understand the connection between their career issues and other developmental processes. DCT offers an informal and, with practice, seamless assessment strategy. The case illustration also highlights how the DCT assessment process becomes an effective intervention in its own right. Furthermore, by applying DCT, counselors can select specific interventions that may best help their clients make informed career choices while also encouraging clients' cognitive/emotional development.

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# Informed Consent and Minors

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Nearly every ethical code for mental health professionals requires informed consent, but it is a challenge for counselors who work with children to determine how to involve both parents and children in the process of informed consent. Ethical codes strongly encourage providing child clients with information about counseling, even when consent is not legally necessary; however, little information about the pragmatics of providing children with informed assent is available. In this article, the authors reviewed current Tennessee law and relevant ethical codes to examine practical methods for providing informed assent to children and parents, and assessed a child's ability to participate in treatment decisions.

The American Counseling Association (2005) defines informed consent as a verbal and written review of the responsibilities of both the counselor and the client in the counseling relationship. Counselors provide informed consent to potential clients so they can make an educated decision about the counselor, the counseling process, and whether to begin counseling. Informed consent includes the purposes of counseling, a description of counseling techniques, and strategies that counselors use in counseling sessions. Furthermore, counselors cover the potential risks and benefits of counseling, the counselor's professional background, limits to confidentiality, and the process by which a counselor's services terminate. The American Counseling Association (ACA) Code of Ethics (2005) requires that counselors provide *all* clients with informed consent before beginning counseling, but the Tennessee Code Title 33 Ch.8 (2000), representing the legal side of informed consent, gives parents and legal guardians the right to provide consent for their child's mental health treatment.

The Tennessee Code Title 34 (1992) charges parents with the care nurture, welfare, and education of a child and it may be presumed that consent for mental health decisions are included under those duties. Counselors are under no legal obligation to gain the consent of a minor client before beginning counseling. The risk of this approach is that, if a child is not given an opportunity to consider the treatment to be received, it may feel quite intrusive (Reynolds, Hays, & Ryan-Arredondo,

2001). Fortunately, proactive counselors position themselves to include both the parent or guardian and the child in the process of informed consent and treatment planning while remaining legally and ethically consistent at the same time.

Many counselors struggle, however, to understand the dynamic interaction between professional ethics and state laws (Mappes, Robb, & Engels, 1985). To help clarify the confusion that many counselors experience regarding minor clients and informed consent, this article will explore the legal and ethical obligations for counselors in Tennessee. The purpose of this article is to explain Tennessee state law implications on a minor's ability to provide informed consent to treatment, and the relevant state and national ethical codes related to a minor's ability to provide informed consent. The article concludes with implications for practice, which describes legally and ethically consistent suggestions for informing minor clients about the counseling process, as well as techniques for assessing a minor's competence to provide informed consent and participate in decision-making in the therapy process.

## Legal Issues

As a nation, the United States has a long history of laws that limit children's ability to provide for their own needs. The review of major laws that limit rights of children offers a clearer understanding of current legal and ethical standards , primarily because children have historically been little more than the legal property of their parents (Lawrence & Kurpius, 2000).

As early as the 17th century, the principle of *patriae potesta* dominated many family laws and invested the father with absolute power over the child, permitting abuse, neglect, or even selling the child into slavery (Halasz, 1996; Lawrence & Kurpius, 2000; Morrison, Morrison, & Holdridge-Crane, 1979). The principle of *patriae potesta* most clearly manifests in the passing of the Stubborn Child Act of 1646, a Massachusetts law that allowed the state to execute disobedient children. (Lawrence & Kurpius, 2001). The law stated that if a child refused to obey his parents, parents could bring the child to court and testify to his stubborn nature. If the court magistrate found the child to be unrepentant and incapable of self-control, the family could hand over the child to the state for execution (Cole, 1974).

