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The current mission of NOHS is to strengthen the community of human services by: (a) expanding professional development opportunities, (b) promoting professional and organizational identity through certification, (c) enhancing internal and external communications, (d) advocating and implementing a social policy and agenda, and (e) nurturing the financial sustainability and growth of the organization.

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Teaching Undergraduates about Mindfulness

Keith Lahikainen, Champika K. Soysa

Abstract
Research demonstrates that using mindfulness techniques with clients as well as in developing professional efficacy among students leads to positive outcomes. This article presents the results of a mindfulness teaching intervention by examining baseline and post-teaching impacts among undergraduate human service ($N = 91$) and psychology ($N = 83$) majors at two institutions. After being exposed to a teaching module on mindfulness, students at both institutions increased their ability to differentiate between the facets of mindfulness and increased their willingness to use mindfulness themselves and with future clients. The findings support the inclusion of mindfulness education in human services curricula.

Teaching Undergraduates about Mindfulness

Contemporary mindfulness interventions evolved from mindfulness practices that date back thousands of years in Eastern spiritual traditions, most notably Buddhism (Bruce, Manber, Shapiro, & Constantino, 2010; Carmody, 2009). The concept of mindfulness has been widely studied and applied to a variety of helping professions and clinical settings over the last few decades. Researchers have investigated the value of mindfulness techniques in several therapeutic interventions that combine mindfulness with stress reduction (Kabat-Zinn, 1990) and behavioral and cognitive therapy (Linehan, 1993; Segal, Williams, & Teasdale, 2002). Despite the fact that mindfulness techniques evolved from a predominantly religious context, they can be taught in a completely secular way to impact the brain, influence the experience of emotions, and alter behavior (Davidson, 2010). For example, researchers have examined the benefits of mindfulness practice in relation to both the well-being of helping professionals as well as their effectiveness as helpers (Carmody, 2009; Fauth, Gates, Vinca, Boles, & Hayes, 2007; McGarrigle & Walsh, 2011; Shapiro, Astin, Bishop & Cordova, 2005; Thomas & Otis, 2010). Because mindfulness can be applied across a wide range of human contexts and experiences (Bruce et al., 2010), the authors investigate the value of such an approach in an educational setting involving undergraduate student learning.
Definitions of Mindfulness

Due in part to its long and culturally diverse history, the definition of mindfulness has suffered from a lack of clarity and universal consensus. Generally described as a purposeful paying of attention in the present moment in a manner that is non-judgmental (Kabat-Zinn, 1994), researchers have employed a variety of descriptors and methods for studying mindfulness. Grossman (2008) has argued that mindfulness is difficult to define because much of the Buddhist concept cannot be directly interpreted through a Western lens. As a result, he points out that mindfulness descriptions vary from being a trait or state of mind to that of a mental process.

Traditionally, mindfulness and mindfulness meditation have been commonly used as interchangeable labels in reference to the same concept. Meditation is not, however, equivalent to or synonymous with mindfulness, although mindfulness is promoted by practices such as meditation (Davis & Hayes, 2011). Mindfulness meditation is the practice of exercises (e.g., body scan, yoga, sitting meditation, Zen, chanting) that contribute to higher levels of mindfulness (Carmody & Baer, 2008). References to mindfulness meditation from this point forward indicate an active engagement in being mindful, although through specific means. In need of a more parsimonious and research based definition of mindfulness (Carmody, 2009), we adopted the theoretical model proposed by Baer, Smith, Hopkins, Kriememeyer, and Toney (2006) who identified five facets of mindfulness: (a) observing sensations, perceptions, thoughts, and feelings; (b) describing these internal experiences with words; (c) acting with awareness instead of automaticity; (d) non-judging inner experiences; (e) non-reacting to these experiences.

Benefits of Mindfulness

Research has consistently established a wide variety of benefits to the practicing of mindfulness. Carmody and Baer (2008) reported that well-being increased after a mindfulness-based stress reduction program. The ability to attend to internal affective and cognitive states in psychotherapists increased with their level of mindfulness (Fauth et al., 2007). Additionally, mindfulness has been shown to have a strong positive association with the satisfaction professionals derive from helping others (e.g., compassion satisfaction) and reduces self-reported levels of burnout in clinicians (Thomas & Otis, 2010).
Mindfulness based therapeutic interventions have long been shown to have a marked effect on psychological functioning and symptom severity, such as those experienced with depression, stress and anxiety (Bruce et al., 2010; Greason & Cashwell, 2009; Grossman, Niemann, Schmidt, & Walach, 2004; Hofmann, Sawyer, Witt, & Oh, 2010; Shapiro, Schwartz, & Bonner, 1998; Waelde et al., 2008). Additionally, mindfulness training has been demonstrated to decrease negative affect and is positively related to positive affect (Collard, Avny, & Boniwell, 2008; Jha, Stanley, Kiyonaga, Wong, & Gelfand, 2010). Lastly, research has revealed that mindfulness meditation attenuates prolonged reactivity to emotional stimuli (Ortner, Kilner, & Zelazo, 2007) and can help students preparing to counsel others to become less reactive to stress-related or anxiety-provoking events they may encounter with clients (Schure, Christopher, & Christopher, 2008).

**Mindfulness in the Curriculum**

To date, little has been written regarding the development of methods to increase mindfulness skills in professionals or undergraduate students training in the human services. To date, however, the human service literature has pointed out and called for the need to explore the use and relevance of attention to time in professional education and practice (Woodside, McClam, Diambra, & Varga, 2012). Mindfulness, as a disciplined practice, increases one’s attention to the present moment and allows one to capitalize on the awareness of time.

Recent writings in the human service literature also call for the need to incorporate empathy training within the human services curricula (Bayne, Pusateri, & Dean-Nganga, 2012) and to promote self-care practices amongst human service professionals in order to prevent compassion fatigue and vicarious traumatization syndrome (Neukrug, 2013). Mindfulness methods have been shown to develop an individual’s capacity for empathy as well as present-moment awareness (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007). Greason and Cashwell (2009) suggested that teaching mindfulness might be important as it could facilitate empathy for others. A 15-week Mindful-Based Stress Reduction course successfully increased the capacity for empathy and compassion in college students (Schure et al., 2008).

In addition, researchers have connected mindfulness practices to an increase in preventative self-care strategies and tools for those in the helping professions (McGarrigle & Walsh, 2011; Schure et al., 2008). Specifically,
Shapiro et al. (2005) demonstrated that an eight week Mindful-Based Stress Reduction intervention effectively reduced stress and increased perceived quality of life and self-compassion in health-care professionals. There is also strong support in the literature that teaching and encouraging mindfulness practices is useful in training those in all helping professions (Rothaupt & Morgan, 2007; Sherman & Siporin, 2008; Thomas & Otis, 2010).

Students who major in human service programs are required by ethical standards to develop and demonstrate awareness of their own beliefs, values, and behaviors as they relate to working with others (National Organization for Human Services, 1996). Developing human services curricula that could foster and support such development is therefore critical. The present study examined whether learning about mindfulness benefited undergraduate students training for careers in the human services. Given that the literature has demonstrated the benefits of mindfulness for clients receiving mindfulness-based clinical interventions and for therapists and counselors in their professional efficacy, self-care, and development of empathy, it is reasonable to assert that undergraduate students would benefit from the infusion of mindfulness education into a human services curriculum.

Given the above premise, the authors specifically examined the impact of exposing undergraduate students majoring in either human services or psychology to a teaching module on mindfulness and its correlates. We assessed levels of mindfulness, well-being, students’ ability to identify the five facets of mindfulness, and students’ willingness to use this knowledge themselves and with others both before and after a teaching module on mindfulness and its correlates. We used a mixed-model (or factorial) design, where course type was the between subjects factor (human services versus psychology students) and pre and post assessments were the within-subjects repeated measures factor. In addition, the authors investigated the five facets of mindfulness as predictors of well-being.

The authors formulated five hypotheses. First, we expected that students would learn about mindfulness by reading our research protocol, just as they would learn by reading a textbook. We, therefore, expected that the ability to differentiate between aspects of mindfulness would be higher than by chance prior to the teaching module. Second, we expected that students would demonstrate a greater than chance willingness to use mindfulness themselves and with others after reading and responding to the research protocol, before the teaching module. Having established baseline learning through the first two
hypotheses, in the third and fourth hypotheses, the focus shifted to assessing the impact of the teaching module. The third hypothesis was that students would increase their ability to identify the five facets of mindfulness after the teaching module. The fourth hypothesis was that students would increase their willingness to use mindfulness after the teaching module. Finally, the authors hypothesized that the facets of mindfulness would predict well-being among students both before and after the teaching module.

**Method**

**Participants**

The participants were full-time undergraduates in human service courses at a private college (N = 91) and psychology courses at a public university (N = 83). Students were recruited from courses taught by the authors. All students in these courses voluntarily chose to participate in the study and were offered an Institutional Review Board (IRB) approved alternative to their participation. IRB approval was sought and received for this study at both institutions. Across both samples, 97% of the participants were between 18-25 years of age. Of the 174 undergraduates across both the human services and psychology courses, 86% were women and 14% were men. All participants carried at least a 12-credit course-load in the semester of recruitment, indicating full-time status. Regarding ethnicity, 86% were White non-Hispanic, 6% were Hispanic, and African American/Black and Asians were 2% each. Students in human services courses reported a mean income of just over $5,000 per year, where a score of two on the Likert scale reflected $5,000 or less, and three indicated an income of $5,000-$10,000 (M = 2.13, SD = 0.51). These students worked close to 45 hours per week, where a score of three on the Likert scale indicated 16-30 hours per week and a score of 4 reflected 31-45 hours per week (M = 3.81, SD = 2.00). Students in psychology courses reported a mean income of close to $10,000 per year (M = 2.80, SD = 0.84) and worked about 16-30 hours a week (M = 3.09, SD = 1.32) on the same scales. The disparities in income and hours of work may be because the latter group of students at a state university had year-round employment (rather than vacation-only employment), working fewer hours per week but yielding greater annual income (Table 1).
Table 1:
Descriptive Statistics for all Study Variables Pre-Teaching Module and Post-Teaching Module

<table>
<thead>
<tr>
<th></th>
<th>Human Services (n = 80)*</th>
<th></th>
<th>Psychology (n = 76)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Module</td>
<td>Post-Module</td>
<td>Pre-Module</td>
</tr>
<tr>
<td>Mindfulness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observing</td>
<td>2.98</td>
<td>0.63</td>
<td>3.02</td>
</tr>
<tr>
<td>Describing</td>
<td>3.48</td>
<td>0.60</td>
<td>3.48</td>
</tr>
<tr>
<td>Awareness</td>
<td>3.47</td>
<td>0.63</td>
<td>3.23</td>
</tr>
<tr>
<td>Non-Judging</td>
<td>3.40</td>
<td>0.83</td>
<td>3.32</td>
</tr>
<tr>
<td>Non-Reacting</td>
<td>2.76</td>
<td>0.51</td>
<td>2.72</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>48.35</td>
<td>8.77</td>
<td>49.11</td>
</tr>
<tr>
<td>Mindfulness Quiz</td>
<td>4.23</td>
<td>1.69</td>
<td>4.29</td>
</tr>
<tr>
<td>Willingness to use</td>
<td>12.18</td>
<td>2.88</td>
<td>13.74</td>
</tr>
</tbody>
</table>

Note. *Descriptive analyses were run accounting for missing data, so that n was consistent for each group across all Means and Standard Deviations. M = Mean; SD = Standard Deviation. Mean scores were used for the Mindfulness subscales because item numbers varied across subscales.

Measures

Demographics. The authors developed a questionnaire for this study in order to obtain demographic data and to confirm eligibility criteria for the study. Questions included age range, gender, ethnicity/race, and full-time student status.

Mindfulness. The Five Facet Mindfulness Questionnaire (Baer et al., 2006) was comprised of the following subscales: observing, describing, acting with awareness, non-judging, and non-reactivity. The questionnaire had 39 items scored on a five-point scale, ranging from 1 = never or very rarely true to 5 = very often or always true. Higher scores indicated higher levels of mindfulness. Subscales had eight items, except non-reactivity which had seven. Subscale comparisons were based on mean scores. Predictive analyses utilized the raw subscale totals in order to maintain variability of score range. Baer et al. (2008) reported good construct validity and reliability. In the present study, internal consistency reliability (Cronbach’s alpha) was within an acceptable range, between .72-.94 across subscales at the two institutions.
Well-Being. The Warwick-Edinburgh Mental Well-Being Scale-WEMWBS (Tennant et al., 2007) was a 14-item measure with each item scored on a five-point scale, ranging from 1 = strongly disagree to 5 = strongly agree. The summation of all items yielded a total score where higher scores indicated greater well-being. Tennant et al. reported that the WEMWBS showed high correlations with other well-being scales indicating scale validity. They further stated that test-retest reliability at one week was 0.83. In the present study, internal consistency reliability (Cronbach’s alpha) was within an acceptable range, between .91-.95 across institutions, in keeping with those reported by the original authors.

Mindfulness Quiz. The authors constructed a 7-item quiz using items from the Five-Facet Mindfulness Questionnaire (Baer et al., 2006). Students had five response options for each item, representing the five facets of mindfulness: observing, describing, awareness, non-judging, and non-reacting. Correct responses earned one point and incorrect responses a zero, for a total of seven points. Higher scores reflected better differentiation between facets of mindfulness. This knowledge-based quiz was comprised of dichotomous responses that did not lend themselves to reliability analyses.

Willingness to Use Mindfulness Questionnaire. The authors developed this measure to assess student willingness to use mindfulness themselves and with others, including future clients. This five-item questionnaire had five response choices ranging from 0 = definitely did not teach me to 4 = definitely taught me. A sample item about willingness to use mindfulness themselves was “Completing all these questionnaires taught me new ways of thinking about/ understanding my own thoughts, feelings, and behaviors.” A sample item addressing willingness to use mindfulness with future clients was “Completing these questionnaires taught me about ways I could understand future clients, patients, etc. in a professional context.” The total score was the summation of all the response scores, with higher scores indicating greater willingness to use mindfulness. Internal consistency (Cronbach’s alpha) ranged from .81-.90 across the two institutions, serving as independent evaluations of reliability.

Teaching Module. The authors developed a teaching module on mindfulness conveyed through a lecture and slide presentation by one of the authors. The lecture began with definitions of mindfulness and well-being. For example, mindfulness was defined as paying attention with intention, in the present moment, and without judgment (Kabat-Zinn, 1994). Well-being was
defined as including self-acceptance, purpose in life, and personal growth (Keyes, Shmotkin, & Ryff, 2002). The presentation detailed the five-facet model of mindfulness (Baer et al., 2006). For example, observing included attending to sensations, perceptions, thoughts, and feelings. Describing was the ability to label internal experiences with words. Awareness was acting with conscious awareness as opposed to auto-pilot. To conclude, non-judging was about placing no value judgment on internal experience and non-reacting was about noticing without response. After teaching students about the preceding concepts, the instructor addressed recent research on the positive relationship between mindfulness practice and well-being. The lecture ended with a list of benefits of mindfulness, such as having more balance in life and less emotional volatility. The same instructor presented the 30-minute module at both institutions to ensure consistency.

**Procedure**

All participants were volunteers who responded to the protocol during class time after the instructor left the room. The alternate activity was to read the research protocol without responding to it. The instructions were read by a student volunteer from each class. Because the IRB classified this as an exempt study at both institutions, no names were recorded, only protocol numbers. The instructors could not identify participants from non-participants, thereby ensuring confidentiality.

The protocol consisted of five questionnaires presented in the following order: (a) demographic form; (b) Five Facet Mindfulness Questionnaire; (c) the Warwick-Edinburgh Mental Well-Being Scale; (d) the Mindfulness Quiz; (e) the Willingness to use Mindfulness Questionnaire. Participants took about 30 minutes to complete the protocol. One week later, the teaching module was presented and the research protocol was repeated.

**Results**

**Descriptive Analyses**

In order to examine baseline levels of mindfulness among both human services and psychology students, a mixed-model (factorial) ANOVA was performed where course type (human services vs. psychology) was the between-subjects independent variable and facets of mindfulness (mean subscale scores of observing, describing, awareness, non-judging, and non-reacting **pre-teaching**...
module) were the within-subjects repeated measures dependent variable. This analysis revealed no significant difference by course type, meaning that students in human service courses did not differ from students in psychology courses in terms of overall mindfulness. Furthermore, there was no course type x facets of mindfulness interaction. This means that the facets of mindfulness did not vary by course type. There was, however, a main effect of facets of mindfulness, \( F(4, 692) = 41.23, p < .001 \), indicating that reports of the five facets of mindfulness differed from each other. Post hoc analyses indicated that Non-Reacting scores were significantly lower than all other facets of mindfulness. This last finding occurred despite controlling for the number of items in each subscale by using subscale means for the analysis.

**Hypothesis Testing**

We used one sample t-tests to examine hypothesis one. In these analyses, scores on student responses to the Mindfulness Quiz pre-teaching module were compared to correct responses by chance alone (one in five chance for seven questions = 7/5 = 1.4). Students in human services courses (\( M = 4.03, SD = 1.70, n = 93 \)) scored higher than chance alone pre-teaching module, \( t(92) = 14.90, p < .001 \), as did students in psychology courses (\( M = 4.84, SD = 1.73, n = 85 \)), \( t(84) = 18.30, p < .001 \). This established baseline ability to differentiate between the facets of mindfulness. Hypothesis one was supported.

We used one-sample t-tests to examine hypothesis two. In these analyses, scores on student responses to the Willingness to use Mindfulness Questionnaire were compared to the scale Mean (scale mid-point = 2, total for five items = 2 x 5 = 10). Students in human service courses (\( M = 12.05, SD = 3.20, n = 94 \)) scored higher than chance alone pre-teaching module, \( t(93) = 6.22, p < .001 \), as did students in psychology courses (\( M = 11.14, SD = 4.11, n = 87 \)), \( t(86) = 2.58, p < .05 \). This established baseline willingness to use mindfulness. Hypothesis two was supported.

We used a mixed model (factorial) ANOVA to examine hypothesis three, where course type (human services vs. psychology) was the between subjects independent variable, and ability to differentiate between facets of mindfulness pre and post teaching module was the within subjects repeated measures dependent variable. We controlled for hours of work and income, in case these dimensions influenced levels of mindfulness. The analysis revealed a main effect for pre and post teaching module, where all students were more successful at
differentiating between aspects of mindfulness post-teaching module compared to pre-teaching module, $F(1, 170) = 5.44$, $p < .05$, supporting hypothesis three. Furthermore, the analysis indicated a main effect of course type, $F(1, 170) = 14.53$, $p < .001$, where the psychology students demonstrated greater overall ability to differentiate between aspects of mindfulness than the human services students. There was no significant interaction in this analysis, meaning that the increase in ability to differentiate between facets of mindfulness did not vary by course type.

In order to test hypothesis four, we used a mixed-model (factorial) ANOVA where course type (human services vs. psychology) was the between subjects independent variable and willingness to use mindfulness was the within subjects repeated measures dependent variable. We controlled for hours of work and income again, in case they influenced levels of mindfulness. We found a main effect for willingness to use mindfulness $F(1, 174) = 129.03$, $p < .001$, where willingness to use mindfulness themselves and with others increased post-teaching module (all students together), supporting hypothesis four. In addition, there was an interaction between course type and willingness to use mindfulness $F(1, 174) = 34.15$, $p < .001$, indicating a greater increase in willingness to use mindfulness post-teaching module among psychology students compared to human services students. There was no main effect of course type, indicating no difference in overall willingness to use mindfulness between human service and psychology students. The authors used stepwise regression analyses to examine hypothesis five (see Table 2). The inclusion and exclusion criteria were $p = .05$ and $p = .10$, respectively. All five facets of mindfulness were entered as potential predictors in every analysis. Well-being was the outcome variable in every instance. Among human service students, non-judging, describing, and non-reacting predicted well-being, accounting for 39.2% of its variance before the teaching module and 43.6% of its variance after the teaching module. That is, of the total 100% of well-being that could be predicted by any set of variables, the facets of mindfulness accounted for 39.2% pre-teaching module, and 43.6% post-teaching module, among the students enrolled in human services courses.

On the other hand in continuing testing of hypothesis five among students in psychology courses before the teaching module, describing, non-judging, and observing predicted well-being and accounted for 41.8% of its variance. After the teaching module, among students in psychology courses, describing, non-reacting, and observing predicted well-being and accounted for 36.3% of its variance. That
is, of the total 100% of well-being that could be predicted by any set of variables, the facets of mindfulness accounted for 41.8% pre-teaching module, and 36.3% post-teaching module among the students in the psychology courses.

Table 2

Regression Analyses of Mindfulness Predicting Well-Being: Significant Predictors Pre and Post Teaching Module in the Human Services and Psychology Courses

<table>
<thead>
<tr>
<th>Predictors</th>
<th>β</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a) Human Services: Pre-Teaching Module (n = 88)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Judging</td>
<td>.34***</td>
<td>[0.22, 0.66]</td>
</tr>
<tr>
<td>Describing</td>
<td>.34***</td>
<td>[0.31, 0.91]</td>
</tr>
<tr>
<td>Non-Reacting</td>
<td>.33***</td>
<td>[0.39, 1.20]</td>
</tr>
<tr>
<td>1b) Human Services: Post-Teaching Module (n = 88)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Judging</td>
<td>.42***</td>
<td>[0.39, 0.89]</td>
</tr>
<tr>
<td>Describing</td>
<td>.31***</td>
<td>[0.26, 0.83]</td>
</tr>
<tr>
<td>Non-Reacting</td>
<td>.26**</td>
<td>[0.27, 1.27]</td>
</tr>
<tr>
<td>2a) Psychology: Pre-Teaching Module (n = 86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describing</td>
<td>.35***</td>
<td>[0.28, 1.02]</td>
</tr>
<tr>
<td>Non-Judging</td>
<td>.35***</td>
<td>[0.26, 0.91]</td>
</tr>
<tr>
<td>Observing</td>
<td>.25**</td>
<td>[0.17, 0.92]</td>
</tr>
<tr>
<td>2b) Psychology: Post-Teaching Module (n = 81)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describing</td>
<td>.35***</td>
<td>[0.29, 1.05]</td>
</tr>
<tr>
<td>Non-Reacting</td>
<td>.24*</td>
<td>[0.12, 1.29]</td>
</tr>
<tr>
<td>Observing</td>
<td>.24*</td>
<td>[0.06, 0.92]</td>
</tr>
</tbody>
</table>

Note. ***p ≤ .001, **p ≤ .01, *p ≤ .05.

1a) Adj $R^2 = .39, F(3, 84) = 19.68, p < .001$; 1b) Adj $R^2 = .44, F(3, 84) = 23.40, p < .001$

2a) Adj $R^2 = .42, F(3, 82) = 21.32, p < .001$; 2b) Adj $R^2 = .36, F(3, 77) = 16.23, p < .001$

Discussion

Researchers have established the value of teaching mindfulness to students in the helping professions (Rothaupt & Morgan, 2007; Sherman & Siporin, 2008; Thomas & Otis, 2010). Most of this literature has focused on students in graduate programs, leaving a gap regarding the benefits of teaching undergraduates about mindfulness. In the present study, the authors examined baseline undergraduate learning about the five facets of mindfulness and willingness to use mindfulness by reading and responding to a research protocol, and again following a teaching module, among students at two separate institutions who were enrolled in human services and psychology courses. In addition, the authors examined the five facets of mindfulness as predictors of well-being among these same students. Overall, our hypotheses were supported with only minor variations across the students enrolled in human services and psychology courses, which could be accounted for by other factors as discussed later.
Research on the five facets of mindfulness has seldom focused on undergraduates (Baer, Lykins, & Peters, 2012). Our descriptive analyses confirmed baselines for the five facets of mindfulness among undergraduates, which is rare in the literature. Before the teaching module there was no difference in mindfulness between the human services and psychology students, indicating that our findings were consistent across the two institutions. Among the five facets of mindfulness, non-reacting was the lowest reported. We used mean scores for these comparisons because the subscale representing non-reacting had one item less than the other four subscales. The levels of mindfulness reported by our students were comparable with those reported by de Bruin, Topper, Muskens, Bogels, and Kamphuis (2012) for undergraduates in the Netherlands.

Students in both the human services and psychology courses learned about mindfulness simply by reading and responding to the research protocol. That is, their scores were higher than expected by chance alone (a one in five chance of a correct response because there were five response choices). Similarly, both the human services and psychology students demonstrated a higher than chance willingness to use mindfulness themselves and with others after responding to the research protocol. The authors conducted these analyses to establish baseline learning prior to the teaching module. Furthermore, the findings indicated that students learn by reading research protocols just as they learn by reading textbooks prior to any instruction by a professor. A review of the literature indicated that there are no data on student learning based on reading and responding to research protocols alone. The findings of the present study contribute to the sparse literature on the benefits of research participation for students (Coulter, 1986).

Having established that students learned about mindfulness by reading and responding to a research protocol, the authors investigated potential increases in their ability to differentiate between the facets of mindfulness after a 30-minute teaching module on mindfulness. Students at the institutions at which the research was conducted work several hours a week, including some who work 40 hours a week. According to Vindholmen, Hoigaard, Espnes, & Seiler (2014) hours of work and income could influence levels of mindfulness, so the authors controlled for these demographics when examining the potential benefits of the teaching module. All students improved their ability to differentiate between the five facets of mindfulness (observing, describing, awareness, non-judging, and non-reacting) after the teaching module, compared to before the teaching module.
These findings speak to the benefits of presenting a brief introduction to mindfulness in undergraduate courses in the human services. Neukrug (2013) has already addressed the inclusion of diverse approaches to human services practice in examining future trends in the field. The addition of a module on mindfulness would complement these initiatives. Such an introduction could create familiarity with the subject matter and thereby set the stage for greater receptivity at the graduate level, which could benefit future professional practice in the human services. However, it is important to note that familiarity and willingness to use mindfulness does not indicate mastery or ability. Davidson (2010) has noted in his appraisal of current research that between 2,000 and 45,000 hours of lifetime practice are required to be competent in using mindfulness. Such a large number of hours of practice cannot be attained through coursework or trainings alone and requires regular practice of mindfulness in everyday life in order to reap the psychological benefits (Carmody & Baer, 2008).

After showing that all students demonstrated a greater than chance alone willingness to use mindfulness themselves and with others just by reading and responding to the research protocol, the authors examined potential increases in this willingness after the 30-minute teaching module. As predicted, student willingness to use mindfulness improved post-teaching module compared to pre-teaching module. Once again, these findings speak to the benefits of a brief introduction to mindfulness for undergraduates in the human services. Although, students in the psychology courses demonstrated a greater increase in their willingness to use mindfulness post-teaching module compared to the human services students, possibly reflecting greater learning in this exercise among the psychology students. However, this observation may be an artifact due to instructor novelty as the teaching module presenter was the professor of the human services courses and a guest lecturer for the psychology students. Nonetheless, more research is required on differential increases in the willingness to use mindfulness.

In addition, students in the psychology courses demonstrated a greater ability to differentiate between the five facets of mindfulness than their counterparts enrolled in the human services courses (considering pre and post-teaching module scores together), this may reflect greater receptivity in some student populations based on course levels (e.g., 200-level or 300-level). Such a finding, however, cannot be established with certainty in this study.
Lastly, we investigated the five facets of mindfulness as predictors of well-being both before and after the teaching module on mindfulness amongst the human services and psychology students (see Table 2). In the human services students, mindful non-judging, describing, and non-reacting predicted in descending order well-being both before and after the teaching module. The factors accounted for 39% of the variance in well-being before the teaching module and 44% of that variance post teaching module. Meanwhile, in the psychology students, mindful describing, non-judging, and observing predicted well-being in descending order pre-teaching module, accounting for 42% of the variance. Post-teaching module, describing, non-reacting, and observing predicted well-being in that order, accounting for 36% of the variance. A notable shift occurred in predicting well-being amongst psychology students post-teaching module, from non-judging to non-reacting. Overall, it appears that describing was important for all students before and after the teaching module, non-judging was important for all students pre-teaching module, and non-reacting was important for all students post-teaching module. Thus, although non-reacting was the least reported facet, it was one of three predictors of well-being for both human services and psychology students post-teaching module. The differing predictors of well-being are worthy of note and further research is required to explicate their meaning.

**Limitations**

There were several notable limitations to this study. First, the sample size, although reasonable for research at small institutions, could limit the generalizability of the results. In addition, the comparison across institutions included sample populations with different majors, which could make it difficult to draw conclusions based on academic discipline or institution alone. The comparison of samples across majors at the same institution, or same major across institutions, could generate different results. A third limitation involved the inability to assess a potential instructor novelty effect when examining outcomes following the teaching module across the two institutions. Future researchers could consider using a third-party consultant to deliver the teaching module as way to control for this effect. It should be noted, however, that the study attempted to assess in-classroom learning, which aimed to examine the benefit of mindfulness education in the curriculum delivered by the actual instructor of such courses.
The longevity of the learning observed in the study could also be considered a limitation. As is the case with all teaching, immediate learning outcomes do not always stand the test of time. A follow-up assessment of learning maintained over time would be useful in determining the intervention’s relative duration. Since the learning intervention was a brief one-time module, expanding the content and length of the intervention may help maximize a change in learning.

Lastly, as there is a sparseness of research in the human services field on mindfulness education, much of the supporting literature is drawn across disciplines (e.g., counseling, nursing, psychology, social work). Although such applications and comparisons are often useful, caution needs to be taken in making definitive conclusions based on perceived similarities between professions. In the future, studies evaluating the usefulness of mindfulness techniques specific to a human services context, for both professionals and their clients, could help to inform the value of and best ways to implement mindfulness education in the human services curriculum. Part of this may involve the design of learning interventions that apply concepts of mindfulness to human service case scenarios or discussions of the potential for specific applications to human service practice.

**Implications**

In an increasingly challenging and complex profession, there are many implications for the use of mindfulness in human services practice and education. With an increased demand for interventions that work, the efficacy of mindfulness techniques in clinical interventions has been well-documented and continues to grow in scope and practice. Although human service professionals work to minimize or eliminate the impact of external barriers faced by clients (Johnson & Bonner, 2013), it is vitally important to help clients cope with environmental conditions that are often beyond their immediate ability to control. A practitioner’s knowledge of and willingness to use mindfulness interventions with those facing issues such as poverty and systemic oppression, may provide clients enough internal relief to allow time for environmental changes to occur (Neukrug, 2013).

Mindfulness is also beneficial to human service professionals themselves. In addition to increasing empathy for others, facilitating self-compassion, and reducing stress, it may help protect practitioners from the ill effects of the work
that they do (Poulin, Mackenzie, Soloway, & Karayolis, 2008). Since it is likely that practitioners will face increased exposure to crises, disasters, and traumas, mindfulness has shown promise in reducing negative post-disaster effects experienced by disaster personnel after events like those endured after Hurricane Katrina (Waelde et al., 2008). Finally, effective human service education and training involves teaching students to become more engaged, increasingly aware of themselves and others, able to self-direct their attention in complex environments, and more willing to proactively practice self-care (Sweitzer & King, 2013). Mindfulness has been shown to influence all of these factors in a positive direction, making the implementation of mindfulness education into the human services curriculum a promising strategy to consider.

**Conclusion**

This study established the benefits of teaching undergraduates in the helping professions, including the human services and psychology, about mindfulness. We found that all students could differentiate between the facets of mindfulness and that they demonstrated a willingness to use mindfulness simply by reading and responding to the research protocol. Later, both ability to differentiate between facets of mindfulness and willingness to use mindfulness increased in both human services and psychology students following a teaching module. Finally, we investigated the five facets of mindfulness as predictors of well-being, and established both shared and unique predictors across the two groups of students. Our findings could inform undergraduate curricular development in the human services, which could benefit graduate training and human service practice.

**References**


Perceptions of the HS-BCP Credential: A Survey of Human Service Professionals

Narketta M. Sparkman, Edward S. Neukrug

Abstract
With the Human Services Board Certified Practitioner credential (HS-BCP) being a few years old, this article sought to obtain the current perception it by members of the National Organization of Human Services (NOHS). A survey of NOHS members suggests that respondents overwhelmingly heard of the credential, that 42% had obtained the credential, and that a large number who were not credentialed indicated a desire to obtain it. Perceived awareness of employers was also obtained from NOHS members, as well as differences as a function of demographics and the perceived value of the credential. In addition, respondents expressed their views regarding their preference toward using the NOHS or HS-BCP code of ethics. Suggestions for increasing the visibility of the credential were made, and future directions of research related to the credential were suggested.