Morrison, et al. (1979) recognized that children had no First Amendment rights historically because, under the auspices of the United States Constitution, the law did not consider children as people. Children more closely resembled property, indicating that parents essentially decided everything that concerned the interest of their child. Most states prohibited children from making decision for them regarding legal or medical issues. Despite the increased recognition of the rights of children since the days of *patriae potesta*, the basic idea that children are parental property remains. However, current rationale for legal rights of parents over children has evolved over time.

Today, common understanding is that children lack the developmental maturity to make intelligent and appropriate decisions in their own best interests. In Tennessee, the law reflects the idea that children lack the maturity to make decisions for their own self care. Consequently, in Tennessee, children cannot legally consent to most healthcare decisions, including counseling services, except in the case of children who have reached the age of majority (16 years old or legally emancipated), according to Tennessee Code Title 34 (1992) and Title 33 Ch. 8. (2000). The existence of exceptions may indicate that Tennessee law considers a child's right to act on his or her own behalf under some circumstances, yet in most cases, parents rights take precedence over the wishes of the child.

## Ethics

Not only do counselors consider the law when providing informed consent and dealing with minors, but they also consider relevant ethical guidelines. These authors' experiences in working with professional school counselors operating under the ASCA model is that it is common practice to include informed consent as part of the parent handbook and achieve informed

consent with parents en masse at the beginning of each school year. This article focuses on how a counselor would use informed consent in an individual case basis. The American Counseling Association (ACA) code of ethics is of particular importance to the Tennessee counselor because the General Rules Governing Professional Counselors (2009) states that all licensees shall comply with the current ACA code of ethics. The ACA Code of Ethics (2005) requires counselors to provide informed consent in both written and verbal formats. Counselors provide informed consent at the beginning of the counseling relationship to offer the client adequate information to make an educated decision about whether to enter into a counseling relationship. Additionally, ACA Code A.2.a states that informed consent is an ongoing process in counseling and one that counselors continuously document throughout the relationship. ACA Code A.2.b delineates information that counselors should address in informed consent and includes, but is not limited to:

> … purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the counselor's qualifications, credentials, and relevant experience; continuation of services upon the incapacitation or death of a counselor; and other pertinent information. (A.2.b, 2005)

ACA further addresses two topics of particular importance for this article: developmental sensitivity in informed consent and clients who are unable to provide informed consent. ACA ethical code A.2.c discusses the importance of developmental sensitivity when providing informed consent. According to this code, counselors communicate information in a way that is respectful of developmental level of the client. Furthermore, counselors should use clear language to provide informed consent. ACA code A.2.d addresses those clients who are unable to provide informed consent, whether due to being a minor or for any other reason. The code states that the counselor is to gain informed assent, or the client's agreement, before proceeding with counseling, even though it will not be legally binding. Furthermore, ACA states that counselors should involve clients in the counseling process when appropriate. However, the phrase "when appropriate" sometimes causes confusion because the counselor is obligated to determine when it is actually appropriate to involve the client in the counseling process and then how to do so.

Directives from the ACA Code of Ethics are especially pertinent and important for counselors who work with clients of various developmental levels, including children. Although the various ethical codes provide guidelines for pointing counselors toward ethical and clinically sound practice, it remains the duty of the counselor to determine how to enact these directives. Counselors are on their own when determining how to implement these ethical codes into practice.

## Practice

Tennessee state laws and ethical codes challenge counselors to incorporate legal and ethical guidelines into clinical practice. Essentially, the Tennessee Code states that, when a counselor works with a child client, the child's parent or guardian is the legal client. The parent or guardian has the right to consent to services, to terminate services, as well as access to all confidential information. Counselors must obtain informed consent from the parent or guardian before they begin to see a child in counseling. Therefore, to remain legally and ethically consistent, a counselor must provide and thoroughly explain informed consent to the parent or guardian of the child client. In addition to legal and ethical requirements, these authors believe that providing informed consent is an important part of therapy. Providing the child informed consent communicates that they are an important part of the therapeutic process, the therapist respects the child, and sets a precedent for the type of relationship that the counselor seeks to establish, namely one of mutual respect and involvement.

The counselor is not required to provide any of this information to the child; however, counselors must also consider the development of the counseling relationship with child clients. If child clients do not feel a part of the process, they may feel

powerless in the counseling relationship and reluctant to engage in the therapeutic process. The challenge for the counselor is to treat the child as an active part of the therapeutic process while being legally and ethically consistent in respecting the legal rights of the parent. The method of including a child in informed assent and treatment planning leaves many counselors confused. Currently, there is little guidance concerning what information child clients should receive and to what extent they should be involved in the treatment process.

The Association for Play Therapy (APT), a leading organization in child mental health, offers counselors a possible reconciliation for this situation. APT advances play therapy and play based approaches for mental health professionals who use play as a developmentally appropriate and therapeutic approach for communicating with children (APT, 2008). APT has been used in this article as opposed to other organizations for two major reasons: (1) APT is an organization that is devoted to the development and training of professionals who provide direct counseling/responsive services to children of many ages and (2) the basis of the approaches accepted and espoused by APT are based in meeting the developmental needs of the child. The Association for Play Therapy has developed a voluntary code of ethics (APT), including two relevant statements concerning informed consent and children. First, a counselor should develop and present a therapeutic plan based on developmental principles to both the client and the guardian in an understandable manner (APT, 2008). Second, a counselor should act in the best interest of the child when that child cannot legally give informed consent (APT). In most instances, this means involving the child's parent or guardian by seeking informed consent from this person because children legally cannot consent to counseling services (under most circumstances). However, APT further states that counselors should present a therapeutic plan not just to the parent or guardian, but to the child as well. Still, although APT offers counselors guidelines for best practice, the counselor determines how to involve child clients in the planning of therapy and the therapeutic process.

## Assessing a Minor's Competence to Understand Informed Consent

Competence to make decisions is an important and much debated issue in informed consent. According to Fundudis (2003), children under the age of 18 are considered incompetent in the matter of making decisions in many courtrooms, but researchers have shown that 14-year-olds do not differ significantly from 18-year-olds in their decision-making. In a study evaluating the ability of children to make informed consent decisions using children aged 9, 14, 18, and 21, children aged fourteen that were presented four hypothetical informed consent scenarios did not differ from adults in overall decision making or reasoning process (Weithorn, & Campbell, 1982). Furthermore, researchers have also shown that 15-year-olds do not differ significantly in decision making from adults (Fundudis). The law typically does not allow a child younger than eighteen to consent to treatment without parental consent. However, it is vitally important to facilitate cooperation between parent and child to provide increased responsibility for children in therapy and allow them to feel as though they are an important part of the therapeutic process.

According to Fundudis (2003), however, it would be inappropriate to use chronological age as the sole guide when determining the participation of a minor in treatment decisions. Pollack and Billick (1999) proposed the child's developmental competency, not chronological age, should guide the degree of participation in treatment decisions. Fundudis (2003) suggested that counselors focus on task-specific developmental competency when assessing a child's ability to make decisions. However, for many, it is unclear which developmental competencies a counselor should observe when determining participation in treatment decisions.

When considering a child's developmental competence, some questions that these authors believe are important to address include: Should a counselor follow the standard of developmental competency when considering a child's ability to

understand informed consent? If a child is mature enough to make some decisions, should that same developmental competency apply to all treatment decisions? Does competency extend to all decisions, even those that might have serious or even lethal consequences, or does it only apply in some situations? Significant questions remain concerning how to assess the developmental competency needed for children to make treatment decisions.