Perceptions of the HS-BCP Credential: A Survey of Human Service Professionals

The role of the human service professional was first defined during the 1960s when the field was established (McPheeters, 1990; Neukrug, 2013). As then, today’s human service professionals tend be associate or bachelor-level practitioners who are trained as generalists, which is defined as a human service professional who has “interdisciplinary knowledge, who can take on a wide range of roles and often works side by side with a number of other professionals” (Neukrug, 2013, p. 3). Over the past fifty years, to establish the field as a profession, educators and practitioners involved in human service work founded a national organization, developed accreditation standards, created an ethics code, founded a journal, developed master’s and doctoral programs, and most recently, developed a credential—the Human Service Board Certified Practitioner (HS-BCP) (Haynes & Sweitzer, 2005; Hinkle & O’Brien, 2010; Kincaid & Andresen, 2010; Wark, 2010).

The journey towards credentialing was not easy but was necessary if the human service professional was to gain recognition and respect within mental...
health professions. In fact, a review of literature suggests that over the years many
have used such words as “assistant” to describe human service professionals and
tended to view them as second-rate when compared to counselors, social workers,
and psychologists (Evenson & Holloway, 2003). The credentialing process was
aimed at solidifying a professional identity, developing an increased professional
look for human service professionals, and increasing the status of the human
service professional as compared to related mental health professionals (Milliken
& Neukrug, 2010). Hinkle and Obrien (2010) suggest that “the overreaching goal
[of credentialing] was to create a certification program that would provide quality,
value, and integrity for practitioners, their employers, and consumers of human
services” (p. 24).

The HS-BCP was established in 2008 as a joint effort between the
National Organization for Human Services (NOHS), the Council for Standards in
Human Service Education (CSHSE), and the Center for Credentialing and
Education (CCE) (Hinkle & Obrien, 2010). Having had a history of developing
other professional credentials, CCE was seen as pivotal to the development of a
credential as it had the professional knowledge to craft a certification that would
be valued by a wide range of professionals, and because the organization was
specifically created “for assistance with credentialing, assessment, and
management services” (CCE, n.d.a, para. 4). To steer the development of the
credential, a certification program development committee was established that
included members from NOHS, CSHSE, and CCE. Ultimately, this committee
decided that the criteria for credentialing would include education, experience,
assessment, ethics, and continuing education (Hinkle & O’Brien, 2010).

Relative to education, it was decided that any individual with a technical
certificate through a master’s degree in human services, or a closely related
degree (i.e., counseling, social work, marriage and family counseling, or criminal
justice), could sit for the exam (Hinkle & O’Brien, 2010). In addition, individuals
with related degrees could sit for the exam if they had taken 15 credits in
specified coursework. Today, this includes three or more courses in the 11 content
areas assessed on the exam “including at least two semester hours (three quarter
hours) in ethics in the helping professions, two semester hours (three quarter
hours) in interviewing and intervention skills, and two semester hours (three
quarter hours) in case management” (CCE, 2013, p. 3). For experience, the
number of years of post-degree experience varied considerably as a function of
the level of degree; those with a technical degree needing five years of experience
while those with a master’s degree needing only one year of experience. In addition, it was decided that those who graduated from a CSHSE accredited program did not need to demonstrate post-degree experience (CCE, n.d.b).

The assessment process took the form of a multiple choice exam based on case vignettes, the content of which was suggested by a national job analysis which identified 10 areas: “assessment, service planning and outcome evaluation; theoretical orientation/interventions; case management, professional practice, and ethics; administration, program development, evaluation, and supervision” (Hinkle, & O’Brien, 2010, p. 25). Today, the exam covers the following 11 areas: (a) interviewing and interpersonal Skills, (b) group work; (c) case management; (d) human development; (e) ethics in the helping professions; (f) social and cultural issues; (g) social problems; (h) assessment/treatment planning; (i) intervention models/theories; (j) human behavior; (k) social welfare/public policy (CCE, n.d.b).

Per the CCE, it was suggested that practitioners meet certain requirements in order to renew their credential. Thus, to maintain one’s credential, the committee suggested that continuing education would encourage practitioners to remain abreast of current trends important to the profession. Today, those who are credentialed need to gain 60 continuing education hours during each five year certification period which includes a minimum of six hours specific to ethics (CCE, 2013).

CCE also developed its own ethics code, and today, human service professionals have two codes which they could follow—one developed by NOHS (currently in a revision process) and the separate code developed by CCE. The reason for CCE developing its own code was two-fold (Wark, 2010). First, it was quickly realized that not all individuals who became credentialed would be members of NOHS. Therefore, these individuals would need an ethical code to follow. Second, as with most ethical codes in the helping profession, NOHS’s code was aspirational being based on principles for which human service practitioners should strive to attain. Thus, this code is broad and covers 54 important areas that are typically addressed in an ethical code. In contrast, CCE’s code was developed to focus, sharply, on a minimal number of specific ethical behaviors necessary to “withstand legal challenges and focused on behavioral expectations” (Wark, p. 20). This created somewhat of a dilemma for those who are both credentialed and members of NOHS—which code to follow?
The establishment of the HS-BCP is the culmination of the efforts of a number of human service practitioners and educators who wanted to continue the professionalization of the human service field. Along with accreditation, a national association, an ethics code, the creation of a journal, and other professional activities, it provides one more step toward the settling in phase of the human service profession (Milliken & Neukrug, 2010). To understand if the human service credential has “taken hold” and found a place in the profession, this research sought to (a) determine how familiar members of NOHS were with the HS-BCP credential; (b) approximate the percentage of members who had attained the credential; (c) examine demographics of those who are most likely to attain membership; (d) understand the importance that holding a credential has to members; (e) determine whether non-credentialed members were planning on becoming credentialed; (f) discover any benefits seen by those who already had the credential.

Method

Instrument

After conducting a review of the literature regarding the newly developed HS-BCP, a preliminary survey was developed to assess the knowledge, impact and value, and affiliation to an ethical code. This survey was distributed to six faculty members from a large human services program at a medium-sized mid-Atlantic University who were asked to take the survey and provide feedback regarding its efficacy and usefulness. A number of changes to the survey were completed after this feedback.

Following the completion of the informed consent statement, the survey requested demographic information, including age, ethnicity, highest degree obtained, and major or field of the highest degree. In addition, respondents were asked whether they primarily identified as a student, practitioner, faculty member, or “other” (options were given to write in responses). A separate question asked what individuals secondarily identified as professionally.

Demographic questions were followed by a series of questions regarding knowledge of the HS-BCP. Participants were asked whether they had heard of the credential, if they were credentialed, if they were intending to attain their HS-BCP, whether their employer had heard of the credential, and if they perceived a need for further education about the HS-BCP. These items were followed by a series of questions regarding the value of the HS-BCP. Included in this series
were questions on the extent the credential has or will add value, ways in which
the credential has impacted them, whether their colleagues valued the credential,
whether the credential was equal to other credentials (e.g., NCC, ACSW, LPC,
LCSW, CSAC) and the value and support their employer placed on the
credential.

Finally, questions regarding ethics were addressed, including whether
respondents were familiar with both the NOHS ethical code and the ethical code
of HS-BCP and which code they viewed as governing their profession. The
survey concluded with an open ended question asking respondents to note any
other questions or concerns they had regarding the HS-BCP.

Procedure

A copy of the survey and procedures for the study were approved by the
college's human subjects committee. An initial e-mail and two additional emails
were sent over a 3-month period to all members of NOHS. These e-mails included
an explanation of the survey, an informed consent statement, and the survey's
URL. After the third email, it was found that only a few additional surveys had
been completed and it was decided to discontinue survey requests.

Results

Response Rate

Of the approximate 1,300 members of NOHS, at the time of the survey,
we hoped to obtain a response rate of approximately 248 to allow for a 95%
confidence interval (CI) with a margin of error of 5% (Dattalo, 2008; Smith,
2004). Of the members contacted by e-mail, 241 (18.50%) responded to the
survey (95% CI; margin of error of 5.7%). This rate is probably higher than the
19.5% and likely has a lower error rate as non-deliverable emails may run as high
as 25% (Hoonakker & Carayon, 2009). Response rates to e-mail surveys have
been mixed and present some unique challenges, such as difficulty in ensuring a
representative sample of respondents (Jansen, Corely, & Jansen, 2007; Ye, 2007).

Demographic Information

Respondents (N = 241) had a mean age of 49.35. Of these, over one-half
identified as White (n = 135, 56%) and about one-third identified as African-
American (n = 80, 33%). Of the remaining, 6 (2.5%) were Latino/Latina, 5 (2.1%)
were native American, 1 was Asian, and 15 (6.2%) identified as “other.” Master’s
degrees were held by 38.59% of participants (n = 93), doctoral degrees by 28.10%
(n = 68), associate degrees by 16.59% (n = 40), bachelor degrees by 12.48% (n = 30),
and high school diplomas by 4.58% (n = 11). Those that indicated their
highest degree was in human services included 43.98% of participants (n = 106),
while 15.35% received their highest degree in “other” (n = 37), 12.03% in
psychology (n = 29), 08.29% in social work (n = 20), 7.50% in counseling (n = 18),
2.90% in education (n = 7), 2.48% in marriage and family (n = 6).
Participants that had not majored in a field were 5.80% (n = 14). Respondents
indicated they primarily identified as faculty (n = 93, 38.59%) with 24.90%
identifying as students (n = 60), 23.24% identifying as practitioners (n = 56), 26
(10.79%) as “other,” and 3.49% as unemployed (n = 6). When asked to identify
their secondary affiliation 34.7% identified as practitioners (n = 75), 29.63% as
“other” (n = 64), 19.91% as students (n = 43), 8.33% as faculty (n = 18), and
7.41% as unemployed (n = 16) (25 or 5.47% did not respond).

**Knowledge of HS-BCP Credential**

Of the 241 respondents, 90.04% (n=217) indicated they had heard of the
HS-BCP credential, and 42.32% (n = 102) noted they had obtained their HS-BCP
credential. Of the 139 who had not obtained the HS-BCP, 55.39% (n = 77)
indicated they were planning on obtaining the credential, 28.06% (n = 38) were
not sure if they would obtain the credential, and 12.23% indicated they were not
planning on obtaining the credential (n = 17) (7 did not respond). About half of
the respondents believed their employer had heard of the HS-BCP credential and
over 90% indicated there was a need to increase education about the HS-BCP (see
Table 1).

| Employer Awareness of HS-BCP and Need for Education on HS-BCP (N = 241) |
|-----------------|----------------|----------------|----------------|----------------|
| Employer aware | Strongly Disagree | Strongly Agree | Strongly Not | Not Sure |
| of HS-BCP       | n = 57 23.65%   | n = 62 25.73%  | n = 39 16.18% | n = 31 12.86% |
| Need for furthn | n = 4 21.58%    | n = 11 21.58%  | n = 77 31.23% | n = 149 11.18% |

Table 1
Impact and Value of HS-BCP

When asked if the HS-BCP “has added value, or will add value, to my current position” 36 (34.62%) of the 102 who had their credential indicated it did not, while the rest indicated it had or will add value somewhat (n = 32, 30.77%), a moderate amount (n = 25, 24.04%), or very much (n = 11, 10.58%). This contrasts with the fact that about one-half of those who had obtained their credential indicated “the credential has done nothing for me.” Although 24 (29.60%) respondents indicated the credential had led to an increase in status, other benefits to having the credential were noted by only small numbers of individuals (see Table 2).

Table 2

<table>
<thead>
<tr>
<th>Impact of HS--BCP on Member (N = 102)</th>
<th>n</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The credential has done nothing for me</td>
<td>52</td>
<td>50.98%</td>
</tr>
<tr>
<td>The credential led to an increase in status</td>
<td>24</td>
<td>19.60%</td>
</tr>
<tr>
<td>Allowed me to apply for a job that I would not have been able to apply for</td>
<td>6</td>
<td>6.14%</td>
</tr>
<tr>
<td>The credential led to a promotion</td>
<td>6</td>
<td>5.82%</td>
</tr>
<tr>
<td>The credential led to an increase in salary</td>
<td>5</td>
<td>4.90%</td>
</tr>
<tr>
<td>Allowed me to apply for a promotion at my current job</td>
<td>4</td>
<td>3.92%</td>
</tr>
</tbody>
</table>

Respondents were mixed in their responses concerning whether they believed their colleagues valued the credential, whether they viewed the credential as equal to other credentials, and whether they considered their employer as valuing and supporting the credential (see Table 3).
Table 3

Value of HS-BCP (N = 241)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My colleagues value the HS--BCP</td>
<td>n = 40</td>
<td>16.60%</td>
<td>34.05%</td>
<td>37.76%</td>
</tr>
<tr>
<td>The value of HS-BCP credential is equal to</td>
<td>n = 60</td>
<td>24.90%</td>
<td>38.17%</td>
<td>21.99%</td>
</tr>
<tr>
<td>other credentials</td>
<td></td>
<td></td>
<td></td>
<td>14.94%</td>
</tr>
<tr>
<td>My employer values</td>
<td>n = 39</td>
<td>16.18%</td>
<td>38.17%</td>
<td>37.34%</td>
</tr>
<tr>
<td>and supports the HS-BCP credential</td>
<td></td>
<td></td>
<td></td>
<td>8.30%</td>
</tr>
</tbody>
</table>

Ethics

Almost all (n = 227, 94.19%) of the 241 respondents were familiar with NOHS’s ethics code and a large number were familiar with the HS-BCP ethics code (n = 196, 81.3%). When asked if the NOHS code is the “code of ethics that governs my profession” most respondents responded in the affirmative (see Table 4). Similarly, when asked the same question about the HS-BCP, a large number of respondents also responded in the affirmative (see Table 4).

Table 4

Adherence to Ethical Code (N = 237; N = 232)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The NOHS code is the code of ethics that</td>
<td>n = 9</td>
<td>3.80%</td>
<td>12.66%</td>
<td>38.82%</td>
</tr>
<tr>
<td>governs my profession (N = 237)</td>
<td></td>
<td></td>
<td></td>
<td>39.24%</td>
</tr>
<tr>
<td>The HS-BCP code is the code of ethics</td>
<td>n = 9</td>
<td>3.88%</td>
<td>29.74%</td>
<td>44.39%</td>
</tr>
<tr>
<td>that governs my profession (N = 232)</td>
<td></td>
<td></td>
<td></td>
<td>21.98%</td>
</tr>
</tbody>
</table>
Credentialing as a Function of Demographics

When grouping 240 respondents by ten-year age groups, the youngest age group (21-30 years) showed the lowest percentage of those credentialed (n = 13; 7.69%) while the oldest age group (61-70 years) showed highest percentage of those credentialed (n = 40; 72.50%). The other age groups had similar percentages credentialed (n = 62, 31-40 years: 40.90%; n = 62, 41-50 years: 30.65%; n = 81, 51-60 years: 41.98%).

To understand differences in demographics, Chi Square statistics was used. When comparing Whites and African American on attainment of the HS-BCP, no significant differences were found, with 44.44% of Whites having obtained the credential and 46.25% of African Americans having obtained it $X^2(1, N = 215) = 0.1, p = .75$. Other ethnic/cultural groups were not included due to the low number of respondents in the sample.

Examining differences in attainment of the credentials as a function of degree was significant and the higher the degree, the more likely one would have a credential $X^2(3, N = 230) = 13.98, p = .003$. Since all 11 individuals with a high school diploma were not able to obtain the credential, they were eliminated from the data. Of the remaining respondents the following percentages had credentials: 9 of 40 (22.5%) at the associate level, 10 of 30 at the bachelor level (33.33%), 45 of 93 (48.39%) at the master’s level, and 38 of 67 (56.71%) at the doctoral level.

Differences based on primary identification of respondent was significant $X^2(3, N = 235) = 40.36, p = .0001$, with higher percentages of practitioners (n = 56, 60.71%) and faculty (n = 93, 55.91%) being credentialed as compared to students (n = 60, 11.67%) those who identified as “other” (n = 26, 26.92%), and those who were unemployed (n = 6, 33.33%; not included in Chi statistic due to low numbers).

Of the 24 respondents who perceived an increase in status on the job, 11 were practitioners, 7 were faculty, 3 were students, and 3 were “other.” Of the 10 respondents who stated that the credential was responsible for them receiving a promotion or allowed them to apply for a promotion at their current job, 4 were practitioners, 4 were students, and 2 were faculty. Of the 10 individuals who stated the credential allowed them to apply for a job they wouldn’t have been able to apply to otherwise, 5 were students, 3 were faculty, and 2 were practitioners. Finally, of the 52 individuals who stated the credential has done nothing for them, 29 were faculty (n = 93, 31.18%), 15 were practitioners (n = 56, 26.79%), 3 were
unemployed (n = 6, 50.00%), 3 were “other” (n = 26, 11.54%), and 2 were students (n = 60, 03.33%)

**Discussion**

The purpose of this study was to examine NOHS members’ perceptions of the HS-BCP credential, and based on these views consider its impact on the field of human services. The study examined the familiarity of the credential by NOHS members, elicited the percentage of members who had obtained the credential, examined demographics of those who were most likely to obtain the credential, and examined the importance of the credential to participants. In addition, the study further sought to determine whether non-credentialed members were planning to become credentialed and the benefits seen by those who already obtained the credential. Two hundred and forty one (241) NOHS members participated in the survey and contributed to the current understanding of the credential within the human service field.

With 217 of 241 participants having heard of the credential, clearly NOHS and CCE have created awareness of the HS-BCP. Interestingly, the largest percentage of individuals who were credentialed were older than 60 years of age, perhaps because these individuals saw themselves as instrumental in the professional development of human services, culminating with the development of the credential. No significant differences were found between Whites and African American participants on the percentages being credentialed; possibly indicating that culture/ethnicity plays little, if any, role in attainment of the HS-BCP. However, there were differences found based on educational attainment, with those who have a master’s or doctoral degree being more likely to have been credentialed. These individuals may place a higher value on the credential because they have made a longer and deeper commitment to the field.

Although, many of the participants in the survey had some knowledge of the credential, less than half of the respondents (about 42%) had obtained it. However, over half of those who have not obtained the credential are planning on attaining it, indicating that there is strong interest in becoming credentialed. Although having a strong interest in obtaining the credential is laudable, it should be kept in mind that the respondents in this survey were highly skewed toward faculty—individuals who are likely to most advocate for such a credential. It would be interesting to see if such knowledge and interest in the credential is as evident in a national sample of individuals who are not members of NOHS.
With over half of respondents believing their employers have had some knowledge of the credential, it seems clear that awareness of the HS-BCP credential is present within the NOHS community. It would be interesting to see if employers of human service professionals who are not members of NOHS have the same perception. Individuals within NOHS clearly have a desire for continued spreading of knowledge about the degree with over 90% of them wanting to educate others about the credential. These individuals clearly view the credential as important to the profession.

Despite the apparent knowledge of the credential amongst respondents and a fairly sizable percent of respondents’ employers, close to half of respondents indicated their employers were not aware of the credential. With one purpose of the HS-BCP being to demonstrate to stakeholders that credentialed professionals have met high standards of practice (Hinkle & O’Brien, 2010), there is clearly some work to do. As licensed social workers, counselors, and psychologists had to work to spread knowledge of their respective license to gain awareness by professionals and their employers, so will human service professionals. Without recognition, the intended purpose of the credential itself has failed its stakeholders. Educating the community through advertising, building awareness, targeting human service agencies, and presenting on the credential at human service related conferences can greatly increase the visibility and perceived value of the credential.

Although some individuals found a variety of benefits to having the credential, like a promotion, increased status, a salary increase, and the ability to apply for other jobs, over half of those who have their credential indicated that the credential has “done nothing for me.” Furthermore, over 30% of respondents believe that the credential has not and will not add value to their current position. Also, over 50% of respondents indicated that the credential was not as valued as related credentials in other fields and that their employers and their colleagues did not particularly value the credential. All of this is troublesome. It is critical that NOHS and CCE continue to make efforts in helping human service professionals, administrators at human service agencies, and the public at large, know about the credential. They may want to launch advertising campaigns with the public, publicize the credential with human service agencies, and advocate for lobbying efforts with state legislators (Curry, Eckles, Stuart & Qaqish, 2010). Such efforts will increase the knowledge and respect for the credential and increase the likelihood that more individuals will obtain the credential. More individuals
obtaining the credential ensure that increased numbers of human service professionals have obtained the appropriate training and the concurrent knowledge and skills to work effectively with clients.

It should be noted that although faculty had the highest percentage of those who stated that the credential has done nothing for them; this may be because credentials are rarely seen as important in the promotion and tenure process. However, this does not mean that faculty members do not support the credentialing process as faculty are aware of how credentials positively impact students and budding human service professionals and how they protect the public from incompetence (McClam & Diambra, 2006).

In examining the knowledge of ethical codes and adherence to a specific code, the majority percentages of respondents reported familiarity with both codes and saw both governing the profession. Although the codes are fairly different, with the NOHS code being an aspirational code and the HS-BCP code being a code that can be used in litigation, it is difficult to understand how high percentages of respondents can see both codes as the one that governs their profession. Perhaps NOHS and CCE can come to a working agreement on how the two codes can be used together for ethical decision-making and to drive the values of the human service professional.

Limitations

A number of limitations are evident in this research. First, it is always difficult interpreting the results of survey research (Creswell, 2009) and one can usually only make educated guesses as to the reasons behind why individuals respond the way they do. Also, because this survey only assessed NOHS members, the results tell us little, if anything, about the broader population of human service professionals. In addition, although we apparently reached saturation relative to the number of individuals who responded, respondents may not be reflective of the larger population of NOHS. As NOHS does not keep demographic information on their members, we cannot compare those who did respond to those in the larger population of NOHS members.

The survey brought us some contradictory results. On the one hand, there seems to be a general embracing of the HS-BCP, with fairly large numbers of individuals having either obtained the credential or planning to obtain the credential. However, many individuals did not find the credential particularly beneficial. It is difficult to understand such results, except to hypothesize that the
credential is still in its infancy stage and that respondents have hope and faith that the credential will become more useful and powerful in the future. Future research should focus on repeating this study to specifically see if NOHS members see the credential as more beneficial in the future. Also, doing a similar survey with human service practitioners who are not NOHS members would be important. It is likely, that those who are NOHS members have more knowledge of the credential and more at stake to becoming credentialled than those who are not.

**Conclusion**

This study indicates there has been growth in the knowledge, awareness, and importance of the HS-BCP. However, findings also indicate there are areas in which the value of the credential can be strengthened. The HS-BCP is a relatively new credential and it will take time for it to become fully established in the field. This study provides suggestions for advancing awareness of the credential and offers areas that should be targeted by governing bodies so that more individuals will become cognizant of its importance in the training of highly competent human service practitioners and, ultimately, effectively servicing their clients. The HS-BCP was created to regulate the profession and establish quality, value and integrity within human service practitioners. Building awareness of this credential will help to drive the value of it. Strategic planning is essential if the credential is to become a driving force in development of competent human service professionals.

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Secondary Traumatic Stress and the Role of the Human Service Practitioner: Working Effectively with Veterans’ Families

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Abstract

Posttraumatic Stress disorder (PTSD) is an increasing mental health concern in the military veteran population. It is important to note that PTSD is a systemic diagnosis, meaning that the well-being and emotional health of family members is impacted by living with a veteran suffering from PTSD. Some family members may develop secondary traumatic stress (STS) symptoms. This manuscript will describe secondary traumatic stress and will explore the role of the human service practitioner in working with family members with STS. Future research in this area will also be explored.

Secondary Traumatic Stress and the Role of the Human Service Practitioner: Working Effectively with Veterans’ Families

As of March 2013, approximately 2.5 million veterans were deployed to Iraq and Afghanistan (Adams, 2013). Many veterans are deployed multiple times during their careers, which has caused an increase in service related disability status for veterans (Spiegel, 2008). Multiple deployments have resulted in increased mental health issues among the veteran military population. Approximately, 5 to 20% of U.S. soldiers returning from service in Operation Enduring Freedom (OED), Operation Iraqi Freedom (OIF), and Operation New Dawn have signs of depression or Posttraumatic Stress Disorder (PTSD) and about 30% of veterans on their third or fourth tours have experienced some form of emotional “illness” (Fisher & Schell, 2012; Spiegel, 2008).

As rates of PTSD in the military are increasing (U.S. Department of Veterans Affairs, n.d.a), the family system of veterans is also experiencing increased stressors, demonstrating that PTSD is a disorder with far-reaching implications (Gavloski & Lyons, 2004). According to Cook, Slater-Williams, and Harrison (2012), 55% of veterans are married and 43% have children under the age of 18. Symptoms of PTSD can also impact the veteran’s spouse, children, community, friends, and overall family and social functioning (Brainlinemilitary, 2004). Trauma, and the symptoms associated with PTSD, can be transmitted to individuals within the veteran’s family and is often referred to secondary

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traumatic stress (STS) or secondary traumatization (Cook, Slater-Williams, & Harrison, 2012). In this article, we will briefly discuss PTSD and explore the impact the trauma/stress disorder can have on the family, notably the children and spouse, in the form of STS. We will also examine how the human service practitioner (HSP) can work effectively with family members of veteran’s experiencing PTSD.

What is Posttraumatic Stress Disorder (PTSD)?

Once considered an anxiety disorder, PTSD has now been reclassified as a “trauma and stressor-related disorder” in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (American Psychiatric Association, 2013a; U.S. Department of Veterans Affairs, n.d.b). According to the American Psychiatric Association (2013b), the diagnostic criteria identify “the trigger to PTSD as exposure to actual or threatened death, serious injury, and/or sexual violation” (para. 3). The exposure must result from directly witnessing or experiencing the traumatic event, learning a close family member has been exposed to a traumatic event, and/or experiencing repeated or extreme exposure to the aversive details of the traumatic event. The disturbance must cause “clinically significant distress or impairment” (para, 3) in important areas of functioning such as, work, family, and social interactions.

According to the American Psychiatric Association (2013a), the DSM-5 focuses on the behavioral aspects of PTSD and divides the condition into four diagnostic clusters: re-experiencing, avoidance, negative cognition and mood, and arousal. Re-experiencing is characterized as experiencing intrusive memories, flashback, or other significant psychological distress related to the traumatic event. Avoidance refers to the evasion of reminders of the traumatic event, including memories, thoughts, feelings or external stimuli. Negative cognitions and mood can represent various feelings, perceptions, and behaviors such as blaming self and others, estrangement from others, inability to remember key aspects of the event, and diminished interest in daily activities. Finally, arousal is characterized by impulsive and/or self-destructive behavior, sleep disturbances, aggression, hyper vigilance, and other related issues.

Stigma of PTSD in the Military

Hindering their chances of receiving the treatment they need, veterans may be reluctant to disclose their trauma and stress-related symptoms (Newman, 2011). According to the U.S. Department of Veterans Affairs (n.d.a), there are
treatments available for PTSD, but many veterans will not seek out this assistance. One reason for this refusal is the potential stigma with regard to being labeled as having a “disorder.” The label of a disorder may negatively affect how a veteran is treated in determining eligibility for security clearances and/or readiness for deployment (Fisher & Schell, 2013). One way military leaders approach this issue is by proposing that the mental health community change the language to Posttraumatic Stress Injury (Fisher & Schell, 2013; The American Legion, 2012). Proponents of this argument suggest that the term injury may increase access to treatment and may decrease the stigma associated with the word, disorder. However, there is little empirical evidence pertaining to the use of the term “injury,” and despite a request by senior military leadership, the APA decided not to change the name of PTSD (Fischer & Schell, 2013).

One major consequence of failing to disclose PTSD symptoms and seek appropriate mental health services is the alarming suicide rates of veterans (Ilgen et al., 2010). According to Cook, Slater-Williams, and Harrison (2012), veteran suicide rates are twice the rate of civilian suicide rates with suicide rate surpassing combat related deaths (the suicide rates reported only capture completed suicides and not suicide attempts). In addition, 20% of veterans who made suicide attempts and 21% of veterans with completed suicides also had a history of substance abuse (Cook et al., 2012).

Secondary Traumatic Stress

PTSD is a system phenomenon and it can impact the veteran’s spouse, children, community, friends, and overall family and social functioning. Trauma can be transmitted to individuals within the veteran’s family and is often referred to as secondary traumatic stress (STS). STS is “the natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from wanting to help a traumatized or suffering person” (Figley, 1995, p.7). STS can also be characterized as the psychological distress experienced by an individual who is exposed to recollections of the trauma experiences of the others—also referred to as indirect trauma exposure (Dekel & Goldblatt, 2008). Symptoms can mimic those seen in PTSD and can affect the families of veterans as well as human service professionals who work with these individuals (The National Child Traumatic Stress Network, n.d.). STS is not recognized by the DSM-5 as an official mental health diagnosis and is often used interchangeably with vicarious trauma and Intergenerational Posttraumatic
Stress Disorder (Dekel & Goldblatt, 2008; The National Child Traumatic Stress Network, n.d.).

**Effects on the Family System**

While STS is not recognized by the DSM-5, the familial effects are almost inevitable. According to Friedman (2006), veterans face a multitude of psychological challenges in their transition from the war zone, where they were in an unremitting combat-ready hypervigilent state to one’s home life. When a military parent or spouse has PTSD, there is an increase in anxiety, marital problems, verbal abuse, substance abuse, and economic distress, which can lead to higher divorce rates, behavior problems in children, and an overall increase in family stress (Brainlinemilitary, 2014). Families can become more isolated due to social anxiety or avoidance from their veteran family member. If the veteran engages in acting out behaviors (e.g., aggressive behaviors, argumentative responses with others), it can also lead to family alienation (Jordan et al., 1992; U.S. Department of Veterans Affairs, n.d.c). According to Jordan and colleagues (1992), family members may not understand the nature of PTSD and know how to react to the veteran’s behavior, which can further impact the veteran’s PTSD symptoms. According to The U.S. Department of Veterans Affairs (n.d.c), family members can experience a variety of reactions to a veteran’s PTSD symptoms including: sympathy, negative feelings, avoidance, depression, anger, guilt, and health problems.

**Effects on the Spouse**

In addition to the familial effects, a veteran’s PTSD can also affect the spouse. When the veteran shows PTSD symptoms after returning from war, his/her spouse is often torn between caring for the veteran and protecting the children from abusive behaviors. In addition, if a veteran’s PTSD prevents her/him from maintaining employment, the spouse may need to leave her/his job in order to care for the veteran. This can cause additional emotional and economic strain on the spouse by having to be the primary caregiver for both the veteran and children (Hayes et al., 2010). Overall, caring for a veteran with PTSD often results in overall higher levels of emotional distress and lower levels of marital satisfaction (Dekel, Solomon, & Bleich, 2005).
Effects on the Child

According to Klarić et al. (2008), “children react more intensively to parental emotional states and behavior than to real danger” (p. 496). Whether a parent with PTSD is exhibiting rage and violent behaviors or avoidance and emotional distance, his/her behavior will impact the child’s development (Dekel & Goldblatt, 2008). These circumstances can affect children throughout their lifetime because parents have difficulty providing a “safe base” that would promote appropriate psychosocial development (Klarić et al., 2008; Levinson, 2011). The more severe PTSD symptoms expressed by the parent, such as witnessing the parent’s reactions to flashback and nightmares, paranoia, rage, and extreme fear, the greater emotional distress the child will experience (Dekel & Goldblatt, 2008). A parent can further affect the child’s emotional wellbeing and development by failing to celebrate a child’s successes, focusing on the negatives, and imposing unreasonable or inconsistent punishments, which are additional symptoms of PTSD in veterans (Cook et al., 2012; Dekel & Goldblatt, 2008; Klarić et al., 2008). In turn, according to Cook et al. (2012), the child will react by mimicking the parent’s hyperarousal and avoidance (over-identification), taking a parent role (rescuer), and/or isolating from the parent (emotionally uninvolved). In addition, the child may experience depression, anxiety, guilt, somatic complaints, nightmares, isolation, behavior problems, irritability, decrease in academic performance, difficulty maintaining and making friends, regressive behaviors, substance abuse, and disassociation.