Fundudis (2003) suggested four competencies for determining a child's overall developmental competency. Fundudis' four competencies also provide a more complete picture of the child and a more accurate assessment of the child's ability to participate in treatment decisions. The first competency is the child's developmental age. When assessing developmental age, a counselor should look beyond the child's chronological age and assess how chronological age compares to the child's developmental level/stage, history, and maturational progress. A counselor can observe the child's behaviors in session and elicit reports of the child's behavior at home by caregivers. The counselor can then compare reports and personal experience of the child to developmentally appropriate behaviors outlined in child development literature.

The second competency Fundudis (2003) recommended assessing is the emotional state of the child, such as temperament, mental state, mood stability, attachment history, and level of adjustment. A counselor who notices a child demonstrating wildly fluctuating emotional states in session, such as moving from fierce anger to warm interaction and then back to being furious with the counselor again, should consider these emotional fluctuations when deciding how to involve the child in treatment decisions.

The third competency that counselors consider is the socio-cultural background of the child. The counselor should consider the client's religious beliefs, cultural values, and family values, as these views can strongly influence ideas about counseling and the decision making process (Fundudis, 2003).

The final competency is the cognitive level of the child, which is composed of language skills, memory, reasoning, and logical skills. When a counselor assesses a child's cognitive level, understanding Piaget's stages of cognitive development, namely the Preoperational stage (generally ages 2-7) and the Concrete stage (generally ages 7-11) are helpful (Broderick, & Blewitt, 2003).

Children in the preoperational stage (ages 2-7) assume that others perceive, think, and feel just as they do (Berk, 1994). Children in the preoperational stage also base their thoughts on immediate perceptions and center their perceptions on one particular element of a situation rather than the full picture. Children in the preoperational stage typically exhibit a cognitive feature called *centration* (Broderick & Blewitt, 2003). Centration indicates that children are only able to focus on one aspect of a situation at a time.

When counselors inform a child about certain aspects of the counseling relationship, they should understand that some children will display difficulty attending to multiple points at one time. This is an important point to consider, as informed assent is a complicated and abstract concept that requires sustained attention to many points over a short period. A counselor unfamiliar with the concept of centration may grow excessively frustrated when as a child client grows bored and distracted during the presentation of informed consent.

Another developmental issue to consider in preoperational children is egocentrism. Children demonstrating egocentrism have difficulty taking different perspectives and looking at a situation from multiple perspectives, posing difficulties for a therapist trying to explain a difficult ethical concept that requires perspective taking (Broderick & Blewitt, 2003), such as confidentiality or appropriate counselor client interaction outside of session.

When working with children in the Concrete stage of cognitive development (ages 7-11), counselors are aware that children rely upon causational thinking, basic logic concepts, and an ability to attend to multiple facets of a situation. Children in the Concrete Operational stage (ages 7-11) present special challenges for the counselor when discussing ethical issues or informed assent. Children in concrete operations use rigid logic and expect to be able to map any concept onto the physical world. They have difficulty understanding abstract concepts such as confidentiality and multiple relationships (Broderick, & Blewitt, 2003).

One solution for the counselor is to use examples that are connected with real life activities as opposed to abstract explanations of counseling (Broderick & Blewitt, 2003). Chi, Hutchinson, and Roberts (1989) suggested that the more experience a child has with a particular domain of knowledge, the more the child can think in a logically advanced manner. One implication of this finding is that the counselor might use a domain of knowledge that the child is familiar with when using examples, such as school, home, or another domain of knowledge with which the child is well acquainted.

Once a counselor makes a determination that the child is of an appropriate developmental level and will be included in decisions about the treatment process, the next step is to explain informed assent. However, one area in which informed assent is most obscure, especially for children, is the language used to explain this particular concept. Aside from informed consent, many materials produced for health consumers are too difficult for children to read (Green, Duncan, Barnes, & Oberklaid, 2003). Green et al. suggested three levels of readability for health consumers: Formal, Standard, and Informal. Formal language contains excessive professional jargon and is difficult to interpret for even the most educated client. An example of formal language would be, "A multicentre, randomized, double-blind, crossover trial of the efficacy of Drug X in treating children with pulmonary disease" (Green et al., p. 701). In contrast, the least difficult language format to understand is informal, which is jargon free, but loses information in order to make the language readable. An example of informal language would be, "Testing a new drug for lung disease" (Green et al., p. 701). Even though the general meaning of this sentence is clear, significant information is lost in translation. Instead, Green et al. recommended the use of Standard language, a middle-ground which mixes formal and informal language that promotes readability while maintaining all essential information.