Role of the Human Service Professional

In recent years, there has been a surge of research on the most effective treatment interventions for veterans with PTSD, including cognitive processing therapy (CPT), eye movement desensitization reprocessing (EDMR), and Prolonged Exposure Therapy (PE) (Department of Veterans Affairs Department of Defense, 2010). While there is value in these investigations, the research has largely ignored the treatment of secondary traumatization of family members living with a veteran with PTSD (Galvoski & Lyons, 2004). Thus, this section will outline the four strategies that HSPs can utilize when working with secondary traumatization: education, mobilizing services, brokering resources, and advocacy. Each of these strategies aligns with the defined roles and skill standards of HSPs.
Strategy 1: Education

HSPs are defined as educators, tutoring and mentoring clients in a variety of different contexts (Neukrug, 2013). This role is aligned with the “Education, Training, and Self-Development” skill standard which suggests that HSPs should be able to share knowledge with others (Taylor, Bradley, & Warren, 1996). HSPs in a variety of different contexts will work with veterans with PTSD as well as the spouses and children of these veterans (Military One Source, 2013). Thus, this section will outline how the HSP can effectively take on the role of educator when working with secondary traumatic stress.

Research indicates that educating children about a parent’s trauma response may actually serve to inhibit their potential of acquiring secondary PTSD (Cook et al., 2012). Conversely, without education about the symptoms of PTSD and the expected outcomes of the disorder, it is not uncommon for children to imagine things to be much worse than they actually are (Grosse, 2001). Thus, the HSP working with children of veterans can provide information and knowledge to the child about PTSD using age appropriate dialogue. More specifically, it is important that the information provided helps children understand what PTSD is, what the effects of PTSD are in terms of parent functioning and/or the symptoms that the parent may experience, and what to expect over time. Additionally, the child may need reassurance that PTSD (and the parents’ change in behavior) is not their fault and that specific symptoms/emotional changes in the parent are to be expected (Grosse, 2011). By educating the child about PTSD, the HSP can help the family to normalize and contextualize their current difficulties. The HSP can also help children understand what is happening in their family (Brainlinemilitary, 2014). Spouses, in addition to children, can also benefit from education. Thus, the HSP can provide the spouse with explanations of the clinical diagnosis of PTSD, symptoms of PTSD, and the effects that trauma can have on relationships and on families (Buchanon, Kempainnen, Smith, MacKain & Walsh, 2011).

In addition to educating the family system about PTSD, the HSP should also educate the family members about secondary PTSD (Huebner & Mancini, 2008). This approach may help to understand the root cause of the child’s behavior. For example, a HSP can help parents to realize that their behaviors directly impact their child’s well-being. However, it may be particularly difficult for a veteran with PTSD to evaluate what information their children can process and comprehend when they are struggling with their own emotional responses.
(Cozza & Lieberman, 2007). Additionally, HSPs can educate the parents about the importance of having regular and open communication with their children. For many children, a parent’s manifested symptoms of PTSD can be stressful to witness, and if the veteran is unable to discuss his/her symptoms, the child may feel that their parent does not care for them and may no longer love them (Price, 2009).

**Strategy 2: Mobilize Services**

Mobilizing is one of the primary roles and functions of a HSP. When mobilizing services, a HSP organizes support and services for their clients (Neukrug, 2013). The role of mobilizer also aligns with the community and living skills and support skill standard, which encourages the HSP to match specific support and interventions to the unique needs of individual participants and recognize the importance of friends, family, and community relationships (Taylor, Bradley, & Warren, 1996). Thus, with regards to these aforementioned role and skill standards, it is critical for the HSP to know what type of support (civilian and military connected) is available to the family.

Given the systemic nature of PTSD (Galovski & Lyons, 2004), strategies like family therapy and couples therapy may also be beneficial. Additionally, psycho-education for children and for spouses who are living with a parent with PTSD can be helpful (Galovski & Lyons, 2004; Nader, n.d.). Support groups for children and spouses who may be experiencing symptoms of secondary traumatization may also be a place for the child and spouse to talk about their feelings and experiences in a safe environment with other participants’ who may have similar circumstances (Cook et al., 2012).

**Strategy 3: Brokering Resources**

A broker, another one of the 13 defined roles and function of a HSP, helps clients find and use resources (Neukrug, 2013). Brokering resources also aligns with the community and service networking skill standard which encourages HSPs to be knowledgeable of the supports and services available and skilled in assisting their clients to gain access to these services (Taylor et al, 1996). Thus, as a broker working with families of veterans, the HSP can provide his/her client with a list of resources that will offer support to those experiencing symptoms of secondary traumatic stress. The following list represents a sample of resources that are both government and non-government affiliated:
Government resources.

- U.S. Department of Veterans Affairs: the branch of the federal government that offers benefits and medical care for veterans and their dependents.
- Military One Source: a Department of Defense website that provides information, support, and resources at no cost to active duty, National Guard, and Reserve members and their families. The website offers support 24 hours a day, 7 days a week (Military One Source, 2013).
- Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury: a Department of Defense organization that serves as a center of excellence to advance psychological health and traumatic brain injury prevention and care. The organization offers a 24/7 call center and live chat resource staffed by health consultants to provide confidential answers and resources (Defense Centers of Excellence, 2014).

Non-government agencies.

- Veteransandfamilies.org: an organization dedicated to advocate for the wellness of veterans and their families.
- Veterans of Foreign Wars (VFW): a non-profit organization that provides information, resources, and a sense of community for veterans.
- Veterans’ Families United Foundation: a non-profit organization that provides immediate support for veterans and their family members who may be in need of mental health services.
- Operation Homefront: Hearts of Valor: a program that seeks to support family members who are caregiving for wounded service members. The program runs retreats, support groups, and online forums for caregivers (Operation Homefront, 2014).
- Camp C.O.P.E.: a program that runs weekend camps for children and families of military personnel. At the camp, certified mental health professionals teach children coping skills to assist them with issues such as deployment and/or living with a service member who has been wounded or killed in action (Camp C.O.P.E., 2014).
- Operation Purple: a program that provides camps for military families. The camps offer support for various phases of military life,
deployment, reintegration, and coming together after physical or emotional injuries. There are three different camps: one for children, one for families, and one specifically for wounded service members and their families (National Military Family Association, 2014).

- **Courage to Care, Courage to Talk Campaign**: an educational campaign for hospitals and other healthcare sites. The goal of this program is to facilitate and improve communication around war injuries between healthcare providers and families and within the family, especially in regards to talking to children (Center for the Study of Traumatic Stress, 2014).

- **Military Kids Connect**: an online community for military children (ages 6 to 17) to support one another and find resources in dealing with the psychological challenges of military life (Military Kids Connect, 2014).

- **Family of a Vet**: a non-profit organization that offers online support and resources for family members of veterans with PTSD and TBI. The organization also offers community education packets that can be used with community organizations, civic institutions, and school systems (Family of a Vet, 2014).

- **Seed of Hope Books**: a website that aims to empower families who are dealing with issues of war, trauma, or mental illness by providing information, encouraging communication, and offering support. The website features helpful books for families and children of service members.

**Strategy 4: Advocate**

HSPs are finally called to embrace the role of advocate, supporting and defending the client’s causes and rights (Neukrug, 2013). Taking on the role of advocate is also aligned with the advocacy skill standard, which encourages HSPs to identify and use effective advocacy strategies with their clients (Taylor et al., 1996). Additionally, given that PTSD is a systemic phenomenon (Gavloski & Lyons, 2004), the HSP is encouraged to raise awareness and promote understanding about the potential effects of living with a veteran with PTSD. Within an agency setting, the HSP might advocate for changes in agency policies that may affect veteran families (Bayne, Pusateri & Dean-Ngana, 2012). Many
military-connected families prefer to seek mental health support outside of the VA system in community-based agencies due to issues surrounding confidentiality and/or fear that seeking help within the VA system could harm their career (NYS Health Foundation, 2011). Thus, the HSP could advocate for adding information about military affiliation and deployment history on agency intake forms. If a client responds affirmatively about a deployment history, the HSP could then inquire further about the possibility of parental PTSD and symptoms of vicarious traumatization in children and/or spouses.

HSPs can also advocate for clients experiencing symptoms of secondary traumatization. In recent years, the government and society at large has focused on providing support and interventions to veterans with PTSD (Galovski & Lyons, 2004). While this is certainly important, the HSP is encouraged to also advocate for services and programs for family members experiencing secondary traumatization. Advocating for clients with secondary traumatization could occur within both military connected and non-military connected agencies (Fisher & Schell, 2013). The HSP is also encouraged to advocate for the needs of children experiencing secondary traumatic stress within schools (Nader, n.d.).

**Future Research**

Future research on effective treatment strategies for secondary traumatization would fill a major gap in the literature and would assist HSPs working with veterans’ families. Presently, the research is limited on secondary traumatic stress. STS is currently not recognized by the DSM-5 as an official mental health diagnosis (Dekel & Goldblatt, 2008; The National Child Traumatic Stress Network, n.d.). While the authors of this manuscript are not advocating for the inclusion of STS in the DSM-5, more research is needed on the psychological impacts and effects of secondary traumatic stress on individuals. One avenue for gaining more information would be through phenomenological qualitative studies. Phenomenological studies examine one’s lived experiences and perceptions by accessing the participant’s voices (Patton, 2013). Thus, qualitative phenomenological studies could explore the experiences of veteran family members (specifically spouses and children), focusing on the psychological impact of living with a veteran with PTSD.

In addition, more research is needed to examine the experiences of providers working with PTSD and STS. In this manuscript, a section is included on the role of the HSP. While this information is extrapolated from the roles and
responsibilities of HSPs, research that focuses on the pre-service training of HSPs could be useful for human service educators. For example, a quantitative or mixed methods study could explore to what extent, if at all, knowledge about military families, PTSD, and secondary traumatic stress is integrated into the practitioners’ pre-service education or professional development experiences.

**Summary**

PTSD is a major concern within the veteran population (Adams, 2013). While PTSD has gained increased attention in recent years, the secondary impact of living with an individual suffering from PTSD has been largely ignored (Cook et al., 2012). This manuscript provided the reader with information about PTSD and secondary traumatic stress and concluded with a section on how HSPs can effectively work with individuals suffering from secondary traumatic stress. Given the increasing rates of PTSD in veterans, HSPs will undoubtedly encounter family members experiencing STS, and it is imperative that they are educated and informed about family members’ specific needs. While the research on STS is valuable, future research on the psychological impacts of living with a family member with PTSD is warranted. Furthermore, studies on the pre-service experiences of HSPs related to the topic of STS and PTSD could be valuable to human service educators.

**References**


Abstract

Behavioral health treatment expanded within the past 20 years by including a mindfulness-based approach. A review of the literature describes mindfulness and its incorporation into various mental health settings. Results of mindfulness-based interventions offered within healthcare practices are promising. Human service professionals are encouraged to become knowledgeable of mindfulness skills to augment service delivery with diverse client and consumer populations.

Mindfulness: An Overview for Human Service Professionals

The application of mindfulness as a counseling intervention has gained significant attention among healthcare researchers and practitioners within the past decade (Germer, 2013). The proliferation of literature on mindfulness-based psychotherapeutic techniques correlates with the expansion of mindfulness-oriented practice in human services and counseling settings. The Buddha taught that humans could transcend suffering by acknowledging its existence and openly accepting the inevitability of change. Because there is such an emphasis on acceptance, transcendence, and transformation in Eastern philosophies, these concepts can be viewed as humanistic in nature (Graham, 1986). The Buddha’s teaching is compatible with the goal of human services centering on the human ability to enhance the overall quality of life and actualize full potential. There is an understanding that Buddhist psychology is a “classical wisdom teaching about how to reduce suffering” (Weiss, 2009, p. 5). Because of this, academia is critically examining aspects of its application in medical and behavioral healthcare practices (Germer, 2013).

The funding for the research and publication of studies on mindfulness, as well as its use in the treatment of mental health conditions, is growing significantly (Kabat-Zinn, 2003). Considering the evolution of Buddhist psychology and its integration into Western theory, growing popularity of incorporating mindfulness skills into practice, and increased number of empirical research studying the effectiveness of mindfulness-based interventions in mental health settings, it is important for counseling and human service specialists to enhance their understanding and knowledge of this rapidly expanding area of
practice. This review offers a comprehensive survey for students and practitioners in counseling and human service professions by briefly explaining the origin of Buddhism, defining the concepts of suffering and mindfulness, and discussing the incorporation of mindfulness in human services practice. Abridged descriptions of therapeutic modalities embracing mindfulness strategies are also incorporated into this review including mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), and mindfulness-based relapse prevention (MBRP) for addictive behaviors.

**Suffering**

Human beings do not want to be helplessly bound by feelings of confusion, fear, uncertainty, and discontent (Hagen, 1999). Despite a basic desire to avoid discomfort and be free from pain, the human condition is prone to suffering. Suffering can arise when humans experience physical sickness, chronic pain, emotional distress, grief, aging, and dying. Humans will be “perpetually disappointed by a changing and unsatisfactory world” if never-ending fulfillment is expected (Harvey, 1990, p. 53). Going further, the experience of suffering is intensified and exacerbated when the cause of suffering is seen as permanent and immovable. The universal human phenomena of attempting to bring about happiness by resisting things we do not want, or clinging to things we desire, is an ill-advised method to lessen discomfort and end suffering.

It is commonly known that healthcare practitioners have examined the sources of disease and prevention of illness. Mental health providers ranging from psychiatrists, psychologists, professional counselors, marriage and family therapists, clinical social workers, and human service practitioners are in helping relationships with those suffering with emotional distress. Theories and interventions utilized by various mental health practitioners are diverse and widespread, but regardless of the heterogeneity of these professionals, they share the objective of remediating problems and helping clients feel better through the therapeutic relationship. Suffering can be assuaged when human services interventions successfully help clients change the way they relate to their identified problems (Germer, 2005a). In order for true relief from suffering to occur, it is important for practitioners to educate clients that their situation is not “uniquely personal, unchangeable, or generalized to all aspects of life” and “no
matter what the situation, one has the freedom to choose how to perceive and understand it” (Yahne & Miller, 1999, p. 225).

Miller and Thoresen (1999) defined suffering as a “form of unhealth” (p. 4) and as a general reason people seek help. Furthermore, they proposed that if health is to be viewed more than the mere absence of disease, it is the duty of healthcare and human service professionals to look beyond the limited task of generally identifying and abolishing disease and illness and consider the larger duty of improving the richness and quality of life. Humans have a desire to escape from the pain of suffering and, if avoided, they miss a great learning opportunity that it affords (Rubin, 1996). It is further asserted when people go through a process of understanding and accepting painful situations, suffering can greatly enhance lives (Rubin, 1996). Through the process of working through suffering, people can expect “greater knowledge, openness, sensitivity, compassion, and passion” (Rubin, 1996, p. 91) to be delivered. Bearing in mind this proclamation, the training of human service providers on mindfulness-based interventions is warranted considering mindfulness affects positive change, augments healing, and empowers the individual.

The medical model’s conceptualization of suffering considers it to be a symptom of an underlying disease, psychological arrest or injury, or distorted beliefs, thoughts or behaviors that have been learned. As a result, treatment is prescribed to reduce the symptoms by attending to source of the disorder (Cottone, 2012; Fulton, 2009). This traditional model of suffering contrasts with the Buddhist formulation where there is no escape from the impermanence in life. Suffering is viewed to originate from attempting to capture and maintain what is pleasing and rejecting and avoiding what is displeasing. Siegel, Germer, and Olendzki (2009) indicated that many mental health practitioners hastily focus on solving a client’s problem, and therefore, sidestep the importance of self-understanding and acceptance. These researchers emphasized that when humans attempt to evade problems through “change-seeking activity” (p. 19), emotional and behavioral distress is inadvertently intensified.

Human service and counseling professionals should be alert to the risk of causing unintentional harm when the sole focus is on resolving a client’s problem, but if correctly utilized, mindful awareness can be considered a “strategic correction to some modern treatment trends” (Siegel et al., 2009, pp. 18-19). Incorporating a few tenets of Buddhist philosophy, where suffering is seen to arise from one’s pulling and pushing, allows human service specialists to help
clients reinterpret the concept of suffering from an oppressive condition into an illuminating experience. When such a shift in perspective occurs in clients, a possible antidote for suffering is set in motion. Because of this, it is advocated that human service workers obtain training and incorporate mindfulness-based interventions into social services programs. By practicing nonjudgmental awareness and acceptance of what is happening in the present moment of their experience, individuals are offered the ability to sidestep symptom management and ultimately be released from unhealthy habitual patterns.

**Origins of Buddhism**

In order to introduce the concept of mindfulness and its effect on the alleviation of suffering for mental health and human services consumers, it is important to briefly provide a historical account of this term. Buddhism originated approximately 2,500 years ago in an attempt to reduce human suffering after Siddhartha Gautama attained enlightenment and became the Buddha (Gach, 2009; Harvey, 1990). The word *Buddha* is derived from the Sanskrit root *budh*, which is interpreted as “to awaken” (Gach, 2009, p. 5), and is a descriptive title meaning *enlightened one* (Harvey, 1990, p. 1). While Siddhartha Gautama is seen as the founder of Buddhism, the emphasis of Buddhism is not on the person, but rather on the wisdom teachings of the Buddha and the awakening that his lessons offer (Harvey, 1990).

Prince Siddhartha Gautama was born approximately 560 B.C.E. in a kingdom between what is now known as India and Nepal (Gach, 2009). In an effort to ensure Siddhartha would succeed him one day as ruler, his father sheltered him within the lavishness of the palace walls, and controlled the environment when he ventured outside in order to protect him from the reality of human suffering (Gach, 2009; Harvey, 1990). This proved to be unsuccessful as Siddhartha inevitably came in contact with sickness, aging, and death. As his curiosity grew regarding these human conditions, he left his family at the age of 29 and ventured into the world to search for the meaning of life. After years of study, investigation, contemplation, and meditation, he finally achieved enlightenment at the age of 35 while sitting under the Bodhi Tree (Harvey, 1990). With mental clarity and a state of being awakened, he described the origination of suffering and the path for its alleviation.
The Four Noble Truths

After his enlightenment, the Buddha said, “I teach one thing and one thing only, suffering and the end of suffering” (Gach, 2009, p. 77). In the first sermon after his enlightenment, the Buddha described Four Noble Truths that serve as the foundation of Buddhism and represent the basic principles to mitigate suffering. The Four Noble Truths are as follows:

1. Truth of suffering.
2. Truth of the origin of suffering.
3. Truth of the cessation of suffering.

The first noble truth is where the Buddha introduces the universal phenomenon of suffering or *dukkha*. Dukkha refers to “all those things which are unpleasant, imperfect, and which we would like to be otherwise” (Harvey, 1990, p. 48). The Buddha’s second noble truth, the arising of suffering, involves “not getting what one wants, having to cope with what one does not want, and confusion about conflicting desires” (Olendzki, 2005, p. 290). Plainly stated, suffering is manifested when humans crave and cling to what is pleasurable (i.e., desiring permanence), while avoiding and rejecting things considered unpleasant. At the source of afflictions, craving and desire are typically nearby (Hagen, 1999).

This leads to the third noble truth where the Buddha taught all that begins eventually ends (Hagen, 1999). By shifting expectations of how things should be in life, to simply noticing how things are in life, the Buddha suggests we can be liberated from suffering (Hagen, 1999). If human suffering derives from craving or rejecting then it may be lessened when attachments to rigid outcomes are loosened. Herein lies the key to how mindfulness strategies, such as non-judgmental acknowledgement and open acceptance, contribute to the attenuation of suffering. Lastly, the Buddha’s fourth noble truth offers liberation from suffering by following eight guidelines for ethical, moral, and mental development (Segall, 2003) known as the Noble Eightfold Path. The Eightfold Path includes discourses on (a) right view; (b) right intention; (c) right speech; (d) right action; (e) right livelihood; (f) right effort; (g) right mindfulness; and (h) right meditation (Hagen, 1999, p. 53).

Harvey (1990) described the Four Noble Truths as being comparable to certain aspects associated with the practice of medicine where doctors (a)
diagnose an illness; (b) identify the origin of the disease; (c) make a prognosis by determining if it is treatable; and (d) develop a treatment plan for the cure. In this respect, with mindfulness being at the core of Buddhism, the Buddha offers a strategy for the diagnosis and treatment of suffering, and therefore, corresponds with the role of a healthcare practitioner who identifies a problem and offers a curative remedy (Olendzki, 2005). While this medical model paradigm may not appeal to human services and counseling professionals preferring to emphasize the human potential, as opposed to focusing on the pathological features of the individual, it is important to point out that nonjudgmental acceptance and mindfulness practice are seen in both Buddhist traditions and humanistic counseling (Dryden & Still, 2006). This is further made evident when considering humanistic counselors already model the basic tenets of mindfulness when accepting and non-critical responses are offered to clients through the act of unconditional positive regard. Mindfulness-based practices present an option for audiences looking for empirically supported interventions, underpinned by Buddhist philosophy, where acceptance of thoughts, feelings, and behaviors is emphasized rather than the diagnosis and alleviation of pathology (Dryden and Still, 2006). Whether the human service professional is already aligned with the humanistic movement or for those desiring to shift their theoretical model away from the dehumanization of symptom management, employing mindfulness-based interventions into practice present the opportunity to help clients attain their goals and achieve their full potential.

Mindfulness

The Buddha taught that feelings, thoughts, and perceptions are known as they arise, as they linger, and as they come to an end (Bodhi, 2002). Mindfulness, a “tool for observing how the mind creates suffering moment by moment” (Siegel et al., 2009, p. 26), allows individuals to carefully pay attention with thoughtful regard to what is happening in the present experience. Mindfulness includes both formal and informal practices (Germer, 2013). Meditation, a formal practice, is not to be confused with informal practices of integrating mindfulness skills into daily life. Formal meditation involves training the mind to sustain attention as the practitioner observes and learns how the mind operates (Germer, 2013). This type of meditation is typically associated with sitting in a fixed posture for an extended period of time while focusing on the breath, a mantra, or sounds in the environment as they develop and fade. As the mind wanders and gets caught up in
its content, the meditator gently notices and then returns awareness to the object of meditation (Germer, 2013). In contrast, informal mindfulness practice involves directing attention in everyday life to any event, emotion, sensation, or action while simply being aware and noting the present moment experience. Examples include labeling feelings, noticing sounds, or being aware of physical sensations and smells while brushing teeth, walking, eating, or washing dishes. Regardless of formal meditation or informal mindfulness practices, a misconception is that these exercises should be suggested to clients to induce a state of relaxation for the mind and body (Germer, 2013). While of benefit, mindfulness is not about relaxing or creating an alternative mind state, but is the disciplined process of exploring how the mind works and developing the ability to receive our experiences in an open, compassionate, and nonjudgmental way (Germer, 2013).

An operational definition of mindfulness is “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment to moment” (Kabat-Zinn, 2003, p. 145). Shapiro and Carlson (2009) defined mindfulness as a “knowing and experiencing of life as it arises and passes...a way of relating to all experience in an open, receptive way...freedom from grasping and from wanting anything to be different. It simply knows and accepts” (p. 5). While problems are inherent in life, humans experience contentment when believed to be in command of stressful situations. However, when people view their efforts as ineffective for dealing with pressures in life, then depression, anxiety, fear, anger, and feelings of helplessness will ensue (Kabat-Zinn, 1990). When problematic conditions arise beyond the immediate control of an individual, the impetus for frustration, anxiety, and despair is set in motion. The impact of stress can be exacerbated when people attempt to avoid reality by engaging in mind-altering substances or pleasure-seeking behaviors. This avoidance compounds the reality of the actual problem and is a counterproductive approach of coping with stressful conditions.

While there is no panacea that will solve all of life’s problems, consciously “learning to work with the very stress and pain” that we encounter can promote greater health and well-being (Kabat-Zinn, 1990, p. 2). With the integration of mindfulness and acceptance-based interventions in practice, human service professionals may help wake clients to the freedom that is offered by being with and accepting whatever is happening during each transient moment of their lives. When this approach is taken, clients are granted “a wider, more
generous, more enlightened perspective” (Chodron, 1997, p. 16) advancing their capacity to actualize healthier outcomes through authentic living.

**Mindfulness-Based Stress Reduction**

Kabat-Zinn was a leader in bringing mindfulness into the healthcare setting when he developed the mindfulness-based stress reduction (MBSR) program. The founding director of the Stress Reduction Clinic and Professor of Medicine emeritus at the University of Massachusetts Medical School, he is known for using mindfulness techniques with individuals struggling with chronic pain and stress-related disorders. Developed in 1979, MBSR is an eight to 10 week program where 30-35 participants meet weekly for two to three hours and one 8 hour day for instruction on meditation, yoga, body scanning, and mindfulness techniques (Baer, 2003; Kabat-Zinn, 1990; Praissman, 2008; Shapiro & Carlson, 2009).

Mindfulness, a method to deeply investigate oneself through the process of paying attention, is established “by assuming the stance of an impartial witness to your own experience” (Kabat-Zinn, 1990, p. 33). Mindfulness meditation skills are taught by instructing clients to nonjudgmentally observe arising feelings, thoughts, and physiological sensations while not becoming entrenched in the content. The cultivation of mindfulness strategies through “moment-to-moment awareness” (Kabat-Zinn, 1990, p.11) consequently allows people to recognize that painful conditions are fleeting, which can lead to a greater sense of control over their lives and ultimately lessen, if not alleviate, suffering. Shapiro, Astin, Bishop, and Cordova (2005) summarized the main principles of MBSR as helping participants to develop a nonjudgmental awareness of emotions, cognitions, and sensations in the present moment to abandon any ruminations about the past or fears of the future, and therefore, to increase understanding of their individually conditioned dysfunctional reactions to stress. Ultimately, the goal of generating healthier adaptive coping strategies may be achieved through the act of fully accepting whatever is happening in the here and now. With the success of MBSR supporting its reason for development, Kabat-Zinn (2003) further developed the model and expanded into a full range of training programs that are incorporated into environments where medical illnesses and psychological issues are of primary concern.
Mindfulness-Based Cognitive Therapy

After the publication of Kabat-Zinn’s (1990) book *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Overcome Pain, Stress and Illness* and research outcomes citing the efficacy of mindfulness-based stress reduction (MBSR), the interest in this alternative treatment was piqued in healthcare professionals and variations of MBSR for the treatment of mental health disorders soon emerged (Shapiro & Carlson, 2009). Segal, Williams, and Teasdale (2002) developed a group intervention known as mindfulness-based cognitive therapy (MBCT) that arose out of the need for an effective treatment approach aimed at preventing relapse for people diagnosed with a major depressive episode. Traditional principles of cognitive therapy are designed to help clients recognize how negative thoughts and beliefs can contribute to and foster depression and, if challenged by disputing and correcting these distorted cognitions, the clients’ mood can be elevated. MBCT offered an alternative method for managing depression.

Similar to basic cognitive strategies, participants are encouraged to develop awareness of their own negative thought patterns. Rather than focusing on refuting the thoughts, MBCT invites clients to allow these thoughts to come and to go and, when seen as an impermanent situation, the thoughts will arise and fall of their own accord and, therefore, bypass the escalation of negative thoughts into ruminative patterns. Additionally, the person is taught that a depressed mood leads to depressed thoughts and consequently leads to the belief that these thoughts represent reality. Clients are encouraged to see these thoughts as fleeting cognitions separate from themselves that are not necessarily true representations or validations of reality (Baer, 2003; Shapiro & Carlson, 2009). Clients are taught that “thoughts are not facts” (Germer, 2005b, p. 125) and instead of attempting to debate them away through conventional cognitive-behavioral techniques, they are encouraged to observe them as they arise and maintain a state of present moment awareness as they fall away. Empirical research conducted by Teasdale et al. (2000) described MBCT as a valid therapy for the prevention of relapse in people diagnosed with recurrent depression and further suggests mindfulness-based interventions are of therapeutic value.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) blends Eastern practice with Western psychological treatment by integrating the concepts of acceptance and change
(Linehan, 1993). DBT is a comprehensive treatment program consisting of individual therapy and year-long weekly group sessions designed for the treatment of borderline personality disorder (BPD) involving the mindfulness skills of non-judgmentally observing thoughts, emotions, and sensations as they occur (Linehan, 1993). An integral characteristic of this therapy emphasizes dialectics or the balance and synthesis of opposing forces. In DBT, skills training is offered to correct maladaptive behavioral skills that are typical for individuals diagnosed with BPD. Linehan (1993) identified the general goal of skills training in DBT is “to learn and refine skills in changing behavioral, emotional, and thinking patterns associated with problems in living that are causing misery and distress” (1993, p. 144). While DBT encompasses behavioral interventions for distress tolerance, emotional regulation, and interpersonal effectiveness, core mindfulness skills are relevant to all other DBT skills and are woven throughout the treatment module. Mindfulness is fundamental in DBT as this skill allows clients to accept and tolerate strong emotions when confronting dysfunctional habits or managing distressing situations. In DBT, the client is taught to nonjudgmentally observe self and others while maintaining awareness of the current situation, to be effective in the present moment, to let go of worries for the past and future, and therefore, change dysfunctional responses in order to enhance the quality of life (Rizvi, Welch, & Dimidjian, 2009). Since its introduction, the validity and efficacy of DBT in the treatment of borderline personality disorder has been empirically demonstrated through a large collection of studies (Shapiro & Carlson, 2009).

Acceptance and Commitment Therapy

Acceptance and commitment therapy (ACT) springs from relational frame theory (RFT), which attempts to explain all human language and cognition. Therefore, the foundation of ACT is based upon how people define and prolong their troubles through the human process of knowing and language (Hayes, Strosahl, & Wilson, 1999). Fletcher and Hayes (2005) pointed out suffering is manifested through the processes of comparing, evaluating, and explaining as people interface with the world through the filter of language. Derived from this background, ACT is seen as a contextual therapy as it “attempts to alter the social/verbal context rather than the form or content of clinical relevant behavior” (Hayes et al., 1999, p. 19).
Similar to other theories previously described where mood is influenced by negative thoughts and people attempt to alter states of mind by refuting negative cognitions, ACT also supports the belief that people attempt to manage their lives through the use of language. A core difference for ACT is rather than altering the mood through debating dysfunctional thoughts, ACT places emphasis on the nonjudgmental observation and acceptance of thoughts as they are in the present moment while changing behaviors in the service of chosen values (Fletcher & Hayes, 2005; Shapiro & Carlson, 2009).

The ACT term *cognitive fusion* suggests that people see thoughts as truths that govern over emotions and behaviors. Through the process of *cognitive defusion*, clients are taught techniques to see thoughts for what they are, not what they say they are, and in so doing, the believability of the thoughts is diminished (Fletcher & Hayes, 2005). An aim of ACT is to help clients see thoughts, feelings, and behaviors as entities separate from the actual person experiencing them (Baer, 2003; Shapiro & Carlson, 2009) such that the thought “I’m a failure” becomes “I’m having the thought that I’m a failure” (Shapiro & Carlson, 2009, pp. 56-57). ACT fosters a nonjudgmental acceptance of what the person is experiencing, seeing these thoughts as passing events and therefore, freeing the individual from the attachment to and influence of language (Fletcher & Hayes, 2005; Shapiro & Carlson, 2009). As a result, the person can achieve increased “psychological flexibility” (Fletcher & Hayes, 2005, p. 319) contributing to the quest for a meaningful life. Fletcher and Hayes (2005) summarized a growing number of studies demonstrating the effectiveness of ACT for the treatment of depression, substance abuse, psychosis, and anxiety, including improved functioning among individuals treated in medical settings.

**Mindfulness-Based Relapse Prevention**

Bowen, Chawla, and Marlatt (2011) incorporated conventional relapse prevention strategies with mindfulness meditation exercises resulting in the development of mindfulness-based relapse prevention (MBRP) for addictive behaviors. MBRP is an 8-week group therapy aimed at the prevention and management of relapse for addictive behaviors. A main objective of MBRP is to reinforce sobriety maintenance and consolidate recovery goals for clients continuing therapy in an outpatient aftercare program after finishing initial treatment for substance abuse and addiction. This group intervention trains clients how to sharpen awareness of their personal triggers, unhealthy patterns, and
automatic reactions in the service of urges and cravings. In addition, individuals are taught to pause, observe, consider their options, and then respond wisely to whatever is occurring in the moment. Ideally, these techniques free clients from being locked into harmful patterns associated with relapse to addictive behaviors.

A hallmark of MBRP is to help clients develop the ability to non-judgmentally notice the rising and falling of cravings and urges, and therefore, releasing them from automatically reacting as they occur. Clients are offered the space to bypass their habitual pattern of immediately satisfying triggers through a process called *urge surfing* (Bowen, Chawla, & Marlatt, 2011). Coaching clients on the urge surfing technique offers them a strategy to mindfully notice that a craving or urge will rise and fall like an ocean wave, resulting in the newfound knowledge that a choice exists to stay fully present until the cravings and urges subside versus immediately reacting at their onset. Mindfulness-based relapse prevention is seen to offer clients a cost-effective alternative to traditional relapse prevention strategies by fusing established relapse prevention interventions with mindfulness meditation practices (Witkiewitz, Marlatt, & Walker, 2005). Due to the recent release of the clinician’s manual of MBRP, future research is desired to examine the potential widespread and long-term efficacy of MBRP.

**Considerations**

Despite growing popularity and mushrooming research, mindfulness as a human service and counseling intervention has limitations. A common concern about integrating mindfulness meditation in human service organizations is a debate over the qualifications of the practitioner (Kostanski & Hassed, 2008) and the possibility of causing damage if unskillfully taught and practiced (Shapiro & Carlson, 2009). To correct inaccurate beliefs and prevent harmful recommendations, human service professionals are advised to avoid the unsystematic employment of mindfulness without receiving appropriate training from qualified and reliable sources. For those desiring to incorporate mindfulness strategies into practice, the University of California, Los Angeles Mindful Awareness Research Center (MARC) offers classes, retreats, and workshops, as well as a certification in mindfulness facilitation. In addition, the *Mindfulness Research Guide* (www.mindfulexperience.org) provides information on mindfulness-based interventions, research publications, and training resources via an online, comprehensive electronic resource and publication database.
Information and resources specific to the four mindfulness-based modalities described in this review are available on the Internet by those researchers and clinicians directly involved in their development. A comprehensive review of MBCT, including clinical research, books, and workshops, are listed on the program’s website (www.mbc.com). Marsha Linehan, creator of DBT, approved DBT certification through the DBT Linehan Board of Certification. Qualifications, requirements, and examination dates for the DBT certification are provided by the Board (www.dbt-lbc.org). Although a certification process does not exist for ACT, a description for learning ACT is located within the training section of the Association for Contextual Behavior Science’s website (www.contextualscience.org/act_training). Professional training resources, audio recordings of MBRP meditation exercises, and research on MBRP are offered by the MBRP team at the University of Washington’s Addictive Behaviors Research Center (www.mindfulrp.com). According to Shapiro and Carlson (2009), the only professional organization offering certification for teachers of MBSR is The Center for Mindfulness in Medicine, Healthcare, and Society (www.umassmed.edu/cfm). The Center for Mindfulness offers rigorous training in order to qualify for an MBSR teacher certification. The training includes, but is not limited to, professional experience and a graduate degree, daily meditation practice, regular participation in meditation retreats, teaching background of four MBSR courses, involvement in a 7-day training period, participation in a supervised MBSR program, and completion of an MBSR practicum (Shapiro & Carlson, 2009). While such arduous training helps to safeguard the welfare of clients who are taught MBSR, the topic of certification aimed at preserving the character of mindfulness practice should be weighed against the importance of not unreasonably restricting its use to clients in need (Shapiro & Carlson, 2009).

In addition to the argument over specific training protocols for counselors incorporating mindfulness into practice, it is a common expectation among the developers of mindfulness-based therapies, such as Kabat-Zinn and Segal et al., that the teacher also be a practitioner (Kostanski & Hassed, 2008). This may be a hindrance to some human service workers who prefer to advocate for the use of mindfulness among clients, but not adopt the principles and practice in their own life. Kabat-Zinn (2003) stated teaching mindfulness can be intimidating and challenging, especially for health professionals who are not trained to do so. He questioned the ability of instructors to be relevant, confident, and authentic if they
have not intimately engaged in their own mindfulness practice. When inexperienced healthcare professionals direct others to deeply explore their own mind and body, they will not be prepared to genuinely answer questions and provide insightful guidance and this deficiency will soon be detected by clients (Kabat-Zinn, 2003). Regardless of the various opinions regarding the qualifications of individuals providing instruction on mindfulness, those in the helping relationship should inform their professional work as outlined in Statement 26 of the National Organization of Human Services’ *Ethical Standards for Human Service Professionals* (1996) by knowing “the limit and scope of their professional knowledge and offer services only within their knowledge and skill base.”

Similar to any intervention, mindfulness meditation involves skill building, practice, and commitment, and therefore, represents another concern about its use in the human service setting. While mindfulness can simply be practiced by maintaining full awareness of moment-to-moment experience without requiring special equipment and costly resources, some individuals may become easily discouraged and quit if they do not quickly experience results (Kostanski & Hassed, 2008). This may be especially true for individuals who encounter multiple life stressors that may hinder devoted daily practice outside a structured setting. In addition, mindfulness may be particularly risky for people experiencing psychosis and severe depression (Kostanski & Hassed, 2008; Briere, 2013) and clients with suicidal thoughts and past trauma experiences (Briere, 2013). Because mindfulness involves concentration, focused attention, and has the potential to arouse painful memories and emotions, it is recommended that severe behavioral health symptoms be stabilized and chronic conditions resolved before mindfulness training begins with any client (Briere, 2013).

When balancing the contraindications of implementing mindfulness-based interventions for human service clients, the potential benefits appear to outweigh the aforementioned limitations. Mindfulness, when used as a holistic intervention, can be a humanizing approach to wellness that does not pathologize or regard a person as psychologically abnormal. Although initial mindfulness practice may lead to an increase in noticing unpleasant thoughts, feelings, and sensations, the impact of this effect will diminish as individuals learn to be less reactive and the overall, longer-term benefits cannot be disregarded (Kostanski & Hassed, 2008). Ongoing research is required to clearly identify both the advantages and
shortcomings of this relatively new therapeutic intervention in the human services field.

Conclusion

It is conventional to focus on the background and historical influences underlying a client’s presenting problem. Additionally, processing the client’s distress as he or she expresses concern about future-oriented events is not out of the ordinary within the context of the human services helping relationship. However, based upon a review of the literature, it appears when mindfulness is brought into the human services milieu by concentrating on the immediate experiences of the client, the client’s ability to develop insight, genuinely connect, and wisely respond in the present is magnified. For those human service professionals guided by the foundational concepts of gestalt therapy, the goal of developing awareness and acceptance of the “here and now” is parallel to that of mindfulness (Perls, 1969). Nevertheless, regardless of the theory guiding the psychotherapeutic community, a central quandary shared by clinicians is, “How can I help the patient to be more accepting and aware of his or her experience in the present moment?” (Siegel et al., 2009, p. 24). By offering clients the opportunity to nonjudgmentally notice and observe the fleeting nature of their experiences, the choice to constructively engage in healthier responses is bolstered and, in turn, negative habitual patterns are broken, emotions are regulated, ambitions are realized, and overall health and well-being is achieved.

It is not uncommon for any human service professional, whether a novice in the field or an experienced practitioner, to encounter a client suffering from the debilitating effects of mental illness. Because of this, it is crucial for human services workers to be adept as clients are taken into their care. Based upon the core components and outcomes of mindfulness, it is no wonder why it has so much to offer the human services profession. Frankl (1992) emphasized a belief in the freedom and power of the individual to choose one’s attitude in the face of suffering. In support of Frankl’s position, overwhelmed and distressed clients are offered the space to pause, take refuge, and enhance their ability to make healthier choices through the application of mindfulness. The focus on facilitating each individual’s capacity to overcome suffering fits nicely under the humanistic philosophical umbrella. Considering these benefits, it is not surprising the ancient meditation technique of mindfulness found its way into the human services community. The joining of Buddhist-based concepts and modern healthcare is a
rapidly emerging practice and the growing literature suggests this is a movement that warrants diligent attention and study. If mindfulness mitigates suffering, then augmenting human services delivery with its practice is in harmony with the guiding principles of the National Organization of Human Services (n.d.), which promotes and supports the physical, mental, emotional, and spiritual health and well-being of clients. The potential benefit for clients advances the need for human services practitioners to supplement their work by recognizing the value of mindfulness-based treatment strategies.

References


A Time to Tell? Legal Issues Regarding the Duty to Warn and Protect

Nathaniel N. Ivers, Randall L. Perry

Abstract
It is important that human services professionals, when faced with potential duty to warn or protect scenarios, understand their legal obligations. However, duty to warn legal statutes can be difficult to interpret and often vary across mental health professions and states. This article raises five issues associated with duty to warn and protect that, when understood, can help clarify human services professionals’ legal responsibilities in client harm situations. These five issues, when used in conjunction with extant professional ethical codes and ethical decision-making models, can improve human services professionals’ legal and ethical decision-making.

A Time to Tell? Legal Issues Regarding the Duty to Warn and Protect

Recent mass killings in Arizona, Colorado, and Connecticut, perpetrated by individuals with severe mental health disorders, stress the responsibility human services professionals have not only to serve individuals with mental health disorders but also to warn and protect, when necessary, individuals in danger of being harmed by their clients. However, legal statutes and ethical codes that address exceptions to confidentiality for reporting potential client harm can be abstruse and often vary significantly across mental health professions and states (Quattrocchi & Schopp, 2005). These legal and ethical ambiguities and variations can confuse human services professionals, as well as leave them vulnerable to legal or ethical violations (Skovholt & Rivers, 2007). The purpose of this article is to raise legal issues that human services professionals should consider when balancing their duty to protect or warn with their obligation to maintain confidentiality. This objective is accomplished by (a) reviewing briefly the Tarasoff v. Regents of the University of California case and discussing its appellate history; (b) reviewing extant literature regarding decision-making models; and (c) presenting issues for human services professionals to consider in potential duty to warn or protect situations.

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Tarasoff v. Regents of the University of California

Tarasoff v. Regents of the University of California, 17 Cal. 3d 425; 551 P.2d 334. (Cal. 1976) is a seminal court ruling that many mental health professions, including the human services profession, utilize to determine their legal responsibilities associated with potential client harm toward others (Skovholt & Rivers, 2007). The court, in its initial 1974 opinion in Tarasoff v. Regents of the University of California (1974), ruled that therapists have a duty not only to warn law enforcement officers of potential threats to others, but also to warn potential victims. The plaintiffs in the case, the parents of Tatiana Tarasoff, sued the University of California-Berkeley for negligence in the death of their daughter. Tatiana was killed by a fellow student, who, before murdering Tatiana, had disclosed to his psychotherapist that he had planned to kill her when she returned from vacation. Upon learning of his clients’ plans, the psychotherapist, under the direction of his supervisor, contacted the university police to have his client involuntarily committed to the inpatient unit of the hospital. After determining that he was stable and after he agreed to stay away from Tatiana, the police released the client from custody. When Tatiana returned to Berkeley, the client murdered her. The court ruled in favor of the plaintiffs, stating that the psychotherapist was negligent in his duty to warn the potential victim, Tatiana Tarasoff, of the impending threat to her life.

In 1976, the Superior Court of California agreed to a rehearing of the 1974 Tarasoff case, and subsequently ruled that therapists have not only a duty to warn but a duty to protect. The court summary of the 1976 case stated the following: “when a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger” (Tarasoff, 1976). Most states have followed the example of California and have developed similar legal statutes as those rendered in both Tarasoff cases (Edwards, 2013). However, some states have given ambiguous rulings regarding Tarasoff and others, like Virginia, have rejected Tarasoff’s duty to warn altogether. A Lexis-Nexis Shepardizing analysis indicates that the Tarasoff ruling has been questioned once, criticized three times, received a positive analysis 65 times, and a concurring opinion 26 times. In essence, although the Tarasoff ruling in many cases is upheld or supported, in some cases it is not. Thus, human services professionals cannot rely solely on the Tarasoff
rulings to determine the appropriate course of action when faced with client harm situations.

**Ethical Codes and Decision-Making Models**

Professional standards, such as ethical codes, can provide additional guidance to human services professionals who face uncertainty about their duty to warn. Statement 3 of the National Organization for Human Services ethical codes states (NOHS, 1996) that “human service professionals protect the client's right to privacy and confidentiality except when such confidentiality would cause harm to the client or others, when agency guidelines state otherwise, or under other stated conditions (e.g., local, state, or federal laws).” Other mental health professions, such as counseling, psychology, and social work, have similar codes of ethics, which communicate the importance of protecting confidentiality, but allow provisions for breaking confidentiality, such as when a client is in danger of harming self or others (American Counseling Association, 2005; American Psychological Association, 2010; National Association of Social Workers, 2008).

Professional codes of ethics are helpful in that they provide specific standards of practice by which members of the profession should practice (Remley & Herlihy, 2010). However, as statement 3 of the NOHS ethical codes (1996) clearly indicates, ethical codes are superseded by local, state, and federal laws. Thus, having knowledge of applicable laws regarding duty to warn or to protect scenarios in a human services professional’s given state or specific profession is still essential (Skovholt, 2007; Wheeler & Bertram, 2012).

Moral, ethical, and legal decision-making models can also be applied to legal and ethical dilemmas. A common and influential decision-making model was proposed by Kitchner (1984). The moral decision-making model developed by Kitchner described five principles that human services professionals can consider when making decisions about how to proceed in difficult legal and ethical situations. These principles include beneficence (promote client welfare), non-maleficence (do no harm), autonomy (protect the freedom and independence of clients), justice (treat clients equitably), and fidelity (fulfill commitments and obligations). A sixth principle, veracity (being truthful to clients), was later added to Kitchner’s (1984) model (Skovholt & Rivers, 2007). Concerning duty to warn scenarios, each of these moral principles should be considered. As such, human services professionals may ask themselves the following questions: How will reporting this (potential harm to others) affect my client? Might it harm him or her?
How will it promote his or her welfare? How might it help him or her? How might not reporting potentially harm my client or others? How might reporting it potentially help my client and others? How might reporting or not reporting affect the freedom of my client or others? Am I treating this client differently than I would treat other clients who may express similar intentions? How does reporting or not reporting contribute to my fulfilling commitments and obligations? How far does this duty to fulfill commitments and obligations extend? Am I being truthful and honest to my client by reporting or not reporting?

Another common decision-making model was proposed by Forester-Miller and Davis (1996). They developed this model specifically for professional counselors, but its guidelines can be applied to the human services profession as well. They integrated the works of multiple theorists, including Kitchner (1994), into a seven-step ethical decision-making model, which includes the following: identify the problem, apply professional codes of ethics, determine the nature and dimensions of the dilemma, generate potential courses of action, consider the potential consequences of all options and determine a course of actions, evaluate the selected course of action, and implement the course of action.

Although each step in Forester-Miller and Davis’s (1996) ethical decision-making model is applicable to and often employed in duty to warn scenarios, of particular importance is step one: gathering information. Duty to warn situations are professional issues, ethical issues, clinical issues, as well as legal issues. Forester-Miller and Davis (1996) suggest that if a clinician determines that a dilemma is a legal one, the clinician should seek legal advice. The authors of this article agree with this suggestion. In addition, as a complement to step 1 of Forester-Miller and Davis’s ethical decision-making model, it would be beneficial for human services professionals to have a greater understanding of the issues that might influence their obligations regarding their duty to warn (Lawrence & Kurpius, 2000; Skovholt & Rivers, 2007).

Hermann (2011, as cited in Gladding, 2013) proposed a legal decision-making model that has eight steps, seven of which are presented in question form. Gladding (2013) listed them as follows:

1. Is there a state statute or federal law related to the dilemma?
2. What is the spirit of the law?
3. Is there a binding case law?
4. Is there a persuasive case law?
5. Is there a workplace policy?
6. What would a reasonable person do?
7. What would a colleague who has a similar education and experience do?
8. Act reasonably based on the answers to the above questions (pp. 74-75).

Human services professionals, when confronted with potential duty to warn or protect dilemmas, would do well to follow these steps. However, as discussed in the following section, answers to these questions regarding duty to warn and protect are often complex. Thus, specific to duty to warn and protect scenarios, this article presents additional questions human services professionals can ask themselves to determine their legal responsibilities in potential client harm circumstances.

Legal Issues to Consider Regarding Duty to Warn and Protect

For a human services professional or provider, the question “Do I have a duty to warn?” is not answered merely by the existence (or non-existence) of a state statute or case that creates either a general or specific duty to warn. Each statute is written differently, with different categories, such as which mental health providers are covered by the statute, what type of harm will trigger the duty, how specific must a potential victim be, is the duty to warn or protect deemed mandatory or permissive, and who must be warned and alerted of the danger.

To Whom Does the Duty to Warn Apply?

Making a determination as to whether human services professionals have a duty to warn requires that they evaluate whether the existence of a law is applicable to them and their profession. State laws, both those created by statutes as well as duties created by court rulings, often differ concerning who is covered under such laws. Some laws may be very broad and apply to many categories of providers. For example, the Massachusetts statute which creates a duty to warn, applies to licensed mental health professionals (Mass. Gen. Laws Ann. Ch. 123 §36B, 2013). The same statute and section further defines a licensed mental health professional as “any person who holds himself out to the general public as one providing mental health services and who is required pursuant to such practice to obtain a license from the commonwealth.” This would seem to indicate that the duty is applicable to psychiatrists, psychologists, social workers, and counselors, as well as any other mental health providers regulated and licensed by the state.
Considering the fact that state mandated licensing to govern the practice of human services does not yet exist, professionals in the field may question their inclusion in statutes stated in this manner. Other states, such as Arizona, Maryland, and Ohio, have statutes that apply a duty to warn to the broad category of mental health professionals (National Conference of State Legislatures, 2013). When stated in this broad manner, it seems clearer that the statutes apply to human services professionals. When stated less broadly, it is important that each human services professional determine whether he or she falls within the defined categories of mental health professional.

Conversely, some states have laws that are more specific concerning which professionals the duty to warn applies. California, for example, cites psychotherapists specifically in its statute, and refers to Section 1010 of the California Evidence Code for a definition of a psychotherapist (Cal. Civil Code §43.92, 2013). The Evidence Code lists 16 different groups of professionals who are considered psychotherapists, and who would therefore be subject to the duty to protect (Cal. Evidence Code §1010, 2013). Human services professionals, however, are not specifically listed in the evidence code. That being said, the evidence code also states that a “person rendering mental health treatment or counseling services” is subject to duty to protect laws (Cal. Evidence Code §1010, 2013). The statement is further defined and explicated in Section 6924 of the California Family Code (2013), which describes the provision of mental health or counseling services as those that are provided by governmental agencies, individuals or agencies contracted with a government agency to provide services, agencies that receives funding from a community united agency, runaway houses or crisis centers, and professional persons (Cal. Family Code § 6924, 2013). Professional persons are defined as the 16 professionals described in the evidence code, and, thus, do not include human services professionals. Although the California code provides clarity for some mental health professionals, it creates additional ambiguity for human services professionals. In particular, given that certain agencies are subject to duty to protect laws in California (e.g., crisis centers), and human services professionals may provide mental health services in these agencies, human services professionals, in certain circumstances, may indeed be subject to California’s duty to protect statute.

A similar statute in Illinois applies to therapists. The statute defines a therapist as “a psychiatrist, physician, psychologist, social worker, or nurse providing mental health or developmental disabilities services or any other person
not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so” (Ill. Rev. Stat. Ch. 740 §110/11, 2013). New York’s statute refers only to a psychiatrist or psychologist, in one part (N.Y. CLS Men. Hyg. §33.13, 2013). However, in another statute it defines the term mental health professional as “[a] physician, psychologist, registered nurse or licensed clinical social worker” (N.Y. CLS Men. Hyg. §9.46, 2013), which may indicate that the legislature did not intend to subject other mental health providers, including human services professionals, to the law. Nevertheless, human services professionals practicing in the aforementioned states, including California, Illinois, and New York, should consult with an appropriate authority in their state to determine if they are indeed exempted from the requirements of the statute. It is possible that the courts in these states have extended this duty beyond the groups explicitly listed in their statutes.

What Type of Harm Triggers the Duty?

Virtually all statutes and cases that create a duty to warn or protect do so for instances regarding a threat or risk of death or severe physical harm. This is the scenario that was present in the Tarasoff (1974) case—the patient had communicated his intent to kill a fellow student. The states that have adopted a duty to warn, either through a written statute or a court case decision, have stated that a threat of death or serious physical injury will trigger the duty to warn. What is less clear, however, is whether the duty to warn is triggered when the risk of harm to a third party is something other than death or serious physical injury. The most common scenario involves a human services professional whose client has a communicable disease, such as HIV or other sexually transmitted disease, but is unwilling to inform his or her sexual partner(s) of the disease or take precautions to prevent the risk of infection. In this situation, human services professionals should seek to determine if they are required to maintain the confidentiality of the client, or if the law allows (or even requires) that they inform identifiable third parties of the client’s infected status and the risks inherent in contact with them. Some states have addressed this issue through public health statutes that require all diagnoses of certain diseases be reported to the state’s department of public health or similar agencies. It is therefore important for human services professionals to be aware not only of their state’s statute regarding a duty to warn relevant to their profession, but also of other statutes that may impose upon the
provider a duty to warn or report to the government, even if no such duty to warn otherwise exists.

A pertinent example of this can be found in North Carolina, which has not, as of the writing of this paper, enacted a statute imposing any duty upon human services professionals to warn third parties of an imminent risk of death (Gregory v. Kilbride, 2002). In Gregory v. Kilbride (2002) the North Carolina court explicitly held that no common law Tarasoff-like duty exists in North Carolina. However, Section 130A of the North Carolina General Statutes (2013) requires that any physician with a license to practice medicine, which would include psychiatrists, who has reason to believe that a patient has one of a number of specified communicable diseases (of which HIV is one), is required to report the disease to the state Commission for Public Health. As it currently reads, however, it does not appear that other mental health professionals are subject to that law. Although the law does not extend to human services professionals regarding a duty to warn a third party of a threat of physical harm, they may still have other legal or ethical obligations to warn or report of which it is important that they be aware. Furthermore, duty to warn and protect laws and the interpretation thereof are dynamic, which suggests that, although human services professionals may not currently be included under duty to warn statutes associated with specified communicable diseases, future written amendments to laws and court decisions could potentially extend that duty to them.

In addition to the threat of serious physical injury, human services professionals may also have a duty to warn or protect to prevent property damage. For example, the statutes of New Hampshire create, for certain mental health providers, including psychiatrists, psychologists, and other providers of mental health services, a duty to warn when there is “a serious threat of substantial damage to real property” (N.H. Rev. Stat. Ann. §§ 329:31, 329-B:29, 330-A:35, 2013). Human services professionals who assume that a duty to warn only applies to risks of physical harm may find themselves in violation of the law if they fail to act in circumstances in which duty to warn statutes include broader definitions of harm, such as the spread of dangerous and infectious diseases or damage to property.

Scope of the Victim

Most duty to warn statutes require that the threat or risk of harm or injury be made against either a specific person or a reasonably identifiable third party.
Delaware, for example, requires that the risk of harm be against a clearly identified victim or victims before a duty to warn will be imposed upon a mental health professional (Del. Code Ann. Tit. 16 §§ 1211-1212 and 5402, 2013). Examples of other states that require the risk of harm be against a specific individual are Illinois, Maryland, and Minnesota (National Conference of State Legislatures, 2013).

Most states have adopted a slightly broader category, usually stated as being *reasonably identifiable* victim or victims. However, as one might anticipate, not all of the state statutes or courts have agreed on what *reasonably identifiable* means exactly. For example, if clients tell a mental health provider that they intend to kill a person they’ve been dating, that *person* may or may not be considered reasonably identifiable. Similarly, the effort which the provider is expected to make to identify the person may vary by state. This spawns some important questions: Is it enough for the provider to ask the client to reveal the identity of the person, or must human services professionals go further in their attempt to identify the person? Is it reasonable to require the provider to call the client’s parents and friends to see if they can help identify the potential target? Unfortunately, these are not questions that can be answered easily, and certainly not within the scope of this article. It is therefore important for the human services professionals in each state to understand how their state has defined *reasonably identifiable*, and what may be required of the provider in attempting such identification.

**Mandatory vs. Permissive**

An important question to ask when determining whether a duty to warn or protect exists is whether such duty is deemed to be *mandatory* or *permissive*. Under a *mandatory* duty rule, the human services professional must take steps required under the statute. If the human services professional determines that the other requirements of the law in their state, as this article has discussed herein, are applicable, then the provider will have a legal obligation to warn or protect. Failure to take the required steps can subject human services professionals to civil liability, and may endanger their ability to maintain their practice. Examples of mandatory duty laws can be found in California, Massachusetts, and Washington (National Conference of State Legislatures, 2013). In fact, the majority of states that have created a duty to warn have done so with a mandatory rubric (National Conference of State Legislatures, 2013).
In contrast, a minority of states have created a more permissive, or
discretionary duty to warn. (National Conference of State Legislatures (2013).
Under these laws, the covered human services professionals may decide to breach
their clients’ confidentiality and warn a third party, but the professionals are under
no legal obligation to do so. The provider retains the discretion of whether or not
to warn. Although the laws of these states are not identical, generally the laws
provide protection for the provider, based on either decision. For the human
services professionals who choose to maintain their clients’ confidentiality, the
laws generally provide immunity from civil liability by any third party who
suffers any harm or damages as a result of the provider’s decision not to warn. For
providers who decide to breach client confidentiality to warn a third party, the
laws provide protections to the providers from any legal or professional liability
to their clients for the breach of confidentiality. A few of the states that have
adopted such permissive duty laws are Florida, Illinois, and Oregon (National
Conference of State Legislatures, 2013).

Whom Must the Provider Warn?

Once human services professionals have determined that a duty to warn is
applicable in their situation, they must ensure that they fulfill their obligation and
duty by informing or warning the proper persons. This may include the potential
victim, their families, as well as law enforcement agencies. Virtually all states that
have adopted a duty to warn statute that explicitly states whom the providers must
warn require the providers to warn the identified potential victim. In some of
these states, human services professionals may fulfill their legal duty by warning
only the potential victim, and the provider is under no obligation to alert any law
enforcement agencies. However, most states that require that the victim be
warned also require the provider to alert appropriate law enforcement agencies of
the threats made by their client. The provider may also have a duty to go beyond
just warning the victim. The provider may also be under a duty to protect the
victim, by ensuring that reasonable and proper steps are taken to protect the
victim from the client. Many duty to warn statutes do not explicitly define to
whom the provider must relay the threat of harm. In these states, human services
professionals would be wise to look to the court cases in their state, to see if there
are any cases in which the courts of that state have determined that the warnings
made by providers were inadequate.
Conclusion

When clients express a desire to harm themselves or others, human services professionals are often confronted with complex and sometimes conflicting moral, ethical, and legal responsibilities. Concerning the law and potential harm, the Tarasoff cases (1974, 1976) provide a precedent as well as some guidance for human services professionals to follow. In the Tarasoff cases (1974, 1976), the court ruled that mental health professionals have a responsibility to take reasonable measures to warn and protect people from harm. Although duty to warn statutes have been adopted in many states, variance among statutes exist and, in some cases, the Tarasoff rulings have not been upheld. The more human services professionals know about the law pertaining to their duty to warn and protect, the better equipped they will be to act legally and responsibly (Skovholt & Rivers, 2007; Wheeler & Bertram, 2012). To that end, in addition to determining whether one has a duty to warn, it is important that human services professionals ask the following: what type of harm will trigger a duty to warn or protect, how specific must the victim be, is my duty to warn mandatory or permissive, and who must be warned and alerted of the danger?

Although the authors believe these guidelines regarding duty to warn are a helpful supplement and complement to extant decision-making models, they are not comprehensive. Thus, it is essential that human services professionals research their own state’s laws, as well as consult with appropriate credentialing boards and seek legal counsel when necessary. Moreover, it also is important, because duty to warn and protect scenarios are not solely legal questions but also moral, professional, and ethical ones, that human services professionals consult professional ethical codes as well as agency policies and procedures for guidance on an appropriate course of action.

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Psychological Aspects of Social Media and Mental Well-Being

Katey Baruth

Abstract
Social media puts an interesting lens on the creation of our digital selves in addition to being the catalyst for drastically changing the way people interact in today’s society. As opposed to the recent past, we can now remain in constant contact with hundreds of so-called friends and even ones we rarely, if ever, see in person. As a result, the impact of social media on mental well-being has become a fast growing area of research. This brief article will highlight current studies that focus on aspects of mental health such as self-esteem, social connection, depression, and cyberbullying in relation to social media.

Psychological Aspects of Social Media and Mental Well-Being
Since the development of the first social media site SixDegrees in 1997, scholars in the field of human services have begun the process of exploring the many ripe areas of study in this arena (Boyd & Ellison, 2007; Heidemann, Klier, & Probst, 2012; Kuss & Griffiths, 2011). The continued increase in popularity of such sites such as Twitter, Google+, Facebook, MySpace, Instagram, and Bebo has created a virtual environment with almost unlimited access to once personal information (Muise, Christofides, & Desmarais, 2009). For example, since the launch of Twitter on March 21st, 2006, the number of registered users of this site exceeds a billion with more than three-fourths of users reporting to be outside the United States (Twitter, Inc., 2014). In March of 2014 alone, 255 million individuals were monthly Twitter users with well over 500 million tweets sent per day (Twitter, Inc., 2014). With the astronomical use of these sites, as well as a change in the perspective in regard to the views of social connection in society, human service researchers have raced to keep pace in exploring the impact of social media on our world (Antonucci, Ajrouch, & Birditt, 2014). Social relationships, whether virtual, face-to-face, or both, are immensely important in the lives of humans around the world (Antonucci, Ajrouch, & Birditt, 2014; Kiesler, 2014). The advancement of social networking sites, in combination with a rise in internet use by all age groups, has almost taken over cyberspace with tweets, retweets, wall postings, selfies, and hashtags, and has changed the way individuals communicate today compared to past generations (Castilles, 2011;
Kiesler, 2014). Even the prestigious lexicographers and linguists at the Oxford Dictionary have recently incorporated such social media driven new words as unfriend, textspeak, emoticons, and smartphone into the ever growing vernacular of the English language (Reed, 2014).

While it is clear that the information super highway is more heavily trafficked today than ever before, scholars have yielded varied results when examining the correlation between psychological factors related to use of social media sites. Researchers once believed that the popularity of connecting with others via the internet would lead to a decline in personal, face-to-face interactions as well as a decrease in social bonds (Ellison, Steinfield, Lampe, 2007). Current researchers, however, have reported that the effect has been quite the opposite, as there has been an increase in reported interpersonal connections due to the rise in usage of social media technology (Ellison et al., 2007). Jacobsen and Forste (2011) suggested that the current methods of social media have many positive benefits such as increasing the perceptions of relationship closeness and connectedness among users (Jacobsen & Forte, 2011). Reich (2010) suggested that these sites often create a psychological sense of community which includes a perception of networked individualism. Networked individualism is the concept that individuals are able to maintain an inherent sense of individuality while at the same time engaging in multiple groups in cyberspace (Reich, 2010). He also suggested that being able to maintain an unique identity while participating in multiple online social groups has a positive influence on the individual’s perception of personal investment of membership in the group, influence on the community, integration and fulfillment of needs within the group, shared emotional experiences within the group, and immersion in the online community (Reich, 2010).

Additionally, Utz, Tanis, and Vermeulen (2012) found that individuals who self-disclose via social media could be likely to build new online friendships, as well as experience a boost in self-esteem. Ellison and colleagues (2007) have found that introverted individuals with low self-esteem have reported that being provided social opportunities to interface, without the anxiety associated with in-person interactions, has been beneficial in making new connections. Researchers have also found that social networking sites can have a positive effect on aspects of identity development, social connectedness, emotional development, community engagement, as well as educational endeavors (O'Keefe et al., 2011).
On the other side of the coin, social networking sites do have many identified risk factors for users. Valkenburg and Peter (2009) have suggested that depression, social rejection, online bullying, and even access to damaging and inappropriate material through these sites can impact an individual’s mental health negatively. Individuals who spent more time on social media sites (in this study Facebook was examined) were likely to have lower self-esteem which was contradictory to other studies (Mehdizadeh, 2010). Furthermore, Cambron, Acitelli, and Steinberg (2010) found that participants with lower levels of self-esteem who did not believe their friendships were of great quality or value on social media sites were also found to be at much greater risk for the development of depressive symptoms.