Green et al. (2003) also provided several suggestions for explaining issues of informed assent to children. Providing identical information to children and parents is not sufficient. The counselor should tailor all language used to provide informed consent, both in writing and conversation, for the developmental needs of the individual child client, and pay specific attention to developmental level. Consequently, the counselor should change information given to children to meet their specific developmental needs. Green et al. (2003) suggested the following methods for tailoring language when communicating with children: simplification of information, comparison, analogies, examples, and pictures or video material. Incorporating pictures and examples by using one of the many books published about counseling sessions for children is a useful and effective method to target the specific developmental level of child clients. These books provide explanations about counseling while providing valuable information about the process of counseling through developmentally appropriate concepts and language.

### Initial Contact

One issue which all therapists of children must address is how to introduce the idea of therapy to a child. Knell (1997) utilizes an approach in which the parents are the source of information about this strange new place to which the child will be taken. Knell emphasizes several points for parents to consider when giving information about therapy to the child: (1) Do not lie (e.g., "Oh, we're going to the toy store, but first we need to make one quick stop"), (2) Do not threaten (e.g., "You will go to therapy or else you don't get any birthday cake." Or (3) Do not bribe (e.g., If you go to the doctor I'll get you something special

from the store"). Instead Knell urges parents to use a simple, concrete, nonjudgmental explanation such as, "You're going to go talk to someone who helps kids by talking and playing with them." In addition to coaching parents about introducing their child to therapy, suggest they read a book such as *A Child's First Book about Play Therapy* (Nemiroff & Annuziata, 1990) or *My Special Playtime* (Solt, 2007). These books can be used by parents to help the child begin to understand the process of therapy. This approach by Knell contains two important components for counselors wishing to involve parents, and thus children, in the informed consent process. First, this approach provides both the parent and child with a short concrete explanation of the counseling process. Second, this approach allows the therapist a chance to model effective relationship skills to the parent, by teaching the parent to be open and honest with the child.

In addition to aiding parents as they prepare their children for counseling, therapists must consider what to tell children in their first session. The following is a list of common items that may be discussed in the first session: what issues have brought them to counseling, the amount of time that will be spent each week, what some children do in counseling, and confidentiality. However, literature suggests that therapists have differing approaches to how much to discuss with the children and the method in which they discuss counseling (Knell, 1997; Oaklander, 1998; Allan, 1997).

Oaklander (1998) describes her approach to introducing children to therapy, in which both the child and the parent are in the room together. Oaklander begins by asking the parent what brings them to counseling, and then asking the child what he thinks about that. Then she sends the parent out and talks with the child telling him about what she can do to make things better, telling the child some things he does in counseling will be fun, and explains confidentiality (Oaklander). These authors believe this approach communicates to the child that he is important through including him in the meeting with the parents which would usually be an "Adults Only" activity. It also communicates that the child will be an important part of the process by asking his opinions, and thus setting the stage for the counseling relationship in which the child is respected as a unique person.

Allan (1997) also introduces the child to playroom discussing many practical aspects of counseling saying something like,

> "This is the play therapy room where we will meet every Tuesday from 3:30 to 4:20pm. It is a special safe place where children come and play and talk about things that are bugging them. What you do or talk about in here is confidential- it's private-it's between you and me… The only time I talk about what happens in here is if you say I can. There are two exceptions: if someone breaks the law and harms you or if you try to harm yourself or someone else" (p.119).