Additionally, studies have shown that many individuals who engage in social media are at risk for psychological or even physical trauma (McQuade, 2009). Individuals who are viewed as being unpopular in their social groups, as well as being seen as isolated, depressed, and anxious as compared to their peer groups, have been shown to fall prey to a growing phenomenon termed cyberbullying (McQuade, 2009). Many victims reported to have been seeking approval, attention, and acceptance by others via social media sites. Targets receiving cruel text and/or images via the internet by way of digital communication devices are likely to be more vulnerable and less resilient to manipulative situations and feel powerless, exposed, humiliated, alone, isolated, and angered by the actions of the cyberbully (McQuade, 2009).

Methods of cyberbullying have also transformed since the rise of smartphones and tables to include cell phones, web sites, blogs, emails, chat rooms, and instant messages (Diamanduros, Downs, & Jenkins, 2008). It is common for cyberbullies to create false email accounts with the intention of sending damaging information or even spam to others. Many times, web pages or sites are created which do not belong to the victim and contain derogatory information which is seen as harmful and damaging. At times, explicit or undesirable pictures are posted with the intention of embarrassing or causing detrimental effects on the victim (Diamanduros et al., 2008). As perpetrators are often anonymous, victims are likely to develop a sense of fear, distrust and also a lack of safety which impacts the individual’s psychological and even physical well-being (McQuade, 2009).

The number of individuals who have reported being cyberbullied widely vary with estimates ranging from 10% to 40% depending on the definition of
cyberbullying as well as the age of the group being studied (Hinduja & Patchin, 2010). Willard (2007) has reported that cyberbullying is likely to manifest itself in one or more of six identified types. Flaming, or online fights, is typically characterized by the use of explicit or volatile electronic messages or pictures including screen shots between individuals or even posted in a public forum on behalf of one party. Additionally, individuals can be harassed (or stalked) by those individuals who send threatening or cruel messages to others (Willard, 2007). Denigration, or online gossip, consists of sending or posting information about another person with the intent of damaging his or her reputation or connections with others. Trickery, or outing, occurs when an individual shares personal and sensitive information via instant messaging which is then forwarded to unintended parties (Willard, 2007). Finally, exclusion occurs when an individual is intentionally prevented from joining a group online (Willard, 2007).

Overall, there are undoubtedly positive and negative aspects to the effects that social media has on our society. Studies have shown that many users report a stronger sense of community, networked individualism, and social connection, as well as improved self-esteem and decreased anxiety (McQuade, 2009). Researchers have also found that many of the negative effects range from depressive symptoms to feelings of social rejection, isolation, and decreased self-esteem. Cyberbullying is also a growing occurrence which can drastically impact the overall well-being of victims (McQuade, 2009). As a result, research in regard to the psychological effects of social media will continue to be an area of focus for social scientists as social media tools will continue to shape our digital lives.

References


The Creation of a “Servicing Veterans and Their Families” Course

Kristi L. Kanel

Abstract

The Human Service Department of a large West Coast University in collaboration with the campus Veteran’s Center developed a new course, “Serving Veterans and their Families,” designed to teach students in the helping fields as well as veterans about the social and emotional needs of veterans and their families and effective intervention in the community.

The Creation of a “Servicing Veterans and Their Families” Course

Since the Iraq (i.e., Operation Iraqi Freedom or OIF) and Afghanistan (i.e., Operation Enduring Freedom or OEF) wars began in 2003, more than one million troops have been deployed (Lincoln, Swift, & Shorteno-Fraser, 2008; Mmari, Roche, Sudhinaraset, & Blum, 2009). Many of our troops have returned home from the Iraqi war zone, and President Obama has made it clear that he intends to have almost all of our troops withdrawn from Afghanistan within the next two years. Over these years, many have noted the various mental health, social, legal, and educational needs of our returning veterans (Brohl & Ledford, 2012; Philipps, 2010; Pryce, Pryce, & Shackelford, 2012; Selby et al., 2010; Shay, 2009; Teten et al., 2010; Yarvis & Schiess, 2008). In fact, the Government Accountability Office found that due to the nature of the combat experiences and multiple deployments, there is a particularly high rate of mental health problems which could explain why these returning veterans often face issues such as job adjustment, relationship adjustment and problems, alienation, substance abuse, PTSD, suicide, withdrawal, and more (Schochet & Broder, 2008).

To address some of the needs of our returning veterans, the Department of Defense (DOD) has funded a variety of programs through the Veteran’s Affairs office, such as TRICARE, which provides care through military treatment facilities and in the civilian health-care market, Military OneSources, which is an information and consultation service provided to all service members; the Veterans Administration hospitals, Community Vet Centers that work doing outreach on colleges through a program called VetSuccess on Campus, National Coalition for Homeless Veterans, and the Sexual Assault Prevention and Response Office to deal with military sexual assault (Pryce et al., 2012; Weiss, &
DeBraber, 2013). While medical practitioners are typically needed to help veterans with a variety of physical injuries, mental health specialists, including human service professionals, are increasingly needed to assist veterans who are struggling with the debilitating psychological effects of their physical and emotional wounds (Pryce et al., 2012).

In addition to the physical and mental wounds suffered by our veterans, we also find children and wives of deployed military personnel suffering from serious anxiety and depressive disorders and a host of behavioral and psychological problems (Lester et al., 2011; Palmer, 2008). In addition, when veterans return home, families must learn to readjust to new roles, couples must learn how to communicate and create intimacy, children must get to know their parent again, and everyone must grapple with the deep psychological “soul wounds” from which the veteran is suffering (Pryce et al., 2012).

With the serious mental health issues that veterans and their families face, it is incumbent on all mental health professionals to be better trained on the multiple mental health problems that these individuals may face. Although human service professionals are usually trained and experienced in dealing with mental health problems in general, they need specialized knowledge on how serving in the military influences treatment.

The Creation of “Serving Veterans and Their Families”

As the campus veteran’s center at our medium sized university in the West began seeing an increase in enrolled veterans, the coordinator approached me and requested that our department create a course focused on the needs and issues facing veterans. Human service students would also benefit from this course because they need training to service the increasing numbers of returning veterans who are facing psychological problems. The course was named “Serving Veterans and Their Families” and the following course description was given: “systematic study of theory, research findings, and intervention strategies related to contemporary issues faced by paraprofessional human service workers in working with veterans and their families, particularly those who have served in the recent Iraq and Afghanistan wars.” The objectives of this course were threefold. Students would learn to use theoretical knowledge to understand the behaviors and needs of veterans and their families, integrate current literature into planning human service interventions for the special needs of veterans and their families,
and understand how the organizational culture of current mental health, social welfare, and educational systems may best service veterans and their families.

After obtaining various textbooks from the local Vet Center, the campus veteran’s center, and other faculty, I chose The Costs of Courage, which was co-authored by a veteran and two social workers (Pryce et al., 2012). I believed this textbook best offered topics that would provide students with a thorough understanding of military culture as well as a multitude of issues facing veterans and their families including an overview of OIF and OEF statistics and a description of the most current war zones, military culture, combat stress injuries, interventions, homeless veterans, college enrolled veterans, women veterans, family needs, and community programs. A second book, Handbook of Military Social Work (Rubin, Weiss, & Coll, 2013), complimented the primary course text. Within this supplemental text, various authors present a multitude of topics such as military culture and diversity, women in the military, ethical decision making in military social work, and secondary trauma in military social work.

Students’ grades were based on two multiple choice exams based on material from the text (20% each), a literature review paper (20%), an interview (20%), and a presentation (20%). The papers were scored based on the students’ ability to apply course concepts to the interviews and to the articles that they researched.

**Instructional Pedagogy**

The course included a mix of lecture, class discussions, film viewing, and student presentations. Some films which students highlighted as being particularly noteworthy included: Restrepo, Cover Me, The Invisible War, Sand Tray Therapy with Veterans and Their Families, Lone Survivor, and Crisis Counseling: The ABCs of Crisis Management. Guest speakers were invited to discuss their experiences as veterans, as counselors of veterans, and as family members of veterans. Students were also required to interview a veteran, or family member, and share these interviews with the class. Additionally, students were required to conduct a literature review of a relevant topic, apply course concepts to the literature, and present their paper to the class. Students, who were veterans or family members of veterans, were encouraged to share their own personal experiences. Students found this to be very interesting and the sharing of their experiences fostered much discussion.
Directly after grades were submitted, students were provided with the opportunity to anonymously evaluate the course and the instructor, offer suggestions, and make comments. Some common elements noted were the passion of the instructor, the commitment the instructor had toward veterans and their families, how the course catalyzed their own interest in working with this population, the importance of organized lectures, and the meaningfulness of small group discussions in which opinions, perspectives about social issues, and other personal feelings could be addressed. They also noted that they enjoyed learning about the military and appreciated the openness the instructor had to fielding questions. They suggested it might be helpful to offer quizzes and to have more veterans in the course who could share their stories. Finally, they noted that they particularly enjoyed the guest speakers and films and would like more of each.

**Conclusion**

It is hoped that this information might serve as a catalyst for other human service programs to create a course such as this. Although returning veterans do have access to some counseling and social services, there will no doubt be a growing need for trained workers to offer a variety of services to this population and their families. It seems only natural that human service students would need to address the many social, psychological, and behavioral needs veterans have.

**References**


Abstract

Since a large number of college students experience a death loss during their collegiate career, it is essential that human service educators understand the importance of student bereavement for aspiring human service professionals, be able to identify bereaved students, and implement strategies to address bereavement issues for future helping professionals.

Grieving Students in Helping Professions

Bereavement, the overall experience of losing a loved one, is a life transition from which college students are not excluded. In fact, an estimated 33 percent of undergraduate college students are grieving the death of a family member or friend within the past year and almost 50 percent have experienced similar losses within the past two years (Balk, 2011; Balk, Walker, & Baker, 2010; Varga, 2013; Walker, Hathcoat, & Noppe, 2012). Accompanying these losses are a variety of grief effects and lack of support mechanisms on campus (Janowiak, Mei-Tal, & Drapkin, 1995; LaGrand, 1981, 1985). These findings are particularly troubling for human service educators who are preparing future helping professionals. In addition to enduring their own possible bereavement, these students may encounter clients who are grieving a loss themselves. It is important, therefore, that human service educators be able to: (a) understand the importance of student bereavement for those aspiring to become human service professionals; (b) identify bereaved students; (c) implement strategies to more effectively prepare future helping professionals with respect to these topics.

Bereaved Students in Helping Professions

The importance of helping bereaved college students is well documented (Balk, 2001; Balk, 2011; Smyth, Hockemeyer, Heron, Wonderlich, & Pennebaker, 2008); however, there is still a need to acknowledge bereaved students aspiring to be helping professionals. While grief is a normal reaction to situations such as death, divorce, relocation, or loss of anything important to an individual, it has no timetable. Unresolved grief, also called prolonged, complicated, or chronic grief, can result in intense feelings of anger, emptiness,
guilt, sadness, and risk for poor health including obesity, clinical depression, and substance abuse (American Cancer Society, 2013; American Psychiatric Association [APA], 2013; Hardison, Neimeyer, & Lichstein, 2005). In fact, the debilitating effects of prolonged grief prompted its inclusion in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (APA, 2013). Any of these symptoms or combination of symptoms can impair the functioning and judgment of a human service professional, resulting in ineffective services for clients, high turnover for human service agencies and organizations, or both. Explicitly addressing the needs of grieving students is important for their professional preparation, their self-care, and the future clients they will serve.

**Identifying Bereaved College Students**

A first step for human service educators is the identification of the bereaved student. Numerous studies have found that grief affects students physically, cognitively, behaviorally, interpersonally, emotionally, and spiritually, and can manifest in various ways (Balk 2011; Beam, Servaty-Seib, & Mathews, 2004; Neimeyer, Laurie, Mehta, Hardison, & Currier, 2008; Servaty-Seib & Hamilton, 2006; Servaty-Seib & Taub, 2010; Walker et al., 2012). Among symptoms are physical (e.g., insomnia); behavioral (e.g., alcohol or drug abuse); interpersonal (e.g., difficulty getting along with others, isolation, and loss of friends); cognitive (e.g., problems with grades as a result of inattention, rumination, or nonattendance); emotional (e.g., intense mood swings); and spiritual (e.g., questioning the purpose of life, religious beliefs, the meaning of one’s life, or why good people die). The presence of any one or a combination signals the need for further consideration from an instructor or advisor.

Students with unresolved grief issues may experience prolonged grief disorder or persistent complex bereavement disorder (APA, 2013; Balk et al., 2010; Prigerson et al., 2009; Varga, 2013). This is a mental disorder that is a result of the inability to cope with the loss of a loved one after a significant period of time has elapsed since the loss. It can have devastating effects such as insomnia (Hardison et al., 2005), elevated rates of suicide ideation (Prigerson et al., 1999), health impairments (Prigerson et al., 1997), and reduced quality of life (Prigerson et al., 1995). Other symptoms cited in the DSM-5 (APA, 2013), include intense sorrow and emotional pain, aloneness, confusion, identity disruption, and impaired functioning in areas such as work and social situations.
Given the incidence of bereavement among undergraduate students, it is likely that human service educators will encounter bereaved college students in their courses or programs. After identifying bereaved students, it then becomes important to understand the supports and resources for these students. A college campus is a complex setting to grieve and comes with specific obstacles and challenges.

**Resources for Bereaved College Students**

The college setting presents a number of challenges for bereaved students. For undergraduate students, who traditionally are young and living away from home for the first time, the college environment is a unique one often with the distractions of social activities, athletics, and fun. Alcohol is frequently glamorized as a rite of passage in college (Kadison & DiGeroimo, 2004). These factors, coupled with seemingly constant academic pressure, make a college campus a difficult place to grieve. Both physical symptoms, such as insomnia and headaches; and psychological symptoms, such as inability to focus or attend classes; may make it difficult to approach instructors or advisors for incompletes, makeup assignments, or extensions. In addition, peer support may be minimal or lacking due to feelings of discomfort talking with or to the bereaved student, resulting in isolation for that student (Balk, 2008; Servaty-Seib & Taub, 2010).

For freshman and sophomore students, adjustment issues to college life may also complicate the grieving process. College is different from high school, offering less structure, more reading and writing assignments, more independence, and more freedom. For residential students, the experience of living away from home for an extended period of time may also be challenging, given the increased freedom, independence, and less accountability.

Although many college campuses are equipped with counseling centers as a resource for grieving students, they often have waitlists to see students (Janowiak et al., 1995). Furthermore, rather than seeking counseling, many grieving undergraduate students prefer to seek support from family or peers (Balk, 2008; Servaty-Seib & Taub, 2010). Unfortunately, non-bereaved peers often feel sad, helpless, and uncomfortable in the presence of a grieving friend (Balk, 2011; Vickio, Cavanaugh, & Attig, 1990).
Strategies to Address Grief and Bereavement Issues

There are a number of ways human service educators can attend to the topics of grief and bereavement in the human service curriculum. The inclusion of grief and bereavement is supported by the curriculum standards of the Council for Standards in Human Service Education (2013) that address the scope of conditions that promote and inhibit human functioning. The inclusion of persistent complex bereavement disorder in the DSM-5 as a condition for further study confirms the seriousness of these life issues. It is important for future human service professionals to know and understand the impact of such a condition on the lives of their clients. Including problems related to grief and bereavement in role plays, critical incidents, case studies, and other teaching strategies may heighten awareness of grief and bereavement and its impact on individuals. Introducing these topics in courses may also provide the springboard needed for the self-disclosure, self-exploration, or both by those students who may have recently experienced a loss or who have unresolved issues relating to a loss. The responsibility then falls to the instructor, the advisor, and/or the counselor to provide the needed support for these students. These topics can also be used to initiate discussions about the self-development of human service professionals and the impact of loss on their personal and professional lives, including the loss of a client.

Finally, human service educators have ethical obligations to “model the personal attributes, values, and skills of the human service professional” and to “create a learning context in which students can achieve the knowledge, skills, values, and attitudes” (Ethical Standards of Human Service Professionals, 2000, Statements 46 and 54). These statements require not only sensitive yet frank discussions of grief and loss during academic preparation but also the examination of the losses and impacts experienced by educators themselves. It is possible that working with grieving students may trigger any unresolved grief issues, making self-awareness one of the most important responsibilities in working with grieving students (Winokuer & Harris, 2012).

References


Stories of Transformative Leadership in the Human Services: Why the Glass is Always Full
by Steve Burghardt & Willie Tolliver

Kayla Waters

Stories of Transformative Leadership in the Human Services: Why the Glass is Always Full encourages us to reflect on the role of leadership and self-care in our professional practices, by showing us “if the work is sacred, then so are you” (p. 163). The first chapter opens with a story about a journalist who is assigned to investigate the impact of budget cutbacks on human services agencies. Through his observations we see how different leaders respond to the inherent challenges of our field. What is most gripping about the story is the familiarity of the characters, which pride themselves on being overworked and exhausted. The leaders openly define “the good” staff people as those who work overtime without pay while the rest leave. As racial tensions bubble through the surface, everyone consumes a steady diet of caffeine, carbs, and cortisol just to make it through each day. This first story would be disheartening, except that the authors periodically hint that a new story will unfold.

In Part II of the book, the authors introduce the leaders of a second agency. They are imperfect people who have practiced the same habits that were displayed at the first agency. However, the professionals at the second agency have learned a healthier way of working. They leave their desks to take short walks, meditate before seeing clients with intense needs, and join their clients in inspirational life-skills classes in order to refresh themselves. Finally, they make up for all of this “lost” time by being more efficient and effective on the job.

After the stories of these different agencies are told, Part III presents a succinct summary of key themes in transformative leadership that the authors have learned through their consulting work and a review of relevant literature. Embedded within this section are opportunities for the reader to reflect on current practices and adopt new skills for the future.

The underlying message of this book is not particularly new. Many traditional texts in our field admonish students to guard against burnout and provide

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excellent guidelines for self-care. In contrast, *Stories of Transformative Leadership in the Human Services: Why the Glass is Always Full* illustrates what burnout actually looks like, because it isn’t always obvious. While many texts tell us that we must take care of ourselves, this book shows us by creating a cast of believable characters, a storyline, and a gut-level sense of recognition. It is just so easy to identify with the leader at the first agency as she deliberately self-soothes with a donut at the end of a tough day. Similarly, the leaders at the second agency don’t have an innate talent for inner harmony, which might appear unachievable to those of us not born so lucky. They just commit to daily efforts of self-care that are practical and manageable.

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Introduction to the Special Topics Section on Current Issues

Ed Neukrug, Brett Gleason, Laurie Craigen, Jill Dustin, Tammi Milliken

We are pleased to publish this special section on current issues in human services in this year’s Journal of Human Services. With the fast-paced world we now live in, the editors of the journal realized that new issues quickly arise and sometimes challenge human service practitioners and educators. Thus, we thought it would be prudent to address some of these current issues so that our readership would remain on the cutting edge of knowing what is transpiring in the field.

In choosing which current issues to include, the editors sent a call out to all human service members of the National Organization of Human Services, asking for their input. We asked those interested in submitting a short current issues article, to first submit a paragraph with a description of the special topic along with a two-sentence statement as to why the topic is important to human services. Five members of the editorial staff of the Journal then read and rated, on a 10-point scale, all 86 submissions. In addition, the five editors chose their top five submissions. All submissions were read, rated, and ranked without author identification. Editors who chose to submit their own articles were not able to rank or vote on their own articles. The sixteen short articles presented in this special topics section of the Journal are the result of this process.

Guidelines to the authors of 16 select articles were sent in which authors were asked to keep their submissions to eight pages of a Word document, which included a title page, abstract, content, and references. APA Manual style of writing was required.

Due to the overwhelming response for submissions, some of the journal editors decided to publish a monograph that presented 26 additional current issues, selected via a separate blind review and peer ranking system. These will be published online, through the NOHS website, although hard copies will be available for purchase. The following are short descriptions of the current issues that we are excited to present in this edition of the Journal of Human Services.
In Mechelle Bryan’s article, *The Significance of Empowerment in the Field of Health and Human Services*, client-centered empowerment, as a method to improve client and patient outcomes, is discussed. She shares the benefits of empowerment in helping clients actively manage their own care, including making better decisions for themselves. She suggests several ways in which practitioners can empower their clients and patients. Some of the more contemporary examples she provides are the use of tele-empowerment and web empowerment. Through tele-empowerment, clients can participate in computer-mediated support groups, online support groups, and moderator-hosted blogs. Web empowerment makes it possible for clients to receive a wealth of information which can assist them in their decision-making regarding their own health care. Additionally, she provides practitioners with tips on integrating client empowerment into the helpers’ work.

The article by Rebecca Cole, Laurie Craigen, and Rebecca Cowan on *Compassion Fatigue in Human Service Practitioners*, describes the serious consequences of compassion fatigue on helpers and on their clients. They reveal that compassion fatigue can lead to increased pessimism at work, a loss of satisfaction in the profession, a decreased sense of accomplishment, physical and emotional exhaustion, and difficulty in the helper’s ability to feel empathy. Notably, it can have detrimental consequences for the human service practitioner and for his or her clients. The authors provide readers with a number of risk factors associated with compassion fatigue and offers suggestions, such as practicing self-care and building strong peer support networks, as a means of prevention.

*Awareness, Recognition, and Action: Meeting the Needs of Geriatric Clients*, by Rebecca Cowan and Rebekah Cole, describes the importance of preparing future practitioners to meet the needs of the growing geriatric population. The authors highlight both human services ethical standards and credentialing criteria that mandate competence with regard to this population. A description is provided of educational topics related to the elderly intended to increase human services trainees’ knowledge, awareness, and skills. Specific approaches for incorporating these topics into the human services curriculum are also provided.

Laurie Craigen and Narketta Sparkman, in their article *The Value and Importance of International Service Learning Programs: A Model for Human Service*
Education, describe the value of international service learning for the professional development of human services trainees. An explanation of various formats of study abroad programming is offered, as well as a description of the difference between study abroad and international service learning. The value of service learning for human service trainees is emphasized and an undergraduate international service learning program to San Jose, Costa Rica facilitated by the authors is described. The program met curriculum requirements for development of human services skills and cultural competency. The impact of the program on student participants as assessed from portfolios and reflective journaling is illustrated.

Human trafficking is a phenomenon that is critically important to human service practitioners. Liza Doran, Darci Jenkins, and Megan Mahoney introduce the concept of human trafficking and discuss how human service practitioners can provide effective services to all victims of human trafficking. In their article, the authors reveal that modern-day efforts focus primarily on providing interventions and resources to female survivors of sex-trafficking. While these services are important, the authors argue that a larger percentage of human trafficking victims never receive the services that they need. Thus, the authors of this manuscript are calling for human service practitioners to be key players in closing gaps in service for all trafficking survivors, regardless of trafficking type, gender, legal status, geographic location, or other statuses. While varying service needs are discussed, the authors argue that the most critical gap is housing. Therefore, in their section entitled, “Relevance to the Field of Human Services,” the authors discuss how human service practitioners can successfully provide housing options for trafficking survivors.

The article, *Cultivating Substantive Peer Interaction in Online Human Service Courses*, by Barbara Hall, reminds us that if online human services courses are offered, they should be meaningful and foster cognitive complexity. The article highlights the importance of encouraging a constructivist learning environment if students are going to gain knowledge, in a meaningful manner, in an online course. The article takes us through ways of designing an online human services course to ensure complex student involvement and interaction, highlights constructivist ways of facilitating the course, and makes suggestions on how to assess the course in ways that offer a more complex analysis of student learning.
than is often conducted. The article suggests that like a traditional classroom, the online learning environment should be complex, interactive, meaningful, and result in helping students increase their cognitive development.

Susan Kinsella and Nancy Wood’s article on *Social Entrepreneurships and Human Services: An Effective Collaboration* discusses the combining of business practices and non-profit thinking referred to as social entrepreneurships and how this concept applies to human services professionals. Human services education is brought up as an ideal area for this model to be discussed and passed on to future human services professionals. Some of the leaders of social entrepreneurships are introduced as well as the success they have seen from implementing this model. The entire human services profession is then encouraged to further examine social entrepreneurships and how this innovative way of thinking can bring more services to marginalized populations.

Diane McMillen and Grace Robert’s article on *Radiance in the Community: Living and Working in Wisdom* introduces a new and exciting approach to working with clients called “3 Principles.” The authors focus on the shift in perspectives that many mental health professions have undergone, leading to more of a “mental wellness” rather than “mental illness” outlook. The 3 Principles are broken down and the readers are given an outline of the individual portions making up the approach: *Mind, Thought, and Consciousness.* Human services professionals are discussed in regards to how the approach can help with burnout and compassion fatigue prevention. The authors wrap their piece up by explaining how following and understanding the 3 Principles approach has the potential to have a radical change in both human services professionals and their clientele.

Brittany Pollard and Tricia McClam highlight service learning in their piece entitled *Beyond the Classroom: Service Learning in Human Service Education.* In their piece they note that service learning has become an increasingly integral part of human service education and is particularly important due to its experiential focus. They talk about the learning that students gain from the experience as well as the benefit it provides to the organizations at which students conduct their service learning activity. They note that it is particularly important to screen students for the specific service learning experience as some students may have chosen a service learning activity due to their own traumas in life (e.g., abuse).
Notably, they give an example of a service learning experience that others can model.

Gina Polychronopoulos, Kristy Carlisle, Robert Carlisle, and Andrea Kirk-Jenkins introduce the concept of behavioral addictions with a particular focus on both gambling and internet gaming disorders. Behavioral addictions, they share, have gained recent attention in the newly revised Diagnostic and Statistical Manual of Mental Disorders (DSM-5). With the inclusion of gambling disorder to the DSM-5, the authors speculate that other behavioral addictions may also be included in future revisions of this manual. In this manuscript, the authors also discuss how human service practitioners can work effectively with clients suffering from behavioral addictions. While the effectiveness of different theoretical approaches are included, the authors argue that practitioners should adhere to the profession’s ethical codes and should only practice within their knowledge and skill base. Additionally, the authors argue that professional development and training on behavioral addictions and diagnostic criteria is critical. They also highlight the need for human service practitioners to make proper referrals and to advocate for the needs of clients struggling with these disorders.

Shawn Ricks, in her article on Teaching and Learning in ‘Post-Racial’ America, offers a number of drawbacks to the belief that we are living in a post-racial America, and suggests that many students (and perhaps faculty) may be under the false assumption about this perspective of race in America. Such an assumption, she suggests, leads individuals to ignore many of the ongoing problems that individuals from diverse cultures continue to face in America. She wisely goes on to suggest that if human service professionals are to be effective with individuals from nondominant groups, they need to understand the drawbacks of believing we are living in a post-racial America. She goes on to recommend that if human service professionals are to be at the “forefront of advocacy, change and social justice” their teachers should create a climate where complex and critical thinking can explore this important topic.

Margaret Sabia, Gregory Hickman, and William Barkley, in their article Delinquency Intervention Development: The Importance of Considering Immigrant Youths’ Adaptive Challenges, addresses the challenges faced by
immigrant youth when adapting to a new culture and the consequences of poor acculturation. While much has been written about the problems caused by these youth, little has been done to promote their well-being and prevent these problems. The authors describe the needs of immigrant youth including transitional and developmental factors that contribute to their health and functionality. They also specify the role of the human services practitioner in developing and implementing strategies for addressing the needs of immigrant youth to promote positive acculturation and future success.

In 2005, Hurricane Katrina, a category three hurricane, caused unprecedented damage to the Central Gulf Coast. In her article entitled, The After-Effects of Hurricane Katrina in Children, Andrea Scott writes about the conduct and mental health challenges that thousands of children continue to experience as a result of this natural disaster. Her manuscript offers a comprehensive model for working with survivors of Hurricane Katrina. The components of this model include social support, crisis counseling, cognitive-behavioral therapy, and family-based interventions. Integrated throughout her model is the active role that the human service practitioners can play with survivors.

In an article on Post-Traumatic Stress Disorder, Marilyn Selfridge focuses on post traumatic stress disorder and human services in her piece. The article begins with the history of PTSD and the evolution of our understanding. The author discussed the symptoms, signs, and triggers of PTSD that human services professionals need to be aware of. Treatment is reviewed, highlighting EMDR and CBT approaches. Finally, the significance that PTSD education and understanding has in human services is examined.

Narketta Sparkman and Tamikia Lott provide an examination of the HS-BCP credential in their article, The Human Services-Board Certified Practitioner: A Review of the Current State. Their report presents an overview of the development, inception, and growth of the HS-BCP including the major components of the exam, current eligibility requirements, and the Center for Credentialing & Education’s (CCE) focus on increasing the value and recognition of the HS-BCP. Of particular interest is their sharing of information on the exam’s current use as an exit test for a number of human service programs. In this context, students’ field knowledge is tested prior to graduation. Those programs
that use the exam as an exit test are given aggregated data on the exam that can be used to compare results across the country and to improve their programming.

Acknowledging the inherent challenges of community development for human services practitioners, Beth Warner in her article *Utilizing Community Practice Experiences to Build Self-Efficacy in Future Human Service Professionals* emphasizes the need to promote self-efficacy among trainees to best prepare them for this important work. The value of community practice experiences for human services trainees is discussed as a means for fostering awareness and skills that contribute to self-efficacy. A university/community partnership in which students worked with neighborhood residents in an urban housing zone to develop a community garden is described as an example of programming aimed at developing students’ self-efficacy. Implications of this project for both students and the community are described.
The Significance of Empowerment in the Field of Health and Human Services

Mechelle Bryan

Abstract
The United States healthcare system is currently undergoing several changes since the Affordable Care Act has gone into effect. One of the main problems in healthcare is the tremendously high costs that are spent annually to provide care to people in the United States. In order to combat the complex challenges and problems that healthcare is facing, medical practitioners, human service professionals, and policymakers should have a solid understanding of the definition and benefits of empowerment. Empowerment utilizes a client-centered approach and has been shown to improve client and patient outcomes and satisfaction. Empowerment can help to cut costs and spending by utilizing web portals, computer-mediated support groups, web-based communities, and by allowing the individual to access Electronic Medical Records online. Empowerment through the internet has the capability to transform the field by making the health care client or patient centric. Numerous studies have confirmed that empowered clients and patients are healthier than non-empowered individuals. Transformation of health care and better quality of life for all individuals can be achieved through various modes of empowerment.

The Significance of Empowerment in the Field of Health and Human Services

Client and patient empowerment is a necessary component in maintaining health and overcoming illnesses and diseases (Bann, Sirois & Walsh, 2010; Mola, Debonis & Giancane, 2008; Muscat, 1998; Rohrer, Wilshusen, Adamson & Merry, 2008). Empowerment can be defined as the process which aids individuals in the development of a set of skills, knowledge, behavior, and attitudes that enables them to generate a higher responsibility for their medical care (Mola, Debonis & Giancane, 2008). When clients and patients gain a better self-awareness of their health issues and take a proactive role in managing their health problems, high costs of health care will be reduced (Lenert, 2010). Client and patient empowerment should become an integral component of health care.

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Literature Review

There is a large percentage of Americans currently suffering from chronic diseases and other mind and body ailments (Bann, Sirois, & Walsh, 2010). Client and patient empowerment exists so that people with health concerns and/or personal struggles can learn to actively manage them (Mola et al., 2008). People are able to make better medical decisions for themselves and all that surrounds their care when they are empowered, informed and involved in their health care. According to Lenert (2010), if patients are empowered, they will make better decisions for themselves, thus balancing the risks and benefits that is inherent within our health care system.

Empowerment places the relationship between the client or patient and the practitioner in equilibrium (Mola, De Bonis, & Giancane, 2008). Health outcomes have been shown to improve as a result of a sound client-provider relationship and empowerment (Rohrer, Wilshausen, Adamson, & Merry, 2007; Mola et al., 2008). At present, no specific reference has been made in the general definition of practice in the field of medicine for inclusion of client or patient empowerment as a necessary element (Mola et al., 2008). In order to transform the current state of health and human services into a more patient centric one, where clients actively manage their health problems and are made to feel as if they are in control of their own health, client and patient empowerment will need to be integrated into traditional health care.

Tele-empowerment is another solution for empowering clients and patients (Levy, Bradley, Morison, Swanston, & Harvey, 2002). The internet is now a vast source for receiving education and learning about various illnesses and diseases. Through tele-empowerment, the Internet serves as a powerful modality for empowering clients and patients through computer-mediated support groups, online support groups, and moderator-hosted blogs (Drake, 2007; Levy, Bradley, Morison, Swanston, & Harvey, 2002; Wentzer & Bygholm, 2010).

Client-Centered Approach as Empowerment

A client-centered approach can help to increase empowerment by helping the individual understand his or her perceived needs (Mola at al., 2008). By helping them to understand their needs, they will be more able to manage problematic symptoms of their disease (Muscat, 1998; Mola et al., 2008, Wentzer & Bygholm, 2010; Bann, Sirois & Walsh, 2010). Clients and patients need to be viewed under a scope that takes into account various factors such as
psychological, social, and cultural conditions. In order to achieve equilibrium between the client or patient and his or her provider, practitioners need to utilize a patient-centered approach to care management and decision making (Wentzer & Bygholm, 2010). When clients and patients are empowered they are able to keep their self-interest as the focus of the medical care process (Mola et al., 2008; Rohrer et al., 2008; Salmon & Hall, 2004).

The healthcare system is structured in a way so that clients and patients are limited, or told to refrain, from utilizing their own resources (Mola et al., 2008; Rohrer et al., 2007). They are often prevented from making their own decisions about care and treatments for diseases and various illnesses. (Lenert, 2010) This may be one contributing factor to the high costs of health care (Lenert, 2010). Clients and patients should not only be empowered to make their own decisions, but they should also be able to feel as if they have options. Physicians and other human service practitioners are persons of authority and possess power over their clients and patients because of their educational backgrounds and knowledge. While it may be helpful to the therapeutic process for practitioners to have authority in medical situations, clients and patients should be able to assume authority over themselves and dwell in a position to make their own changes concerning adverse health conditions (Levy et al., 2002; Mola et al., 2008; Lenert, 2010; Muscat, 1998). Individuals often feel hopeless and helpless in situations that have to do with their care and treatment (Wentzer & Bygholm, 2010). One particular study conducted by (Elit et al., 2003) interviewed women who made decisions about their treatment for ovarian cancer. Most of the women felt that they did not have a choice in making decisions because they had to follow their medical practitioner's orders (Salmon & Hall, 2004).

When individuals are more involved in the care and active management of their diseases, they feel more empowered and are better able to utilize their autonomy to make more informed decisions regarding their care and treatment (Salmon & Hall, 2004; Bann, Sirois & Walsh, 2010). Clients and patients should be able to weigh all of their choices and options rather than be forced to decide between one or two choices (Muscat, 1998). If the field of health and human services is going to be transformed into a more patient centric one, where there are less incidences of chronic disease and reduced economic costs, empowerment through patient-centered care is vital to the process (Mola et al., 2008; Rohrer et al., 2008; Lenert, 2010). Mandatory inclusion of the discipline and theory of empowerment will need to be adopted so that the current healthcare system can
overcome many of its problems. High costs of health care would decrease if more individualized approaches, modes, and methods for client and patient empowerment are utilized (Lenert, 2010).

Transforming the Field of Health and Human Services through Web Empowerment

Technology has undergone a shift and has made it possible for information to be accessed at faster and easier rates. The internet is a prime environment for empowering and meeting the needs of clients and patients. Before the existence of the internet, information was controlled by large publishing houses and this contributed to inflexibility and inaccessibility of data and information (Akerkar & Bichile, 2004; Drake, 2007). The World Wide Web is instrumental to health care because clients and patients are able to receive information concerning their health conditions and what they can do to manage or overcome them (Drake, 2007). According to a quantitative study completed by Wentzer and Bygholm (2010), over 70% of individuals claimed that their decisions about treatment were influenced by information received from the internet. Computer Mediated Support Groups (CMSGs) are necessary for the transformation of the field of health and human services. CMSGs are online communities that enable clients and patients to interact with others in an environment where individuals have the same condition as them (Wentzer & Bygholm, 2010). Participants in computer mediated support groups gain empowerment by having access to information about their illnesses (Oh & Lee, 2012; Wentzer & Bygholm, 2010).

Online participants also learn methods of coping and receive emotional and decision-making support (Wentzer & Bygholm, 2010). Wentzer and Bygholm (2010) hypothesized that individuals who participate in CMSGs are less susceptible to depression and are able to achieve a better quality of life. A study conducted by Oh & Lee (2012), surveyed 464 diabetic members of a computer mediated support community. Greater sense of empowerment, increased decision-making about health care and equilibrium between provider and patient were reported effects of participation in the computer mediated support group (Oh & Lee, 2012).

Tips for Practitioners in the Field of Health and Human Services

The field of human services is concerned with meeting the needs of people and improving the quality of life of those individuals that are served. Empowerment is
a very useful tool for helping to improve people’s quality of life (Bann et al., 2010, Levy et al., 2002; Mola et al., 2008; Wentzer & Bygholm, 2010). One way that clients and patients can be empowered is through emphasizing words that are used to describe their medical condition.

For example, there is a great emphasis on health promotion and empowerment in the field of complementary and alternative medicine (CAM). Many individuals who undergo CAM treatments do not refer to their diseases as “illnesses” but as “health problems” (Bann et al., 2010). The word “illness” is usually seen as debilitative and places emphasis on weakness and the lack of health. Instead of referring to medical conditions as illnesses, the use of terms such as “health problems” could instead be utilized within the field (Bann et al., 2010). The term “problems” offers a more hopeful outlook than “illness” because problems can be resolved.

Ultimately, individuals should be “viewed as experts of their own lives who are responsible for their own health” (Mola et al., 2008, p. 90). The client or patient is the one who has the best idea of how their health condition affects them. Clients or patients need to be more involved and more informed about their health care. Knowledge heightens empowerment. Knowledge about disease prevention, disease management, and health maintenance must be imparted to clients and patients. Besides having their practitioners’ or therapists’ knowledge and opinions about their situations, clients and patients should be able to have their own knowledge and opinions respected by professionals. This knowledge can be attained through various web and tele-empowerment modes such as CMSGs, moderator hosted blogs, practitioner-led tele-health services, e-newsletters, online forum communities, and online seminars. Once the field of health and human services becomes more accepting and inclusive of these modes of achieving knowledge and empowerment, quality of life will be enhanced for all.

Relevance to the Field of Human Services

The Affordable Care Act, recently enacted by Congress, has changed the healthcare system in the United States (Ghosh, 2013; Patient Protection, 2010). Steps should be taken to ensure that empowerment is a primary goal of this healthcare initiative. Health and human service officials and providers should be informed of evidence-based studies that have confirmed that client or patient empowerment can significantly improve health outcomes and quality of life.
Clinically complex issues can be overcome and resolved once empowerment is adopted and included as a mandatory provision of health and clinical care.

References


Compassion Fatigue in Human Service Practitioners

Rebekah F. Cole, Laurie Craigen, Rebecca G. Cowan

Abstract
Increasing rates of compassion fatigue among human service practitioners (HSPs) have wide ranging consequences for the practitioner, the client, and the field of human services. In addition to high turnover rates or the HSP’s early departure from the field, compassion fatigue can also cause serious harm to the client as well as the client/helper relationship. This manuscript will address the signs and symptoms of compassion fatigue, the risk and protective factors associated with the development or prevention of compassion fatigue, and the importance of self-care for HSPs.

Compassion Fatigue in Human Service Practitioners

Human service practitioners (HSPs) are called to serve a diverse group of clients. These clients present a myriad of social and psychological problems, including the past traumas of abuse and the psychological ramifications from unexpected disasters (Martin, 2014). When working with these clients, HSPs attempt to understand their clients’ suffering. However, this understanding may take a toll on HSPs and they may eventually become “fatigued” and unable to fully empathize with clients (Figley, 2002). Compassion fatigue is therefore a serious issue and should be addressed and recognized by the profession. This article will address the signs and symptoms of compassion fatigue, the risk and protective factors associated with the development or prevention of compassion fatigue, and the importance of self-care for HSPs.

Literature Review

Signs and Symptoms of Compassion Fatigue

Compassion fatigue can be identified by increased cynicism at work, a loss of enjoyment in the profession, and a decreased sense of personal accomplishment (Figley, 2002). Additional symptoms of compassion fatigue include intense physical and emotional exhaustion along with an evident distortion in the human service professionals’ ability to feel empathy for their clients, co-workers, friends, and families (Mathieu, 2009). Overall, HSPs may feel...
a sense of hopelessness and confusion in their personal and professional life (Eastwood & Ecklund, 2008).

**Risk Factors**

Several distinct risk factors have been associated with compassion fatigue; for example, female practitioners are more likely than male practitioners to suffer from compassion fatigue (Baum, Rahav, & Sharon, 2014; Sprang, Clark, & Whitt-Woosley, 2007). In addition, practitioners working in rural settings without peer support and access to resources are more likely than their peers to suffer burnout (Sprang, Clark, & Whitt-Woosley, 2007). Finally, practitioners working with clients suffering from Post-Traumatic Stress Disorder (PTSD) have been found to be more likely to suffer from compassion fatigue (Sprang, Clark, & Whitt-Woosley, 2007). Overall, feeling stressed and/or burned out in the workplace is a significant risk factor for developing compassion fatigue (Eastwood & Ecklund, 2008).

**Protective Factors**

Education about compassion fatigue may serve to prevent negative symptoms in HSPs (Sprang, Clark, & Whitt-Woosley, 2007). Self-awareness and ownership of one’s feelings is also a critical protective factor (Knight, 2013). If HSPs are unaware of the negative emotions they are experiencing they will be unable to process them and address them (Warren, Morgan, Morris, & Morris, 2010). In addition, practicing regular self-care has been found to be a significant protective factor against compassion fatigue (Eastwood & Ecklund, 2008).

**Relevance to the Field of Human Services**

Compassion fatigue is an occupational hazard for the field of human services, meaning that almost everyone who cares about their clients will eventually develop a level of it to varying degrees of severity (Mathieu, 2007). In addition to high turnover rates or the HSPs early departure from the field, compassion fatigue can also cause serious harm to the client as well as the client/helper relationship (Simpson & Starkey, 2006). For example, HSPs with high levels of compassion fatigue may be less able to build rapport or respond appropriately to their clients’ traumatic experiences (Simpson & Starkey, 2006).

Due to the risks associated with compassion fatigue, it is important for HSPs to practice self-care throughout their careers (Harrison & Westwood, 2009).
as self-care is an essential part of one’s professional identity (Barnett, Johnson, & Hillard, 2006). The American Counseling Association’s (ACA) Code of Ethics speaks specifically to self-care (ACA, 2014). Section C, titled “Professional Responsibility,” states that “counselors engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (ACA, 2014, p.8). Unlike the counseling profession, the National Organization for Human Services’ (NOHS) ethical code does not have a specific code related directly to self-care (NOHS, 1996). However, under the section labeled “Human Service Professional’s Responsibility to Self,” subsection 35 asserts that human service practitioners should “foster self-awareness and personal growth in themselves. They recognize that when professionals are aware of their own values, attitudes, cultural background, and personal needs, the process of helping others is less likely to be negatively impacted by those factors” (NOHS, 1996, para 38).

In order to fulfill this ethical mandate of practicing self-care, HSPs can take several approaches. Some examples of self-care that have been found to be effective in preventing compassion fatigue are reading for pleasure, taking a vacation, or finding a hobby (Eastwood & Ecklund, 2008). Creative writing has also been found to be a therapeutic means of increasing one’s self-awareness (Warren, Morgan, Morris, & Morris, 2010). Finally, it is recommended that HSPs utilize relaxation techniques, similar to the ones that they teach to their clients, and to avoid media that may depict or discuss traumatic events (Knight, 2013).

It is also important for HSPs to engage in regular supervision in order to prevent and address any symptoms of compassion fatigue (Knight, 2013). Supervisors should help the HSP to become aware of her/his emotions as well as methods of setting appropriate boundaries and developing empathy with clients (Mcrea & Bulanda, 2008). HSPs may also find it useful to build strong peer support networks and to engage in personal therapy in order to process their feelings and emotions in a supportive environment (Harrison & Westwood, 2009).

In conclusion, due to the severe nature of compassion fatigue symptoms and the prevalent risk factors in the profession, HSPs should actively work to engage in self-care and to support these self-care measures amongst their peers and supervisees. In taking these measures, practitioners are not only working to help themselves, but their clients as well. Ultimately, raising awareness about this sensitive issue may help normalize feelings of burnout and compassion fatigue and may urge HSPs to seek the assistance they need.
References


Awareness, Recognition, and Action: Meeting the Needs of Geriatric Clients

Rebecca Cowan, Rebekah Cole

Abstract
As a result of the rapid growth of the geriatric population, there may be more individuals within this age group seeking assistance from human service practitioners (HSPs). Therefore, HSPs must be knowledgeable and comfortable working with individuals within this population. The National Standards put forth by the Council for Standards in Human Service Education emphasize diversity in their outlined curriculum for baccalaureate programs in human services, but do not directly address geriatrics. Despite this gap, it is vital that concepts about aging and the needs of older adults are incorporated into human services courses so that students are able to increase their cultural competency by gaining the knowledge, skills, and awareness needed to work with this client group.

Awareness, Recognition, and Action: Meeting the Needs of Geriatric Clients
According to the U.S. Census Bureau (USCB), as of 2010, over 40 million people comprised the geriatric population which is 13% of the overall national population (USCB, 2011b). In 2011, the first Baby Boomers reached the age of 65 (USCB, 2002) and, therefore, the geriatric population will grow rapidly to 71 million individuals by the year 2030 (Centers for Disease Control [CDC], 2009). The geriatric population is also becoming more diverse with the number of White elders trending down from 80% in 2010 to 58.0% by 2050, Hispanic elders increasing from 7% in 2010 to 20% in 2050, and Black elders increasing from 9% in 2010 to 12% in 2050 (USCB, 2011a).

Literature Review
The number of elders with mental and physical health needs currently outweighs the number of professionals capable of caring for them (Institute of Medicine, 2008; Substance Abuse and Mental Health Services Administration, 2007). The current healthcare workforce is not being adequately prepared to meet the needs of this population as education and training on gerontological issues is not commonly integrated into professional training programs (Karel, Gatz, and Smyer, 2012). Consequently, the United States is facing a health care crisis as our current workforce is “too small and critically unprepared to meet their [geriatric]
health needs” (Institute of Medicine, 2008, para. 4). Karel et al. (2012) found that over the previous 12 months, 20.4% of individuals 65 and older met criteria for a mental disorder. Mental health issues such as dementia, depression, and substance abuse are common in this population (Alzheimer’s Association, 2012; Gfroerer, Penne, Pemberton, & Folsom, 2003; National Alliance on Mental Illness, 2009). Therefore, as a result of the rapid growth of the geriatric population and their mental health needs, there may be more individuals within this age group seeking assistance from human service professionals (HSPs). Therefore, HSPs must be knowledgeable and comfortable working with individuals within this population.

**Relevance to the Field of Human Services**

It is essential that human services educators prepare students to effectively work with elders. A lack of educational opportunities pertaining to geriatrics will potentially contribute to poor mental health outcomes for this population. Unfortunately, the National Standards put forth by the Council for Standards in Human Service Education (CSHSE; 2013) emphasize diversity in their outlined curriculum for baccalaureate programs in human services, but do not directly address geriatrics. Despite this gap in training, it is vital that concepts about aging and the needs of older adults are incorporated into human services courses so that students are able to increase their cultural competency by gaining the knowledge, skills, and awareness needed to work with this diverse population (Remley & Herlihy, 2013). The following describes ways in which these concepts can be incorporated into human services education.

**Utilizing Best Practices in Elder Care**

Coursework for HSPs can specify a variety of ways to assist elders. According to the U.S. Bureau of Labor Statistics (2012), HSPs may use their knowledge and skills to help elders live independently in their homes by providing general support and coordination of care. They may also assist with placement in long-term care facilities if the elder can no longer function independently. HSPs may also help to coordinate hospice care and may find themselves providing comfort to both the client and family. By increasing support, HSPs may ultimately help to combat depression in this population which can help improve their overall health and outlook on life (Ell, 2006).
Recognizing Discrimination and Biases

When implementing these best practices in their work with this population, it is important for human services education to prepare HSPs to be aware of the discrimination and bias that is often faced by this age group. The elderly are often undervalued and many times ignored within our society. Not only do members of the general population hold ageist beliefs but mental health practitioners may also discriminate against this population (Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009). These beliefs may ultimately impact the way these professionals interact with clients of the geriatric population and, therefore, may put client care at risk (Helmes & Gee, 2003). Likewise, human service practitioners’ biases and stereotypes against the geriatric population may negatively affect relationships they have with clients of this population as well as prevent competence in working with this population. It is imperative that these practitioners decrease their stereotypes and biases against the geriatric population as these attitudes may significantly influence the cognitive and physical functioning of the client and may ultimately affect their will to survive. HSPs must be knowledgeable about stereotypes and biases held against the geriatric population and be prepared to delegitimize them when working with clients of this population. As stated in Statement 17 of the Ethical Standards of Human Service Professionals (1996), “human service professionals provide services without discrimination or preference based on age, ethnicity, culture, race, disability, gender, religion, sexual orientation or socioeconomic status.”

Infusing Aging into Human Services Training

Unfortunately, as a result of ageism and stereotypes, many learners may not have any interest in gerontological courses even if they were offered (Hinrichsen & McMeniman, 2002; Holroyd et al., 2009). Therefore, if these learners do not complete courses or participate in educational experiences regarding geriatrics, negative biases and stereotypes they may hold against this population may remain unchanged. Human services instructors may find it helpful to revise the training curricula and incorporate topics into coursework including but not limited to late life psychopathology (including misdiagnosis/underdiagnosis), elder maltreatment, and positive aging. Instructors may also encourage practicums or field observations at various sites who serve the geriatric population (Hinrichsen & McMeniman, 2002). Hinrichsen and McMeniman (2002) found that psychology students completing practicums in
geropsychology had increased knowledge of geriatric mental health, fewer negative attitudes, and higher levels of interest in working with the geriatric population than students who completed practicums elsewhere.

In conclusion, it is important for human service practitioners to be prepared to work with this diverse and rapidly growing population that is in great need of professional services. One element of this preparation is developing the cultural knowledge, awareness, and skills to work with elderly clients. Not only should human service practitioners be trained to be more culturally competent, but also in utilizing best practices for addressing the unique challenges faced by this age group. Ultimately, as with all clients, having this preparation is essential for not only the well-being of the clients themselves, but for our changing and growing society as a whole.

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The Value and Importance of International Service Learning Programs: A Model for Human Service Education

Laurie M. Craigen, Narketta M. Sparkman

Abstract
Given our growing globalized society, students are studying abroad at increasing rates. While different formats of study abroad programs exist, there is a surge in the number of short-term international service learning programs. This manuscript defines service learning and discusses the benefits of international service learning programs, specifically for human service students. The manuscript will conclude with a model of a successful study abroad program in San Jose, Costa Rica for undergraduate human service students led by two faculty members.

The Value and Importance of International Service Learning Programs: A Model for Human Service Education

The United States is a globalized society that demands the understanding of and the ability to work with people from diverse cultural groups. As globalization expands, institutes of higher education have recognized the strategic importance of international educational opportunities (Wang, Peyvandi, & Moghaddam, 2011). Currently, more than 85% of United States colleges and universities offer study abroad programs (Whalen, 2008). Additionally, the number of American students studying abroad has more than doubled in the last 10 years, with particular increases in short term programs and international service learning opportunities (Mapp, 2011; Pariola & Pariola, 2010). This manuscript specifically examines short-term study abroad programs and discusses the benefits of international service learning opportunities, especially in regards to human service students. Also included is a model of a successful human service specific service learning study abroad program in San Jose, Costa Rica.

Literature Review

Short-term Study Abroad Programs

Study abroad programs have been classified into three distinct categories: island programs, direct enrollment/full immersion programs, and hybrid programs (Porcano, 2011). Within island programs, faculty from a home university lead a
group of students in a short-term program abroad (approximately one to two weeks) where they participate in site visits and/or cultural events. In direct enrollment/full immersion programs, students generally apply to a university abroad and are accepted (for semester or year-long stay). Hybrid programs typically share elements of both island programs as well as direct enrollment/full immersion programs (Porcano, 2011).

Currently hybrid programs, also referred to as short-term programs, represent over half of the study abroad population (Mapp, 2011). Despite the shorter length of these programs, students still benefit and there appears to be no significant outcome differences based on the program format (Norris & Dwyer, 2005). Furthermore, shorter-term programs may be more attractive to students who may not be inclined to go abroad for longer periods of time (Norris & Dwyer, 2005; Mapp, 2011). Shorter-term programs can also provide students with the confidence to later participate in semester or year-long full immersion/direct enrollment programs. Many faculty members prefer shorter-term programs because they have more control over the planning of student activities. For example, faculty can design a course that aligns with their university or professional accreditation standards and, as a result, learning can occur in a more focused and intentional manner (Mapp, 2011).

International Service Learning Programs

While varying definitions of service learning exist, there is consensus that service learning programs include activities in the community, particular rendering of a service, attainment of curricular credit, application or development of skills, and practice of structured reflection, in the form of journal responses and/or a final report (Mooney & Edwards, 2001; Wessel, 2007). In service learning programs, the service component is not an additional requirement or course add-on. Rather, the key is integrating service with learning (Pariola & Pariola, 2006). This integration is also found in international service learning programs.

International service learning programs share many similarities with traditional study abroad programs. However, a distinguishing component is the emphasis placed on community-based service activities (Mooney & Edwards, 2001). Research indicates that the potential benefits of service learning on an international scale are multiplied (Pariola & Pariola, 2006). International service learning programs promote growth in a variety of different domains. For example,
students demonstrate growth in intercultural development, reporting significant increases in intercultural sensitivity and cultural awareness (Sindt & Pachmayer, 2005). Furthermore, international service learning programs can promote the value of responsible global citizenship in students and provide students with skills that position them at an advantage in our competitive global marketplace (Grusky, 2000). Students also exhibit growth in personal and academic domains with increased rates of motivation, understanding, and retention of academic material (Wessel, 2007). Additionally, students reported increased levels of empathy, an increased development of their professional identity, and an expanded commitment to social justice issues and advocacy (Mapp, 2011).

Relevance to the Field of Human Services

Over the last 10 years, research has focused on the value and importance of service learning, specifically in human service education (Desmond & Stahl, 2011; Woodside, Carruth, Clapp & Robertson, 2006). Given the focus on interdisciplinary helping in the human services field, the combination of human services and service learning creates a dynamic where the results are mutually beneficial; the community, the student, and the university can benefit from service learning experiences (Desmond & Stahl, 2011). Through service learning experiences, human services students can gain increased knowledge of the human services field and they can critically evaluate and reflect on their pre-service training. Additionally, service learning in human service students also enhances the development of communication skills, self-reflection, and confidence (Woodside, Carruth, Clapp & Robertson, 2006). While the benefits of service learning are clear to human service students, there is a lack of research available on international service learning programs in human service literature.

Model International Service Learning Program

The authors of this manuscript led a short-term/island program service learning study abroad program to San Jose, Costa Rica during their university spring break for nine days. This program took on the common components of service learning and study abroad programs, which included community events, a service component, college credit, reflective activities, and cultural awareness. Students were required to complete both the academic and experiential components of the course. The main focus of the course was skill development; thus, students were required to read a text on helping skills with the goal of
learning these skills (and eventually applying the skills in their service learning activities). In preparation for travel, students also read a text on Costa Rica and began relating human service skills to the culture prior to departure in discussions and reflective activities. A large component of the course was also focused on guided reflection with instructor feedback, prior to travelling to Costa Rica and upon the students’ return. Students were also required to complete an electronic portfolio at the end of the semester, which required the students to reflect on their use of various helping skills in their service learning activities. Students reflected on barriers, cultural differences, and cultural awareness while discussing their integration and use of specific human service skills.

While in Costa Rica, the students participated in three service learning activities at various human service agencies near San Jose. They had the opportunity to interact with the elderly, orphans, and severely ill children and their families. After each service learning activity, the faculty led the students in group reflections and also required the students to reflect individually on their experiences. Consistent with previous reports on the benefits of international service learning programs, the students reported both personal and professional gains in their journal entries. For example, they revealed higher levels of empathy and an increased comfort level working with diverse populations. They also discussed the integration of human service skills and the impact of cultural differences in the use of these skills. Additionally, students reported how they overcame challenges with language barriers and they discussed an increased sensitivity and awareness of the culture in their service delivery. Overall, students wrote that they highly valued their experience in Costa Rica and they synthesized their experiences to apply it to their future professional goals in the human services field.

Conclusion

International service learning programs that are short term are beneficial to human service students. These programs create a holistic opportunity for student learning that is focused on skill development, servicing diverse populations, building advanced skills, mediating cultural awareness and sensitivity to client needs as well as providing opportunities for creative reflection. The successful model presented here can be mimicked by human service programs who desire to create an international study abroad program that meets educational requirements as well as fosters a higher level of critical thinking and advanced skill
development. This model was successful not only because it took on the characteristics of short term service learning programs and short term study abroad programs but its success laid in the integration of these concepts while also reflecting on experiences and differences in the culture.

References


Abstract

Human trafficking is often referred to as modern day slavery. Anyone can be a victim of human trafficking, including women, men, children, adults, foreign-born and domestic, and exploitation can take the form of both sex and labor trafficking. Yet, human service practitioners are much more accessible for female survivors of sex trafficking who are United States citizens. This limited focus effectively excludes a high percentage of those trafficked. As a result, gaps in services exist for trafficking survivors, both due to conflation of human trafficking with sex trafficking and to funding constraints; in turn, these gaps make survivors particularly vulnerable to re-exploitation. By ensuring that services are accessible to all trafficking survivors, human services practitioners have an opportunity to close these gaps and break the cycle of exploitation. This article will provide a brief overview of contextual and systemic factors that create these gaps in service, and will suggest a pathway to close the most critical gap: housing.

Addressing the Gaps in Services for Survivors of Human Trafficking:
An Opportunity for Human Service Providers

Introduction

Human trafficking is modern day slavery (Logan, Walker, & Hunt, 2009). The 2000 Trafficking Victims Protection Act categorizes human trafficking in two ways: sex trafficking and labor trafficking. Sex trafficking is “a commercial sex act that is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age” (22 U.S.C. § 7102[8], 2000). Conversely, labor trafficking is “the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery” (22 U.S.C. § 7102[8], 2000).

In 2012, 400,000 trafficked individuals were identified in the United States. However, up to 27 million people are estimated to be trafficked worldwide at any given time (U.S. Department of State, 2013). Trafficking...
victims tend to come from marginalized and vulnerable populations (e.g., people living in poverty, victims of physical, sexual, or emotional violence, and individuals displaced by armed conflict or natural disaster) and traffickers exploit these vulnerabilities (Omelaniuk, 2005). When these individuals leave trafficking situations, they require comprehensive services to meet their complex needs (Logan, Walker, & Hunt, 2009). However, many trafficking survivors lack access to these services. This article will examine both the need for human service practitioners to respond to all trafficking survivors, regardless of gender, immigration status, or trafficking type, and the need for safe, affordable housing.

**Literature Review**

Anyone can be a victim of human trafficking, including men, women, children, adults, foreign-born, domestic, and of all sexual orientations (U.S. Department of State, 2013). It is therefore critical to provide services that encompass the diversity of the population. Yet, services tend to focus specifically on female survivors of sex trafficking who are United States citizens, despite the fact that there are three victims of labor trafficking worldwide for every one victim of sex trafficking (International Labor Organization, 2012). Although labor trafficking is more prevalent, sex trafficking is more visible in the media and is often used interchangeably with human trafficking (Logan, Walker, & Hunt, 2009). This conflation of sex trafficking with human trafficking is problematic as it de-emphasizes the experience of most trafficking survivors and it creates gaps in identification as well as services (Women’s Commission, 2007). Furthermore, viewing sex trafficking as synonymous with human trafficking “severely hampers the work of anti-trafficking advocates and damages the rights of trafficking survivors” (Kim & Chang, 2007, p. 7) by failing to provide adequate resources for all survivors of modern-day slavery.

Resources for all survivors of human trafficking are scarce. The number of identified survivors has nearly tripled in the last decade, while federal funding for support largely has been stagnant (Alliance to End Slavery & Trafficking, 2013). Publicly funded services for survivors are primarily available through the Office of Refugee Resettlement’s National Human Trafficking Victim Assistance Program and the Department of Justice’s Office for Victims of Crime. Though these critical safety net programs are designed to provide services across the nation, the limited funding appropriated to support these programs creates geographic gaps in service. Thus, depending on location, some trafficking
survivors may not have access to specialized services (Clawson, Dutch, Salomon, & Grace, 2009). Additionally, of the limited funding that does exist, much of it supports female sex trafficking survivors (Women’s Commission, 2007).

Female survivors of labor trafficking and male survivors of both sex and labor trafficking have more limited access to human services and human service practitioners have limited options when working with these individuals (Kim & Chang, 2007). Many practitioners rely on the United States safety net, which includes cash assistance, food assistance, and publicly-funded healthcare to support documented trafficking survivors. As more trafficking survivors are identified, increased funding for this population is required to maintain this temporary support system (Alliance to End Slavery & Trafficking, 2013).

**Closing the Gap in Services through Housing for Trafficking Survivors**

The above literature review indicates that there are extensive gaps in service for human trafficking survivors who do not fall into the subset of female sex trafficking survivors. These survivors tend to be overlooked and under-researched; as a result, they are particularly vulnerable to re-exploitation (Omelaniuk, 2005). Though it is difficult to prevent initial exploitation, human service practitioners can help prevent re-exploitation if all survivors are supported by the services and resources they deserve and require.

One of the most crucial universal human rights and needs is safe housing. Though many female survivors of sex trafficking have access to domestic violence shelters, other categories of trafficking survivors are often excluded from such services (Clawson, Dutch, Salomon, & Grace, 2009). Of the 529 shelter beds specifically designated for human trafficking survivors in the United States, no beds are designated solely for labor trafficking survivors and only two beds are designated for men (Polaris Project, 2012). Although documented trafficking survivors are eligible for federally subsidized housing programs, they face long (or closed) waitlists and can move to the top only if they are fleeing imminent violence, meaning they are currently residing with the perpetrator of their trafficking (Clawson, Dutch, Salomon, & Grace, 2009). Therefore, government housing simply is not an option for many survivors.

Additionally, with housing costs soaring and limited funding available to the majority of trafficking survivors, it often is not feasible for human service practitioners to cover the cost of housing (Women’s Commission, 2007). While shelters can sometimes be used to defray the cost of housing, this temporary
solution tends not to be a suitable or viable option. Survivors identify that some shelters are unsafe and re-traumatizing, an environment quite the opposite of the safe, stable situation required to rebuild one’s life (Women’s Commission, 2007).

Adding to the problem of limited temporary housing options, there are no designated permanent housing options for individuals escaping human trafficking. As a result, service providers’ first task with a new client often is “a frantic scramble to determine where they can stay” (Women’s Commission, 2007, p. 26). Without housing, these survivors are particularly vulnerable to re-trafficking, but with stable housing, they can focus on achieving important goals such as obtaining employment and working with law enforcement to prosecute traffickers (Omelaniuk, 2005).

Lack of permanent housing for trafficking survivors is not a problem without a solution. Funds dedicated to a variety of housing options for trafficking survivors could allow individuals a choice in housing, from shelters to apartments. Demonstration projects have shown that groups with similar vulnerabilities, such as domestic violence survivors, have much greater success achieving their goals when they are permanently housed (Washington State Coalition Against Domestic Violence, 2011). Increasing temporary and emergency shelter options is helpful in the short-term. However, the United States also needs a solution that provides the safety and stability required to build a solid, enduring, long-term foundation for survivors.