This approach allows the therapist to provide information about therapy to the child. These authors believe that communicating practical information about therapy (e.g., what time we meet, what we will do, etc.) is important because it allows children to know what to expect next and provides a measure of safety. This quote also shows that the therapist values the child by placing the focus on the child concerns, e.g., "What's bugging you" as opposed to "Problems your parents have been having with you." Communication in this style places a focus on the child as unique person of worth who the therapist values.

### Parent Consultations

Parent consultation is an area where informed assent is most likely to be an issue when working with a child client. Lines are blurred between what is confidential between the counselor and the child client and what the parent has a right to know during parent consultations. Because the Tennessee Code defines parents or guardians as the actual client when their children are receiving counseling, this means that they have a legal right to know all aspects of the counseling relationship. However,

such an arrangement might quickly silence most child clients in session because the counselor is seen as little more than a spy for their parent or guardian.

It is the experience of these authors that what often helps facilitate X is for the counselor to have an honest discussion with the parent or guardian and the child before counseling begins to explain how confidentiality works. Parents are often reassured when counselors remind them that they have rights to all information in session, but that counseling is most effective for children when parents respect their child's privacy in session. Furthermore, if the counselor determines that the child client is developmentally mature enough to understand confidentiality, then explaining confidentially in a similar way to the child may help ease his or her mind as well.

In order to include child clients in the process, one suggestion to prepare children for parent consultations is to inform them about the process, such as, "I will be talking to your parents about how things are going and to see what I can do to help. Is there anything that you'd like me to tell your parents?" In this example, the counselor gives the child client control in the therapeutic process by asking what the child wants the parents to know. The counselor also gives the child information about what the counselor and parent may discuss during the parent consultation. Moreover, when discussing confidentiality with a preadolescent, a counselor may say, "Do you know what confidentiality is? Well, what you tell me will be just between us, but sometimes I'll be checking with your parents to let them know how things are going. It's also really important to me that you're safe, so sometimes, to keep you safe, I have to tell your parents about things. If there's something you want your parents to know, I can talk to them about that too." In this example, the counselor explains in simple language a few key points about confidentiality and, at the same time, gives the child client enough information to determine what to tell and what not to tell the counselor. Essentially, the counselor has given the child client informed consent in the counseling process and, though not legally binding, it is ethically consistent and creates an environment where the child client feels reassured about the safety of telling things to the therapist.

## Conclusion

Many counselors struggle to understand their ethical and legal obligations when considering informed consent and child clients. Counselors recognize the importance of involving child clients in decision-making regarding the counseling process. Still, exactly how to include them in the counseling process is a difficult question with no clear answer. Legally, counselors are only required to obtain informed consent from the parent or guardian, leaving the child notably absent from the process of therapy. Consequences of omitting the child from the decision-making process include that children may feel reluctant or even refuse to participate in therapy. This situation may leave the counselor face-to-face with a non-verbal and non-responsive child client. Moreover, if the child client is not informed about what information the counselor is required to share with parents or authorities, the child may perceive any communication of sensitive material to a parent or guardian as a betrayal of the counseling relationship. The difficulty for child counselors is to provide accurate information to both the parent or guardian and child so each can make an informed decision about what to disclose in the counseling relationship.

In this article, we have attempted to provide counselors and mental health professionals important information contained within the Tennessee Code and relevant Codes of Ethics on the state and national level so that they may have "informed consent" as to their responsibilities when working with child clients and their parents or guardians. Moreover, because the law and ethical codes lack sufficient detail for practice, we have also provided practical suggestions for counselors to determine what information is appropriate for child clients to know when providing informed consent and how to navigate the gray areas between what child clients share in session and what parents have a right to know. We presented this information as

an introduction to a complicated issue for those who work with child clients. However, because there are no clear answers on the subject of informed consent and minor clients, counselors are encouraged to continue seeking supervision and peer consultation when they encounter the inevitable gray areas that will arise in the future.

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