Relevance to the Field of Human Services

Human service practitioners have an opportunity to ensure that services are accessible to all trafficking survivors. If human service practitioners only serve a specific subset of a vulnerable population, this exclusivity will result in a substantial lack of services for some and an abundance of services for others (Women’s Commission, 2007). Thus, it is critical to the well-being and justice of vulnerable populations that there is equal access to services for all members of the population, and that these services comprehensively provide for individuals’ human needs.

Human service practitioners can start closing these gaps by providing housing options for trafficking survivors. Access to housing is a basic human right and a wise investment; for every $1 spent to provide permanent housing with support to vulnerable populations, $1.54 is saved on other services such as healthcare, emergency shelter, and justice (Mental Health Commission of Canada,
2012). Closing gaps in service will mean that trafficking survivors are better protected against further abuse and are more equipped to achieve enduring personal and economic success (Omelaniuk, 2005). Trafficking survivors should have access to the same level of support, regardless of trafficking type, gender, legal status, geographic location or other variances. This equal access can be realized with an increased awareness of all forms of human trafficking among service providers, and with human services that are equipped to serve all survivors.

Summary

Though anyone can be a victim of human trafficking, female sex trafficking survivors have greater access to human service practitioners. The resulting gaps in services for other subsets of this population make these survivors particularly vulnerable to re-exploitation. By ensuring that services, including access to permanent housing, are accessible to all trafficking survivors, human services practitioners can close these gaps and break the cycle of exploitation.

References


Cultivating Substantive Peer Interaction in Online Human Service Courses

Barbara M. Hall

Abstract
Online education is an established presence in the field of human services, and cultivating substantive peer interaction toward the achievement of learning outcomes and subsequent practitioner competencies is a valuable investment in the competencies of future practitioners. Discussion interaction can be strengthened through design, facilitation, and assessment of online human services courses. This article makes suggestions that could inform the design of online human service courses, including the adaptation of discussion scoring rubrics, revision of student support products, and creation of faculty development around related learner interventions.

Cultivating Substantive Peer Interaction in Online Human Service Courses

Literature Review
The field of human services has experienced a similar pattern of growth as other certificate and degree programs offered in wholly online formats (Allen & Seaman, 2013). Whereas courses offered entirely online do not include an on-site classroom component as seen in blended or hybrid course models, they could be increasingly powerful learning tools if a discussion within a social constructivist environment is included (Hall, 2011). Given the importance of interaction in the scope of work for a human services practitioner, student discussion in online courses needs to be a critical component of learning and deserves significant attention when designing, facilitating, and assessing such classes.

Social Constructivist Learning Environments
The importance of student discussions is rooted in the theory of constructivist learning that asserts that knowledge is actively constructed rather than passively received (McAuliffe & Eriksen, 2010). This represents a monumental shift away from the idea that a teacher disseminates knowledge and the student passively receives knowledge. From this perspective, the sociocultural effects of the environment, particularly dialogue, is critical to the learning process and is an active experience of all involved. If knowledge is to be constructed, then
those individuals constructing the knowledge must converse with one another. Since the majority of dialogue in online courses occurs between learners within asynchronous, threaded discussions, at times other than scheduled class time, such peer interactions need to be significant contributors to the level of learning (Sher, 2009).

**Advantages and Pitfalls of Online Discussion**

There are several benefits to online discussion groups when conducting distance education in the human services. For instance, during an online discussion regarding one’s field placement, the breadth of socio-political contexts presented by students from different geographical locations allows for a more robust examination of diverse social issues and policies.

Also, when discussion is given through an asynchronous online discussion thread, students have the time to critically reflect upon and deconstruct their experiences (Madoc-Jones & Parrott, 2005). Students appreciate these opportunities, as some researchers have found higher rates of student satisfaction, greater depth of discussion, and improved integration of learning among distance education students (Barnett-Queen, Blair, & Merrick, 2005).

However, despite the potential for asynchronous discussion, such discussion threads have sometimes been found to be more superficial than substantive (Hall, 2011). In fact, de Boer, Campbell, and Hovey (2011) found that students were disappointed with the lack of peer interaction within discussion. Since the helping professions are highly personalized and attract social and people-oriented professionals (Rounds, Armstrong, Liao, Lewis, & Rivkin, 2008), it makes sense that students are likely more stimulated with personalized interaction within a discussion thread. With recent research supporting this now established modality, it is critical that we design and facilitate discussions that optimize this kind of learning (Larsen, Visser-Rotgans, & Hole, 2011).

**Design, Facilitation, & Assessment**

The most effective way to balance the advantages and pitfalls of online discussions occurs through course design, facilitation, and assessment. There are many factors that influence course design, including how student discussions could be used to achieve course learning outcomes.

In cultivating substantive peer interaction, the design of the discussion prompt is of paramount importance. Bloom’s revised taxonomy and Webb’s
depth of knowledge offer categories to differentiate the amount of cognition required in a learning activity. Consider, for example, the difference in requiring a student to remember a fact versus to create a project. Discussions tend to be more robust when the initial prompt requires a higher level of cognitive activity (Hall, 2011). It seems intuitive that students would engage and learn more when they are responding to a prompt with a more rigorous cognitive requirement. In addition, stronger prompts are those that allow for divergent responses that can be individualized to the interests and experiences of each student. Prompts that require only a summary of course materials or application to a standard scenario are likely to generate convergent responses in which all of the students’ messages sound very similar, thereby limiting the opportunity for robust conversation with differing perspectives. Again, the ability to engage such differing perspectives is a critical skill in the field of human services, so our online courses should prepare students for this practice in the field.

In addition, robust dialogue is promoted through the use of instructions that offer guidance on how students should respond to their peers. This guidance, sometimes known as peer response prompts or guided responses, offers direction to the students about the content and depth of their responses for each discussion. Optimal peer response prompts are those that promote critical thinking by focusing learners on contrasting ideas, taking opposing positions, debating issues, and challenging the solutions or ideas proposed by peers while balancing anecdotal evidence with scholarly support (Penny & Murphy, 2009). Composing peer response guidance at the same time as the discussion prompt can strengthen the subsequent conversations.

Of course, once a discussion is designed, effective facilitation can keep the conversation moving in the direction of achieving course learning outcomes. Instructors have a vital role by facilitating peer conversations away from simple comparisons toward exploration and resolution of dissonance. Students may be reluctant to disagree with their peers, rather preferring the comfort of offering statements of agreement and corroborating examples. Through course facilitation, students can be encouraged to view difference as an acceptable part of scholarly dialogue.

Once designing and facilitating discussions, the next step is often assessment of those discussions. Assessing the level of knowledge construction enables course revisions in order to increase the quantity or quality of the knowledge construction that occurs through the dialogue. Davies and Graff
(2005) found that the number of points allotted to discussions, as a percentage of final course grade, is an influential factor in the level of attention both students and instructors give to course discussions. That is, students will allocate their time and energy to course discussions to the extent that the discussions are valued within the grading plan.

With the growing use of learning analytics based on the availability of data from learning management systems (LMS) and associated technologies, there may be a temptation to assess discussions based on such data. However, the data from the LMS user activity reports is limited to the amount of time students spent in a discussion and the number of responses they posted in discussions. Thus, the data do not provide the types of qualitative information necessary to evaluate the learning occurring or quality of interactions in the discussions. A better approach is to use rubrics that assess student and instructor participation in asynchronous discussions based on qualitative measures.

Relevance to the Field of Human Services

Cultivating substantive peer interaction is important to the field of human services for several reasons. As expressed by the Council for Standards in Human Service Education (CSHSE; 2013), “the ability to create genuine and empathic relationships with others is central to the human services profession” (p. 8). Students need opportunities to refine interpersonal skills as a learner in order to demonstrate proficiency in interpersonal skills as a practitioner, as referenced by Standard 15 (master’s degree) and Standard 17 (associate and bachelor degrees) from the CSHSE (2013) national standards.

Nearly two decades ago, Siegel, Jennings, Conklin, and Napoletano-Flynn (1998) foreshadowed the emergence of distance education as a viable modality for delivering accredited education within fields parallel to the human services. More recently, Williams (2010) suggested that “the expanded capacity to creatively use forms of presence for teaching and learning is undoubtedly the most important contribution of convergent technologies” (Slide 21). Online education is an established presence in the field of human services, and cultivating substantive peer interaction toward the achievement of learning outcomes and subsequent practitioner competencies is a valuable investment in the competencies of future practitioners.
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Social Entrepreneurships and Human Services: An Effective Collaboration

Susan K. Kinsella, Nancy E. Wood

Abstract
Modern day social entrepreneurship has combined business practices with current social problems to create solutions with replicable results. Both for-profit and nonprofit organizations have found this model appealing as they mold together business models with nonprofit thinking. Mission statements have become less about increasing individual wealth and more about social change and addressing community needs. Today this concept is more mainstream with many organizations now considered as International Social Entrepreneurships (ISE), addressing issues that are more global such as world hunger, clean water, elimination of polio, or increased employment. The human services profession needs to be aware of this model as we educate our students and practitioners to create new types of services for meeting the needs of our communities. This paper addresses the development of social entrepreneurships, current research on their effectiveness, structure of these organizations, and curriculum content the human services profession may want to consider.

Social Entrepreneurships and Human Services: An Effective Collaboration

Literature Review
Back in the 1960’s, the concept of social entrepreneurship was developed using modern day business principles to apply to the creation of organizations whose missions were to help solve a current social problem rather than to create individual or corporate wealth. Both for-profit and nonprofit organizations found this model appealing as they molded together business practices with nonprofit thinking. Their definition of what constituted a profit changed as these organizations defined success in a more socially conscious way (Dees, 2001). Mission statements became less about increasing individual wealth and more about social change. Today this concept has grown and is more mainstream with many organizations now considered to be International Social Entrepreneurships (ISE). Practiced around the world, these successful businesses can be credited with programs that improve schools and education, health care, and welfare in developing countries (Munoz, 2010). The human services profession needs to be
aware of this model as we educate our students and practitioners to create new types of services in meeting the needs of our communities.

The scholarship of engaging students in the learning process has become more important in institutions of higher learning (Calvert, 2011). It is not unusual to see a multidisciplinary approach to teaching students a sense of social responsibility, leadership, ethical issues, values, and social enterprise. Nowhere is this more evident than in the human services discipline. The development of university and community partnerships has been studied, indicating that internships and service learning, key concepts in human services, are conducive to linking theory to practice. When communities and universities work together, students gain valuable practice experience and residents gain resources to assist them with daily living and skills to strengthen control over their own lives (Brown & Kinsella, 2006). Human services students can be taught the same skills learned in private enterprise to develop a social entrepreneurship. It involves learning about three competing and distinct concepts: social welfare, the public sector, and commercial strategies. Pache and Chowdhury (2012) have discussed how students need to create new and innovative hybrid strategies in developing their own social entrepreneurship. They need to consider building a business within a community that may be lacking in services such as affordable housing, job skills training, childcare, or health care.

**Development of the Social Entrepreneurship**

Since the 1980’s, Daniel Bell, Harvard professor and social entrepreneurship mogul, used this model to develop more than 60 new organizations worldwide. Harvard University maintains this legacy by hosting an annual Human Services Summit at the Technology and Entrepreneurship Center to address current issues that are assessed by the world’s top human services and business practitioners, Harvard faculty, fellows, and researchers, and chosen industry experts in business and human services (Harvard University, 2012).

In 2006, Muhammad Yunus, a Bangladeshi economics professor and founder of the Grameen Bank, received the Nobel Peace Prize for his innovative work with another type of social entrepreneurship called micro-lending. His concept of providing small loans to people too poor to be eligible for standard loans, created a successful plan of economic and social development in some of the most devastated nations. Since 1983, the Grammen Bank has loaned 7 million dollars to people in disadvantaged situations with the average loan amount of one
hundred dollars. The repayment of these small loans by the recipients is also very high. Micro-enterprises have been shown to alleviate poverty in some developing countries (Nobelprize.org, 2013). This concept can be taught in business and human services classrooms to teach both financial and social issues. Students can participate as a class in making a loan to a small enterprise in another country and for as little as 25 dollars can learn how their investment can stimulate the economy of a village.

**Social Entrepreneurships and Human Services**

Research has shown social entrepreneurs are driven to produce measurable and significant results, creating new pathways for those who are marginalized and disadvantaged (Alvord, Brown, & Letts, 2004). The past several years has seen an explosion of entrepreneurship and much competition in the social services sector. Clearly what has been learned in the corporate world from big industry has been applied in the not-for-profit world.

The Center for Advancement of Social Entrepreneurship at Duke University defines social entrepreneurship as “an approach to creating social value that embraces the fundamental principles of entrepreneurship” (Duke University, n.d). The human services field can join forces with business, where both fields can improve upon their teaching methodology on social entrepreneurial topics. Simply being owned by a nonprofit is not sufficient grounds to make a business a social enterprise. The enterprise must have as its purpose the enrichment of social issues. Courses where students can learn this concept are popular as universities respond to issues of sustainable community development and social responsibility (Kinsella & Wood, 2014).

Knowing how to establish the structure of the social entrepreneurship is necessary. Both nonprofit and profit agencies can develop a social agenda in its mission, but understanding the law is important with issues of taxation and charitable contributions. According to Bromberger (2013), nonprofit agencies organized under 501(c) 3 of the Internal Revenue Code (IRS, 2014) can be used for social entrepreneurship since they can own for-profit subsidiaries. A charity is permitted to operate a business that supports its mission and purpose. The Salvation Army with its Thrift Store Enterprise is a good example. The profits from the thrift store support the homeless shelters, daily feeding programs, drug and alcohol treatment, as well as after school or children’s programs. A for-profit agency can also have as its mission, support of a social agenda, with proceeds
going to a cause or specific population. Some successful United States companies, like Newman’s Own, the late actor Paul Newman’s food company, donate 100% of their profits to support educational charities. NIKA water, another United States company, sells bottled water and then uses the profits to bring clean water to those parts of the world where drinking water is contaminated. Another option for agency structure is the limited liability company (LLC), which are private legal entities and allow charities and for-profit businesses to merge (Bromberger, 2013).

Schools that offer human services should consider promoting the concept of social entrepreneurship by offering courses in organizational and financial management, grant writing, budgeting, marketing, development of 501(c) 3 agencies, as well as creation of mission statements, and working with boards of trustees. Undergraduate and graduate students in human services can benefit from learning how to become a social entrepreneur in their community.

**Relevance to the Field of Human Services**

The human services profession needs to be at the forefront of the social entrepreneurship movement as we carve out new frontiers of service and implement solutions to community problems on a large scale. It is important that we teach our human services students and practitioners the necessary skills they need to engage in successful issue-advocacy, problem solving innovation, and project development which can be achieved through the creation of a social entrepreneurship. It is one more tool human services students can use to meet community needs. Human services program curriculum can take the lead in teaching fundamental business practices to create successful social entrepreneurs. Already, the human services field addresses social issues such as poverty, hunger and homelessness. Now we can incorporate the importance of sustainability, human resource management, fiscal responsibility, and governmental and community collaboration. The human services curriculum can emphasize the importance of targeting specific groups (e.g., released prisoners, human trafficking victims) and desired outcomes when selecting program options with a sound comprehension of the extent to which publicly supported programs can be marketed for the public good. The field of human services has the perfect opportunity to offer innovative solutions to problems that have recently emerged or for which past solutions have not proven effective. More importantly, human
services understands the delicate balance between meeting the needs of those in crisis and supporting long-term solutions that lead to stability and self-reliance.

References


Abstract
Some believe that our nation is in a “crisis” (e.g., funding, confidence, hope). However, those of us in human services remain cognizant that crisis can be synonymous with opportunity for change. This article will introduce an innovative and exciting inside-out approach to helping, known as the 3 principles. This understanding instills hope and promotes the well-being that exists in all individuals. As practitioners, we are better equipped to address the complexity of needs in our society when we are solidly grounded in our wisdom and focus on the health and resiliency of the people we serve. As our article demonstrates, and we know from the research and our experience as helping professionals, when we practice from this foundation individuals reconnect with their innate health, they regain their power, and they reignite the radiance in their communities.

Radiance in the Community: Living and Working in Wisdom

Literature Review
Readers are guided to consider a shift in perspective that has been occurring in the helping professions for decades. The movement towards a resiliency focused, strengths-based, empowerment perspective completely reshapes our practice and offers an important counterbalance to the pervasive medical model approach to helping. There have always been voices in the human services field that have eschewed the lens of the medical model and espoused that if we truly want to be helpful we need to look in another direction. The inside-out model of prevention and intervention (known as 3 principles) that this article will introduce has energized and simplified this helping philosophy towards strengths and wellness.

Starting with the field of psychology, which historically is deeply rooted in the idea of diagnosing and treating mental illness, there is a stream of researchers who promote a branch of psychology known as positive psychology. This approach focuses on enhancing mental health rather than treating mental illness and takes to heart Seligman and Csikszentmihalyi's (2000) message that, “treatment is not just fixing what is broken, it is nurturing what is best” (p. 7).
Next, in social work, Saleebey (2013) has spearheaded the *strengths perspective*, which he and many others view as a departure from a traditional social work approach. When helpers see strengths, rather than problems and deficits, it fundamentally shifts our perspective from the dangers of the problems to the glimmers of hope for the possibilities. This not only changes the outcome for the individual receiving services, it also dramatically impacts the quality of the helper's experience.

Likewise the work of Benard (2007) and others, whose research on resiliency and protective factors challenges the prominent *risk factors* emphasis, has heavily informed our approach. Seeing resiliency does not ignore or deny the very real challenges that some social, environmental and family-related factors do present to individuals. However, their interest is in the folks who grew up in families and communities with high numbers of risks and yet triumphed over trauma and adversity. These practitioners led decades of research suggesting that we are all born with innate resiliency and a self-righting capacity as part of our genetic makeup. With the knowledge that we do not have to build resilience in people but it comes naturally, human services practitioners can reach for that innate health and wisdom all people possess.

**Foundation of Inside-Out Prevention**

This body of research, from a variety of helping professions, sets the foundation for utilizing the 3 principles. When the studies from psychology, social work, and resiliency took the philosophical stance that people possess the innate, inborn capacity for health, it underscored the idea that our work is much more than just repairing the worst things in life, it is to help people recognize and uncover their natural, internal source of strength. This approach took a quantum leap with the work of Mills when he implemented this *inside-out/3 principles* approach in a low-income housing project, Modello, a place teeming with violence, drug addiction, gangs, school failure, etc. in Miami, Florida (Pransky, 2011a). Although this article is not the place to fully describe what happened (this article will address why it happened) a quick look at the magnitude of community change will be eye opening. Three years after Mills began his work with the 150 families and 650 youth living there, households selling drugs dropped from 65% to less than 20%, crime decreased by 70-80%, the teen pregnancy rate dropped from 50% to 10%, school dropout rates dropped from 60% to 10%, child abuse and neglect decreased by more than 70%, and the parent unemployment rate
dropped from 85% to 35% (Pransky, Mills, Sedgemen, & Blevins, 1997). The remarkable turn-around of these communities is described in the book, *Modello: A Story of Hope for the Inner City and Beyond* by Pransky (2011a).

To facilitate such extraordinary change, Mills and his staff first believed that everyone is born with innate health and access to wisdom (Pransky, 2011a). Through these lenses the researchers were able to see the internal resilience in the residents, despite whatever external unhealthy behavior they were presenting. Secondly, they helped residents understand the nature of *thought* and how it affects one's experience of the world. This understanding of *thought* comes from the 3 principles. Sydney Banks did not have a name for the wisdom he had come to understand, he simply called it *mind, thought, and consciousness*, and these constructs form the foundation for this inside-out understanding. Briefly, Pransky (2003) summarizes these principles: *mind* refers to the universal, formless energy or intelligence behind life, the life force that is the source of all things, *thought*, is the power to create, and *consciousness*, in essence, is “the power to experience” (Pransky, 2003, p. 77). These truths have come to be known as the 3 principles.

While Modello is a more well-known example of individual and community change, 3 principles projects have been replicated in a variety of settings. According to a report on the National Community Resiliency Program (NCRP; Mills-Naim, 2010), an initiative that seeks to use the 3 principles in all areas of helping, there has been outstanding changes occurring in the lives of people throughout the United States. The NCRP trains helpers in hospitals, schools, social services, and police forces and then measures how the understanding of the helper ripples out into the community. What they have found on a community level is that there have been “significant decreases in crime and violence, significant, positive health-related impacts, and improved school behaviors and achievement,” and on a personal level, evidenced indicates “an increase in calm and well-being, a decrease in interpersonal conflict, a larger perspective on separate realities, decreases in anger and judgment, and an increased ability to see innocence in others” (Mills-Naim, 2010, p. 5). These results hold promising implications for the helping field, as the evidence of significant individual and community change is clear and compelling.

**Working from Wisdom**

As practitioners, knowing we have innate health and wisdom can exponentially reduce burnout and compassion fatigue. We are mindful that
difficult situations are opportunities to practice living in our health and withholding judgment toward others. If we experience negative feelings, we realize that we are creating those feelings from our critical or fearful thoughts. When we shift to more compassionate thoughts, our responses and interventions are more appropriate and kind.

Without denying the gravity of the situation or our need to act, the truth is we are better equipped to figure out the situation and confidently respond from quiet wisdom, rather than fearful, frantic reaction. Even in a very difficult situation, such as working with a client in crisis, we can engage more calming thought thus allowing our brain to respond and our body to relax. We can also be more patient with challenging actions of others because we know they are acting out of their troubling thoughts, which seem so real. This frees us from getting caught up in the drama and we are “able to face this crisis in a way that allows us to remain healthy” (Pransky, 2011b, p. 107). In order for human services professionals to spark hope and positive change, we must reach for the health and strength in people and build on what is working.

Can it really be this simple? Can change really be a thought away? We think so. The evidence certainly proves that dramatic individual and community change is possible and that true change comes from the inside, sparked by a thought and the impact of that thought on one's experience of the world. Current brain science research confirms that we create our reality from our thinking. While our neurological pathways create default thinking patterns, we are able to change these with different thoughts (Hanson & Mendius, 2009). The only reason we cannot access our wisdom is because our conditioned thinking clouds it. We all have wisdom and common sense. It's only our thinking that prevents us from seeing and knowing this with clarity.

Relevance to the Field of Human services

The potential of the 3 principles understanding to significantly enhance the delivery of human services cannot be overstated. The possibility for individual change is unlimited when people are helped to see how their thoughts are continuously determining their feelings and their personal reality. Many things happen that we cannot control, but how we experience these events is a product of our thinking. When human service workers enter helping situations seeing strengths and firmly grounded in this understanding of a human’s innate capacity for health, they enter equipped with hope and this shifts the relationship to an
entirely different level. There is no sense of urgency to find solutions. The answers lie within the center of all people. Our role is to recognize their health and help uncover their natural resilience. In addition, we can avoid getting hooked by the behaviors of others that usually goad a reaction. We are free from viewing the world as a place of chaos and of pain, and view it as a place where people are innately good and have merely lost their way.

The essence of this understanding is truly captured by Niebuhr (2008) when he stated, "Nothing worth doing is completed in our lifetime; therefore we must be saved by hope. Nothing true or beautiful or good makes complete sense in the immediate context of history; therefore we must be saved by faith. Nothing we do, however virtuous, can be accomplished alone; therefore we are saved by love" (p. 63). So, with this understanding, we are able to allow joy in our work rather than being overwhelmed by what could be seen as an enormous responsibility. We are free from thinking there is anyone we need to fix, at most we are the catalyst for individuals to find their own wisdom and see that they have their answers. Radiance really does exist in individuals and the communities they form; we simply get to point them toward that light.

References


Beyond the Classroom: Service Learning in Human Service Education

Brittany L. Pollard, Tricia McClam

Abstract
Service learning, sometimes referred to as civic engagement or engaged scholarship, is one of today’s most widely discussed topics within higher education. In human services, it provides students with the opportunity to further their knowledge beyond the classroom by engaging with their community in a wide range of mutually beneficial ways. This article reviews service learning as an experiential construct and details its relevance to human service education in particular. The authors provide a detailed example of a service learning initiative at the University of Tennessee, which pairs student mentors with grieving children throughout the community. Included in the program overview are descriptions of the project’s multiple beneficiaries, as well as challenges faced by program coordinators. Implications are provided for human service educators considering the incorporation of a service learning element into existing curriculum models.

Beyond the Classroom: Service Learning in Human Service Education

Service learning is a widely touted topic in higher education, and provides a foundation on which students can build skills, gain experience, and begin to navigate their chosen field at the professional level. This article reviews service learning as an experiential construct and details its relevance to human service education in particular. An example of one service learning initiative and implications for human service educators are provided.

Providing human service students with the ultimate hands-on learning experience, service learning opportunities allow students to integrate the value of serving others with skills developed in the classroom (Desmond & Stahl, 2011; McClam & Harrower, 2003). Research on service learning models in higher education has exposed its benefits in a number of professional arenas, with several authors citing the numerous purposes embedded in experientially-driven curricula (Lee, Rosen, & McWhirter, 2014; Nicholas, Baker-Sennett, McClanahan, & Harwood, 2011). Particularly prevalent are investigations into how service learning enhances the professional development of those students training to become human service professionals (McClam & Harrower, 2003).
Human service educators have increasingly recognized the merit of providing students with experiential opportunities, and the trend toward developing curricular models based on practice is evident in the literature (Jurgens & Schwitzer, 2002).

Two of the primary themes which emerge upon reviewing service learning-based literature are the necessity of reciprocity and the level of effort required for implementation of successful service learning initiatives (Desmond & Stahl, 2011). In defining the construct of service learning, McClam and Harrower (2003) noted its unique reciprocal nature, citing the mutual benefit of all parties involved as a key feature of true service learning endeavors. Several authors detailed methods for developing, implementing, and assessing service learning initiatives, as well as for navigating challenges encountered along the way (Baggerly, 2006; Jurgens & Schwitzer, 2002). The following sections outline a service learning example at the University of Tennessee, including descriptions of challenges faced and the reciprocity of benefits experienced by all involved parties.

**Service Learning Example**

Although we have no way of accurately measuring how many children are coping with grief at any given time, we do know that many face loss in some capacity during childhood. This knowledge prompted the 2008 establishment of the Grief Outreach Initiative (GOI). The GOI is a service learning project at the University of Tennessee that pairs student mentors with children throughout Knoxville, TN who are coping with broadly defined issues of grief and loss. To date, the GOI has served more than 300 children referred by school counselors and social workers, parents, grandparents, and mental health professionals. Reasons for referral typically include the death of a parent, sibling, friend, or pet, parental incarceration, or other losses related to transition (e.g., divorce, moving).

GOI students enroll in a semester-long course for intensive training on grief and mentorship, as well as the provision of regular supervision. Following background check and fingerprinting clearance, as well as securing student liability insurance, mentors learn about children’s developmental levels, the individuality of grief, and the cultural implications associated with loss. Through experiential exercises, case studies, role plays, group discussions, student presentations, and the interactive modeling of interventions, student mentors are
well-equipped to provide discussion and activity-based mentorship services to their mentees.

Mentors meet with children ages 3 to 18, both individually and in small groups, and utilize interventions frequently based in art, music, children’s literature, writing, game-play, multimedia use, and/or discussion. These activities help them meet the needs of youth who face a multitude of challenges, such as experiencing abuse and/or neglect at home, a seven-year old in so much pain he wanted “to stab himself in the heart,” a third-grader who found his father after he had committed a gruesome suicide, and two siblings and their cousin who saw a family member murdered before their eyes. GOI coordinators recognize that these are the children who often slip through the proverbial “cracks” and emphasize to student mentors that the primary goal of their service is to provide support and consistency to children who may not receive it elsewhere.

As an increasingly popular model in higher education, service learning not only rewards its participants with multiple benefits, but is also routinely accompanied by a number of challenges. In striving to meet researchers’ expectations that participation will impact students’ civic attitudes and personal development (Levine, 2008), human service faculty contemplating the implementation of service learning models must consider both inherent challenges as well as possible benefits. The following section utilizes the GOI to highlight both considerations.

**Challenges and Benefits**

Among the numerous challenges faced in coordinating the GOI is the need for preparation on a number of levels. Service learning courses situate two equally important needs: the needs of learners (the students involved) and the needs of the community served (Desmond & Stahl, 2011). Although both parties benefit from the experience, it can be challenging to navigate the development of a partnership between an educational institution and a community agency or school. One reason is that service learning has historically been concerned with advancing the goals of students, faculty, and the college itself, while ignoring or minimizing agency or community needs and the importance of constituent participation (McClam & Harrower, 2003). Second, when agency or community needs are considered, establishing collaboration often takes a deficit approach, focusing on existing problems rather than available resources (McClam & Harrower, 2003). To combat this deficit approach, the GOI partners with various schools in the community
where its work occurs. One of the first tasks in the development of the GOI was to enlist the involvement of local school counseling coordinators. This contact was helpful in identifying the needs of the school system and its children, understanding policies and procedures, and structuring the entire experience. Thus, in creating any service learning activity, it is crucial to identify the needs of both partners and to understand how those needs may be met.

In addition to efficiently coordinating partnerships during developmental stages, it is imperative to prepare effectively for implementation. Although loss is universally encountered, each individual experiences grief in his/her own personal way. Grief manifests itself on a number of levels affecting human functioning, and those individuals impacted by grief during critical periods of transition or development may be particularly vulnerable to its effects (Taub & Servaty-Seib, 2008). For the GOI, this fact necessitates screening, training, and supervision as critical components of a service learning experience that is emotionally intensive. Some mentors are drawn to the GOI because of their own self-reported “unresolved grief issues;” others are motivated by their own positive support experiences. Being alert to these motivations is necessary in protecting the children who are referred to the GOI and also screened for eligibility. Similarly, regardless of the service learning activity being conducted, it is important that those involved are aware of the impact of their service learning activities, and that students are appropriately screened.

The primary function of any service learning project is the mutual benefit of all parties involved. School personnel benefit from partnerships with the GOI, given that they frequently lack the time or resources to work individually with students in need. Student mentors benefit from opportunities to apply their skills, network and learn about problems encountered in school settings, engage in the community, and build their résumés. Additionally, the children with whom our mentors work benefit from having consistent support as they navigate the grieving process. These benefits are apparent in a number of ways, including the child who reportedly asks for his mentor outside of their weekly scheduled appointment time, the child who is better able to identify and communicate his/her emotions after a semester-long mentorship, and the child who tells us that he/she “still misses mom, but is okay now.” Although we routinely seek formal feedback from all involved parties, it is most frequently via unsolicited communication that we recognize the impact of the GOI and the extent to which all participants benefit.
Relevance to the Field of Human Services

Service learning opportunities such as the GOI have become widely accepted pedagogy in higher education (Jurgens & Schwitzer, 2002; McClam & Harrower, 2003) and will likely continue to be an integral part of human service curricula. Additionally, the interest of both faculty and students in experiential initiatives continues to grow.

For human service educators interested in developing service learning opportunities, it is critical to consider primary goals, inherent challenges, available resources, and the potential for mutually benfitting all participants. Service learning provides human service students opportunities to further their knowledge beyond the classroom, gain awareness of community issues, experience professional development, and enjoy the sense of reward that often accompanies serving those in need (Lee, Rosen, & McWhirter, 2014; Nicholas et al., 2011). The service learning initiative described here constitutes just one example of a valuable experiential opportunity for students training to become human service professionals.

References


The Emergence of Behavioral Addiction in DSM-5

Gina B. Polychronopoulos, Kristy L. Carlisle, Robert M. Carlisle, Andrea J. Kirk-Jenkins

Abstract
The release of the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has sparked continuous debate about the structure, organization, and inclusion or exclusion of mental disorders. The term addiction made its first appearance in the manual with the category of Substance-Related and Addictive Disorders, after much anticipation from mental health professionals. With the emergence of behavioral (process) addictions in the diagnostic manual such as gambling disorder, it is likely that other mental disorders with similar features will follow suit. Speculation about other behaviors that could potentially be addictive includes Internet use, sex, shopping, exercise, and compulsive eating, among others. The goal of the current review is twofold: to explain the concept of behavioral addictions, including a focus on gambling and Internet gaming disorders, and to discuss how the emergence of process addictions may influence the work of human services practitioners. Clinical implications within the human services profession are also discussed.

The Emergence of Behavioral Addiction in DSM-5

Significant changes in organization and structure were revealed when the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in 2013. What was once a multiaxial system is now combined into 22 categories of mental disorders, each grouped and organized based on etiological and phenomenological similarities. The overarching goal for these changes was an effort to align the manual with the International Classification of Disorders (ICD). Some disorders were removed from the manual, while others were newly added, but there is still debate among clinicians and researchers regarding both the practical and empirical validity of the changes that were made to the diagnostic manual (American Psychiatric Association [APA], 2013a). The following review highlights the emergence of behavioral addiction disorders in the DSM-5.
Behavioral addiction is considered an addictive disorder within the category of Substance-Related and Addictive Disorders in the *DSM-5*, and it describes the experience of cravings, strong urges, and disruptions in one’s functioning related to a particular behavior (APA, 2013a). Specifically, reward system pathways in the brain become activated when one engages in the behavior, just as it does when one uses substances. These experiences showed sufficient support in the literature, and the DSM Task Force has introduced this concept in the new manual because of the similarities between these phenomena (APA, 2013a). Several behaviors have been speculated to be addictive in nature in the past (e.g., sex, shopping, exercise, compulsive eating), and human services practitioners may provide therapeutic interventions that are similar to those offered for substance use disorders.

Although not a new mental health concern, gambling disorder (formerly called pathological gambling) is the first and only behavioral addiction to be formally recognized in the *DSM*. Prior to the *DSM-5*, gambling disorder was conceptualized as an impulse-control disorder; however, it is currently included within the category of Substance-Related and Addictive Disorders. This reassignment was justified by the physical, emotional, and neurological similarities that clients experience for substance use disorders and pathological gambling (APA, 2013a), as well as the neurochemical similarities that occur in the reward system pathways of the brain when an individual with gambling disorder engages in the behavior (APA, 2013a; Musalek, 2007; Prakash, Avasthi, & Benegal, 2012).

The diagnostic criteria for gambling disorder are reflective of substance use disorders, such as the need to increase how much money is gambled to achieve the same level of excitement (tolerance), irritability or restlessness when reducing or stopping the gambling behavior (withdrawal), and unsuccessful, repeated attempts to control the gambling. There are also remission specifiers, in which clinicians indicate how long it has been since any of the diagnostic criteria have been met (APA, 2013a). Given that the diagnostic criteria reflect the language of addiction, as well as the phenomenological similarities between gambling and substance use disorders, the reconceptualization of pathological gambling could pave the way for other pathological behaviors to be included in the manual.
Similar to gambling disorder, Internet gaming disorder is found in Section III of the *DSM-5*. This section is reserved for emerging models and mental disorders that are still being researched due to lack of evidence to support their inclusion in the manual (APA, 2013a). Currently, however, there is limited empirical support for the existence of this phenomenon, and more research is needed in order to justify its formal inclusion as a mental disorder (APA, 2013a). For this reason, it is considered an emerging disorder that may be included in future manuals (APA, 2013a). Aside from Internet gaming disorder, there are no other addictive disorders under review in Section III. However, it is important to note that, with the presence of one behavioral addiction in the new diagnostic manual (i.e., gambling disorder), and the prospect that another may be included in upcoming editions (i.e., Internet gaming disorder), it is possible that other behavioral addictions could emerge with further research and empirical support.

Much of the current research on Internet gaming disorder has been performed in Asian countries, where problematic Internet use has been recognized as a significant enough concern for governments to implement restrictions (Liu, Liao & Smith, 2012; Young, 2009). In a review of the literature, Kuss and Griffiths (2012) note that compulsive Internet gaming can lead to social and psychiatric distress. Symptoms that resemble substance-related disorders include preoccupation with gaming, heavier or more frequent use than intended, and risk of interpersonal or occupational loss (Young, 2009). Neurological studies demonstrate biochemical changes occurring in the brain with excessive Internet gaming that are similar to those seen with substance use (Kuss & Griffiths, 2012). However, additional research is needed in order to clinically legitimize Internet gaming disorder for inclusion in future editions of the *DSM*, as well as to support the development of evidence-based therapeutic interventions.

**Clinical Implications for Human Service Practitioners**

The reconceptualization of gambling disorder as a behavioral addiction, as well as the emergence of Internet gaming disorder in Section III of the *DSM-5*, reflects the theory that some behaviors could be considered addictive due to the similarities in symptoms, neuropathology, and treatment interventions (APA, 2013a). Recognizing these phenomenological similarities may improve accessibility of treatment tailored to addictions for people with a gambling disorder. Human service practitioners can use existing therapeutic interventions, such as Cognitive Behavioral Therapy (CBT), the Transtheoretical Model (TTM)
or Motivational Interviewing (MI) techniques, when working with people affected by behavioral addictions. Further research is needed regarding specialized therapeutic interventions to treat specific behavioral addictions.

With the emergence of behavioral addictions, it is possible that further changes may occur in the way addictive disorders are conceptualized, assessed, and treated. For example, the diagnostic criteria in the *DSM-5* reduce the threshold for a diagnosis of gambling disorder from five to four symptoms; thus, there is speculation that the overall prevalence of gambling disorder might increase (APA, 2013a). Further, although there are *other specified* and *unspecified* options for most other mental disorders (including substance-related disorders), the option is not listed in the *DSM-5* for Non-Substance-Related Disorders (APA, 2013a). Clinicians are thus limited from diagnosing a behavior, which appears to be problematic or addictive, other than gambling.

As the diagnostic conceptualization of addictive behaviors evolves, the assessment of addictive behaviors would also be influenced. Recently, a social media addiction scale was created to assess the level of one’s excessive use of Facebook, a social media website (Andreassen & Pallesen, 2013). Although the authors chose to create a specific assessment for one website as opposed to all social media networks, the need for this type of assessment supports the notion that behavioral addiction is being recognized as a phenomenon. This recognition is reflective of the current trend in mental health diagnosis. Although training beyond the bachelor’s degree is required to diagnose and assess clients (Neukrug, 2013), human services practitioners may develop and utilize a working knowledge of diagnosis and assessment to identify potential clients who may qualify for services. Ongoing research may continue to focus on better understanding the potentially addictive nature of certain behaviors such as general Internet use, sex, shopping, exercising, binge eating.

**Relevance to the Field of Human Services**

Human services practitioners work in a variety of settings (e.g., community-based, institutional, residential care) with clients who could be affected by a range of mental health concerns (Neukrug, 2013), which may include addictive behaviors. However, human services practitioners are required to only practice within their knowledge and skill base, as well as to seek out new and effective approaches to working with their clients (National Organization for Human Services, 1996). Therefore, with the emergence of new diagnostic criteria
for addictive disorders, it would be beneficial for human services practitioners to receive training on the diagnostic criteria so they may effectively provide services and referrals to their clients.

As clinicians in multidisciplinary settings develop treatment options for individuals with a behavioral addiction, human services practitioners may benefit from becoming aware of the treatments offered at their agency and in the surrounding community. If human services practitioners receive training to recognize the symptoms and signs of behavioral addiction and become aware of the resources available, they would be better equipped to provide referrals for clients to be assessed and treated by appropriate service providers. Furthermore, human services practitioners also serve as advocates for the mental health profession (Neukrug, 2013) and may do so by seeking to understand behavioral addictions more thoroughly. To better address the phenomenon of behavioral addiction, human services practitioners can advocate for the modification of diagnostic screening and assessment tools, as well as contribute to the development of appropriate mental health skill building interventions.

References


Teaching and Learning in “Post-Racial” America: Implications for Human Service Professionals

Shawn Arango Ricks

Abstract
The current narrative of a “post-racial” America has created problematic environments in which human services teachers and students live, learn and work. Although human services as a field continues to emphasize the importance of diversity, the discourse of “post-racialism” in America has created challenges to effectively teaching and training students and workers. It is important for teachers, students and workers in the field to spend time deconstructing this narrative in order to be more effective to those whom we serve. This article will examine the importance of challenging human services teachers and students to examine their views on the current state of race and diversity in America—going beyond surface levels of difference and gaining a deeper understanding of how the current narrative of post-racialism impacts our roles as effective helpers.

Teaching and Learning in “Post-Racial” America: Implications for Human Service Professionals
I was drawn to the field of human services because of the long history of, and emphasis on, social justice and equity within the profession. This emphasis on diversity is evident throughout the Ethical Standards for Human Service Professionals (National Organization for Human Services, 1996). In addition to diversity, the standards address the importance of advocacy (Standard 16), the importance of having knowledge of various cultures and communities (Standard 18), and having awareness of one’s own backgrounds and beliefs (Standard 19). The standards provide clear and comprehensive structured guidelines under which all human service professionals must adhere. Standards 20 and 21 provide a unique challenge for human services professionals. Standard 20 states “human service professionals are aware of sociopolitical issues that differentially affect clients from diverse backgrounds” and standard 21 states “human service professionals engage in continuing education, professional development, and supervision in order to work effectively with culturally diverse groups.” Although I believe many human service professionals are well intentioned, I wonder how deeply human service professionals have delved into discussions regarding the
systemic and political forces behind race and racism in America, especially when those discussions may be difficult. Are we effectively training students and professionals if we are hesitant or unaware of the difficult dialogues we need to engage in?

In recent years, some have suggested that we are in a post-racial America (Haney López, 2010). However, despite the election of Barack Obama in 2008, and his subsequent re-election in 2012, there remain enormous inequities between Blacks and Whites in the United States (Ladson-Billings, 2006; Oliver & Shapiro, 2006; Pettit & Western, 2004). These inequities run across various markers of areas of health, wealth, and educational attainment. According to Goldman (2009), Blacks remain twice as likely to be unemployed and three times as likely to live in poverty as Whites. In addition, Blacks are disproportionately represented in the juvenile and adult justice systems, as well as in referrals for special education, suspension and expulsion (Alexander, 2012; Blanchett, 2006; Skiba, Michael, Nardo, & Peterson, 2002). These aforementioned disparities, along with the recent deluge of media controversies (e.g., Donald Sterling, Jordan Davis, Trayvon Martin), question whether we are currently in a post-racial narrative. This article wonders how human service educators and professionals are impacted by the post-racial narrative, and how such a narrative impacts service delivery.

**Literature Review**

The election of our nation’s first Black president, Barack Obama, has proven to be a catalyst for dialogue grounded in post-racialism. Even as this national discourse occurs, scholars continue to debate the origins and definition of the term *post-racial*. Cho (2009) argues that amidst the current national discourse, post-racialism:

> is a twenty-first-century ideology that reflects a belief that due to the significant racial progress that has been made, the state need not engage in race-based decision-making or adopt race-based remedies, and that civil society should eschew race as a central organizing principle of action. (p. 1594)

These beliefs lead to a *retreat from race* that is noticeable in three forms: material, sociocultural, and political. Material retreats include the reduction or elimination of state-imposed remedies, sociocultural retreats include a shift in the deference to *Black normativity* on issues of racial justice, and political retreats
include the disbanding of official political entities originally organized for reform (Cho, 2009). Cho also discusses the four key tenets of post-racialism as an ideology: racial progress, race-neutral universalism, moral equivalence, and distancing move. Racial progress asserts that there is no longer a need for racial solutions based on the progress made by the country regarding race and race relations. Race-neutral universalism is directly linked to the racial progress tenet in that it asserts that racial remedies are harmful, and instead race-neutral policies must be created and maintained. Moral equivalence refers to the assumed equality (under post-racialism) of events which subordinated racial minorities and events which attempted to remedy minority subordination. The last tenet of post-racialism refers to a distancing move taken by practitioners in an effort to distinguish their behaviors as part of the ideology of post-racialism.

Bobo (2011) presents additional definitions of post-racialism by different authors. One such definition is:

in its simplest and least controversial form…[post-racialism] is intended merely to signal a hopeful trajectory for events and social trends, not an accomplished fact of life. It is something toward which we as a nation still strive and remain guardedly hopeful about achieving. (p. 13)

Bobo (2011) also suggests three additional meanings for consideration: the Black victimology narrative, the end of racial dichotomies, and the rhetoric of color blindness.

The Black victimology narrative asserts that the traditional issues facing Blacks are no longer pertinent and accurate now that we live in a world free of “overt racial divisions and oppression” (Bobo, 2011, p. 13). This narrative places Blacks in the center of complaints and grievances that are no longer current, akin to playing the “race card.” The second definition argues that based on the changes the country has been going through there can no longer be any validity to traditional separations of Blacks and Whites. This overly simplistic view wants to rush over the painful history America has with race and racism, and instead move forward.

The third definition Bobo presents is the most controversial. This definition has the most in common with the rhetoric of color blindness (Bonilla-Silva, 2006). This definition posits that a large percentage of the United States population is “ready to transcend the disabling racial divisions of the past” (Bobo, 2011, p. 14). This viewpoint is problematic because being “ready to transcend” can be one way to negate the experiences of Blacks in the United States. Many
who subscribe to this last definition may not have a framework for understanding subtle racism. This lack of understanding of subtle racism “is problematic because it defies the widely shared understanding of racism as blatant, easily recognizable behavior” (Reid & Birchard, 2010, p. 479).

The insidious nature of operating from a post-racial ideology is neglectful at best. For Whites who choose to operate from this ideology, it provides the opportunity to ignore White privilege and instead place blame on marginalized groups for not attaining success in general and success comparable to Whites. The faulty logic of post-racialism and color blindness, which negates White privilege, has been refuted by multiple scholars (Alemán, Salazar, Rorrer, & Parker, 2011; Bonilla-Silva, 2006; Cho, 2009; Ford, 2010; Ladson-Billings, 2011). Despite the fact that post-racialism has been refuted by numerous scholars, marginalized groups continue to struggle with the charge of proving that the problem of racism still exists.

Relevance to the Field of Human Services

Recognizing and understanding the current climate of race and racism in America is important for human service professionals. It is unrealistic to expect human service professionals to effectively help others without the contextual knowledge necessary to build the bridges of understanding, compassion, and empathy. Part of this knowledge includes awareness of discussions concerning the narrative of post-racialism. Awareness of this narrative is imperative to understand not only our worldview, but the worldview of those who we serve. In addition, the belief by some politicians and other individuals in positions of power that we are in a post-racial society may impact human service delivery through diminished availability of financial and other resources.

For those of us who are teaching the next generation, understanding the various beliefs about post-racialism will allow us to better prepare our students. Complex and critical discussion should be held in the classroom regarding post-racialism, power, and privilege, as it will be impossible to fully prepare future helpers who are limited by the narrowness of their own viewpoints. Human service professionals have always been at the forefront of advocacy, change and social justice issues. We must continue to lead even when the discussions are complex and uncomfortable.
References


Delinquency Intervention Development: The Importance of Considering Immigrant Youths’ Adaptive Challenges

Margaret F. Sabia, Gregory P. Hickman, William M. Barkley

Abstract
Immigration has continued to be a source of debate in the United States due to immigrant population increases and undocumented entry into the country. The debate is further propagated by public safety concerns associated with the criminal and delinquent involvement of some immigrants. In an effort to address ongoing societal concerns, researchers have focused on ways to promote acculturation as a means to prevent delinquency among immigrant youth. In turn, researchers have empirically established the need to provide culturally sensitive interventions for immigrant youth. However, development of intervention strategies for immigrant youth has lagged behind the empirical evidence creating a lapse in services. The following discussion will elaborate upon the types of unique challenges immigrant youth face within the acculturation process that may contribute to delinquency. Furthermore, the discussion will address the implications adaptive challenges have on the development of intervention strategies and the delivery of services by human services professionals.

Delinquency Intervention Development: The Importance of Considering Immigrant Youths’ Adaptive Challenges

Literature Review
The influx of immigrants into the United States has been a primary concern since the beginning of the 20th century due to public perceptions about the negative impact immigrants could have on American society (Moehling & Piehl, 2009). The immigrant youth population is considered to be one of the fastest growing populations in the United States (Tienda & Haskins, 2011). In 2011, first and second generation immigrant youth made up approximately 30% of the United States school population (Passel, 2011). Despite the immigrant youth group being one of the most rapidly growing segments of the population, we have found very few intervention programs geared towards immigrant youth related to delinquency prevention (Ceballos & Bratton, 2010; Estrada-Martinez,
Caldwell, Schulz, Diez-Roux, & Pedraza, 2013). The lack of effective intervention strategies for immigrant youth is problematic as they are subjected to unique challenges associated with the acculturation process, including cultural and social adaptation, language proficiency, poverty, acculturative stress, intergenerational family conflict, and discrimination (Dettlaff & Earner, 2012), each of which has the potential to increase immigrant youths' risk of delinquent involvement (Bersani, 2014; Estrada-Martínez et al., 2013).

Mesch, Turjeman, and Fishman (2008) have identified protective factors with respect to maladaptive outcomes among first generation immigrant youth such as positive school adjustment, a sense of family obligation, and remaining connected to one’s cultural heritage. While researchers have identified factors that contribute to and prevent delinquency, progress in developing interventions has been minimal (Parra Cardona et al., 2012). The insufficiency of interventions for immigrant youth is a significant issue in the United States, when considering there are ongoing concerns pertaining to criminal and delinquent engagement among the immigrant population (Merolla, Pantoja, Cargile, & Mora, 2013).

Adolescence is a crucial period of development for all youth but has added complexity for immigrant youth as a result of the acculturation process (Rivas-Drake et al., 2014). Their ability to adapt and integrate into their culture of origin, American culture, or a combination of both is dependent upon their mode of acculturation (Sam & Berry, 2010). In this regard, the acculturation process plays a vital role in their behavioral outcomes (Estrada-Martínez et al., 2013; Mesch et al., 2008). Acculturation can alter the beliefs, values, and attitudes of immigrant youth to become significantly different from their parents, leading to a greater propensity for intergenerational and intercultural conflict (Sam & Berry, 2010). Different social contexts present youth with acculturative stress, family and peer conflicts, delinquent peer influences, and discrimination, which can negatively impact their behavioral outcomes (Estrada-Martínez et al., 2013; Knight et al., 2012). Rapid acculturation into American culture is another pertinent factor, as it increases the potential for immigrants to display delinquent behaviors as a result of acculturative stress (Mesch et al., 2008). Recent research exploring generational differences and acculturation has demonstrated increases in delinquency in relation to Americanization among successive generations of immigrants (Bersani, 2014).

The adaptive challenges promoted by the acculturation process also impact identity development of immigrant youth (Rivas-Drake et al., 2014).
Various factors such as cultural orientation (Knight et al., 2012), familial attachment, educational attachment, and delinquent peer influences impinge immigrant youths’ identity development (Trillo & Redondo, 2013). Neblett, Rivas-Drake, and Umaña-Taylor (2012) indicated that identity can influence the development and positive adjustment of youth. Compared to youth with a poor sense of ethnic identity, youth with a strong sense of ethnic identity exhibited less delinquent behavior (Knight et al., 2012). Ultimately, identity construction is one of many adaptive challenges faced by immigrant youth that has the potential to promote poor academic outcomes, mental health issues, and problem behaviors (Rivas-Drake et al., 2014). Congruently, those challenges also become obstacles for human services professionals seeking to prevent delinquency (Dettlaff & Earner, 2012; Estrada-Martínez et al., 2013).

**Relevance to the Field of Human Services**

Immigration is a prominent and widely debated topic in the United States due to immigrant population increases and engagement in illegal activities (Merolla et al., 2013). In 2010, immigrants accounted for 26% of the federal prison population (Motivans, 2013). In 2012, the unauthorized immigrant population increased to 11.7 million (Warren & Warren, 2013). Collectively, the aforesaid issues generate public safety concerns among the general public (Merolla et al., 2013). Human services professionals are responsible for responding to these public concerns and for helping immigrant youth adjust and improve quality of life for themselves and their families. In response to ensuing societal concerns pertaining to immigrant crime and delinquent involvement, human services researchers continue to explore crime and delinquency within the juvenile immigrant community to ascertain empirical evidence of ways to reduce or prevent criminal behavior (Bersani, 2014; Estrada-Martínez et al., 2013; Knight et al., 2012). Investigations of delinquency among immigrant youth have identified various familial, educational, and social factors associated with problem behaviors and delinquency (Bersani, 2014; Estrada-Martínez et al., 2013; Trillo & Redondo, 2013). Parra Cardona et al. (2012) stressed the necessity for practitioners to interpret research findings through the lens of cultural adaptation in order to develop effective intervention strategies for immigrants. However, they also said the development of intervention strategies (e.g., evidence based-parenting interventions) has been minimal and dissemination of such interventions has been scarce.
When considering the rapid growth of and continued concerns over criminality among the immigrant population, there is an increased need for human services professionals to address factors that contribute to criminal and delinquent involvement by immigrants. Human services professionals are ethically bound to provide services that are culturally competent and sensitive (Parra Cardona et al., 2012). Cultural sensitivity and responsiveness of intervention programs enable human services professionals to enhance the efficacy of service delivery by facilitating trust, retention, and program completion of their clients (Ceballos & Bratton, 2010; Parra Cardona et al., 2012).

Essentially, it is imperative that human services professionals understand and take into account the unique adaptive challenges faced by immigrant youth. This will help improve the effectiveness of services provided to the large and growing immigrant population. Additionally, expansion of human services practitioners’ understanding of delinquency and acculturation through empirical inquiry is required to increase the breadth and depth of knowledge about both phenomena. Human services professionals must remain cognizant of the impact these unique barriers and the acculturation process itself have on immigrant youths’ behaviors so they can provide culturally sensitive services and apply current empirical knowledge to develop effective delinquency prevention and intervention strategies. Thus, by engaging in sound empirical research focused on interventions designed to reduce or prevent immigrant delinquency, human services professionals can make important contributions to the well-being of society as a whole while continuing to help individuals develop happier, crime-free lives.

References


The After Effects of Hurricane Katrina in Children

Andrea T. Scott

Abstract

Natural disasters are traumatic events that can have a substantial effect on survivors. The consequences of one disaster, Hurricane Katrina, are still experienced by many survivors. Although Hurricane Katrina may be over in the minds of many, for thousands of children and families, this event will follow them for the rest of their lives. Researchers found that children, post-Hurricane Katrina, reported risk factors for conduct problems and mental health challenges. These problems and challenges included substance abuse, depression, and post-traumatic stress disorder (PTSD). This article explores the relationship between disaster-related experiences and outcomes among minors who witnessed Hurricane Katrina. Although many interventions and models have been applied, various traditional methods and models have been ineffective. This article explains the importance for human services practitioners to apply a comprehensive model that includes social support, crisis counseling, cognitive-behavioral therapy, and family-based interventions for this population.

The After Effects of Hurricane Katrina in Children

Literature Review

On August 29, 2005, Hurricane Katrina, a category 3 hurricane, produced an unprecedented amount of damage along the Central Gulf Coast (Norris & Rosen, 2009; Osofsky, Osofsky, Kronenberg, Brennan, & Hansel, 2009). The effects from this hurricane produced over 1,500 deaths, displaced a number of families, and destroyed homes and communities (Osofsky et al., 2009). The consequences of Hurricane Katrina are on going and produce a significant challenge for human service practitioners in this region (Pash & Winstead, 2008). One group that continues to struggle with the effects of Katrina is children.

Exposure to traumatic events and some level of disaster is common (Neria, Nandi, & Galea, 2008). Previous studies have shown that children, in particular, show great resiliency and will eventually cope successfully after a traumatic life event (Nelson, 2008; Osofsky et al., 2009). However, post-Katrina children who experienced this disaster are facing many mental health challenges, specifically
signs of post-traumatic stress disorder (PTSD) (Cepeda, Onge, Kaplan, & Valdez, 2010; Moore & Varela, 2010; Patash & Winstead, 2008; Weems et al., 2010). PTSD is defined as an anxiety disorder that is triggered by a psychologically distressing event that elicits intense fear, terror, and helplessness in victims (American Psychiatric Association, 2013). In addition to PTSD, post-Katrina children also face other chronic mental health problems such as sleep-disorders, suicidality, depression, panic and anxiety attacks (Cepeda, Onge, Kaplan & Valdez, 2010; DeVaney, Carr, & Allen, 2009; Hensley-Maloney & Verela, 2009; Kessler et al., 2008; Moore & Varela, 2010; Nelson, 2008; Osofsky et al., 2009; Patash & Winstead, 2008; Weems et al., 2010).

In addition to the significant mental health concerns, some post-Katrina children display extreme behavioral and conduct problems such as antisocial tendencies and dangerously aggressive behaviors (Vigna, Hernandez & Kelley, 2009). Additionally, many post-Katrina children report that they use substances to cope with the grief and stress encountered during and after Katrina. For many children, this self-medicating mechanism helps them to cope with the day-to-day activities and memories of their losses during the hurricane (Rowe & Liddle, 2008; Vigna et al., 2009).

Relevance to the Field of Human Services  
Service providers, such as human services practitioners, must understand the critical needs of children of Katrina and their families. Post-Katrina children and families benefit more from interventions that include (a) social support; (b) crisis counseling; (c) cognitive-behavioral therapy; and (d) family-based interventions.

Social Support  
Social support networks are a viable resource to help survivors cope after the traumatic event (Nelson 2008). Support networks can include parents, friends, teachers, service providers, and communities. Social support can also include community organizing, non-kin support, and becoming involved in various self-help activities. If survivors have a strong social support system following the traumatic event, this can serve as a buffer against the development of elevated levels of distress. For example, children who had access to a higher level of social support reported fewer PTSD symptoms. On the other hand, children who did not have a strong social support from teachers or classmates reported stronger
predictors of PTSD symptomatology. Thus, it would behoove human service practitioners to assess avenues for social support to help the survivors find strength and a connection with survivors (Legerski, Vernberg, Noland, 2012; Rowe & Liddle, 2008).

**Crisis counseling**

Crisis counseling, as suggested by Ursano, Fullerston, Benedek, and Hamaoka (2007), includes calming techniques that support ways for decreasing arousal, effective sleeping techniques, supporting feelings of hopefulness and optimism, finding ways to build and support self-efficacy, and finding effective ways for connectedness. A significant aspect of crisis counseling also includes the development of interventions that include coping skills. Coping skills will vary from client to client and are recommended to target the loss of family and nonfamily members, the internalization of pain and fear, trauma from being displaced from family and friends, and extreme community violence (Legerski, Vernberg, & Noland, 2012).

**Cognitive-Behavioral Therapy**

Cognitive-behavioral therapy interventions, as suggested by Hamblen et al. (2009), focus on effective ways to help traumatized survivors process cognitive, emotional, and behavioral reactions to the trauma. Cognitive-behavioral therapy interventions are disaster-specific interventions that have been used for many survivors of disasters such as 9/11 and other hurricanes (Hamblen et al., 2009). Interventions rooted in CBT could focus on identifying and challenging maladaptive disaster-related beliefs and may include psychoeducation, breathing retraining, behavioral activation and cognitive restructuring (Hamblen et al., 2009).

**Family-Based Interventions**

As suggested by Rowe and Liddle (2008), family-based interventions focus on the family dynamic and the importance of the family role in post-disaster recovery. Interventions that are family-based consistently stress the importance of family relationships and support. These interventions could also focus on the strained parent-child relationship and identify deficiencies in parenting practices. More importantly, successful family-based interventions could focus on the child’s functioning and social environment. A comprehensive approach that
addresses the child’s trauma symptoms in the context of both the family’s relationship and the disaster experienced can be an effective way to help children of Katrina process the overall aftermath of the traumatizing event (Rowe & Liddle. 2008).

**Conclusion**

On August 29, 2005, many lives were changed due to Hurricane Katrina. Although it has been nearly nine years since this traumatic event happened, many individuals, specifically children, are still experiencing the long-lasting effects from this unprecedented devastating event. Many children who survived Hurricane Katrina are now experiencing mental health problems (e.g., PTSD and depression), behavioral problems, learning disabilities, and challenges in school. As caring human services practitioners, it is critical that we begin to partner with others service providers and help begin to make a difference in the lives of these survivors through effective and comprehensive interventions and programs. Post-Katrina children and families benefit more from interventions that focus on social support, crisis counseling, cognitive-behavioral therapy, and family-based interventions. Integrating a comprehensive approach that includes family and communities helps to address the various ongoing challenges faced by the victims of Hurricane Katrina.

**References**


Post-Traumatic Stress Disorder

Marilyn A. Selfridge

Abstract
This article presents the importance of education, compassion, and formatting new ways of understanding and treating those drastically affected by post-traumatic stress disorder (PTSD). PTSD is presented as a series of debilitating symptoms that results from any number of traumatic incidences including reactions to combat, abuse, abduction, and any of a number of other traumatizing events. Recent research indicates that the disorder impacts brain functioning, which results in debilitating psychosocial concerns. Symptoms of the disorder, as well as ways to treat the disorder so that the person can return to normalcy, are noted. Ways that human service professionals can be a vital tool in providing the proper care and resources needed to assist those with PTSD are discussed.

Post-Traumatic Stress Disorder

The term post-traumatic stress disorder (PTSD) refers to the damaging effects that occur after an individual has witnessed or has been forced to participate in severe, distressing events, creating symptoms that become disruptive for the individual over long periods of time. With approximately 7.7 million Americans over the age of 18 suffering from PTSD (Anxiety and Depression Association of America, 2014), clearly this disorder calls for national attention.

Today, we have a better insight into this debilitating disorder due to the research involving former combat war veterans and the trauma they have endured (Thompson, 2014). It was these brave veterans that came forward in recent years to disclose what they were living with, explaining the horrors that were embedded in their minds, bodies, and souls, that highlighted the disorder and the need for effective treatment. Many veterans have come together to reveal their addictions, anger, pain, depression, and other life issues associated with the post trauma from war (Thompson, 2014).

History of PTSD

Although PTSD has become a common term in recent years, it was couched in secrecy in the past. However, as long as war and abuse has existed, so
have the symptoms that we characterize today as PTSD. For instance, during World War I, PTSD was called *shell shock*, which was the reaction that some soldiers had to battle trauma (PTSD support services, 2012). At that point, hospitals were replete with individuals with mental disturbances (Ulrich & Ziemann, 1994). Symptoms of PTSD have also been recognized from trauma other than combat, such as reactions to sexual abuse, physical abuse, natural disasters, catastrophic events such as the 9/11 attacks, and more (Hamblen & Barnett, 2006). In the past, symptoms of PTSD tended to be hidden from the public, or called something other than PTSD (e.g., shell shock, hysteria; PTSD support services, 2012). In fact, until recently, it was not uncommon for victims of sexual abuse to be shunned or called “crazy,” when they would disclose their trauma and its associated symptoms (Rainn, 2009). Such responses led victims to feel even more isolated, angry and confused. In addition, associated flashbacks and feelings were encouraged to be kept at bay and secret, thus creating shame-based feelings in the affected individual.

Today, PTSD has come out of the closet. In fact, there are now designated symptoms, as noted in the *Diagnostic and Statistical Manual-5* that are collectively called PTSD (American Psychiatric Association, 2013). As a result of PTSD being formerly recognized in the *DSM-5*, as well as advocacy groups identifying PTSD as an actual disease (Pathways for Change, 2014), today there is much progress in the public recognizing PTSD as a legitimate reaction to devastating trauma.

**Signs, Symptoms, and Triggers**

Whether an individual suffers with PTSD from a natural disaster, sexual abuse, or from the reaction to combat, the triggers and symptoms are similar, regardless of the initiating event (Anxiety and Depression Association of America, 2014). The diagnostic criteria for PTSD is a variable and specific stipulation depending upon each of its four symptom clusters such as intrusion, avoidance, negative alterations in cognitions and moods, and alterations in arousal and reactivity (American Psychiatric Association, 2013).

To sum up the symptoms for all criteria included, the criteria for PTSD symptoms include: (a) recurrent, involuntary and intrusive memories; (b) traumatic nightmares; (c) dissociative reactions; (d) intense or prolonged distress after exposure to traumatic reminders; (e) marked physiological inability to recall key factors of the traumatizing dissociative reactions; (f) persistent (and often
distorted) negative beliefs and expectations about oneself or the world; (g) feeling alienated from others; (h) hypervigilance and irritable or aggressive behavior; (i) self-destructive or reckless behavior, and sleep disturbances (DSM-5, 2013).

Triggers are anything that can alarm or jolt a negative response or reaction in the individual that reminds them of the traumatic event (Kleim, Graham, Bryant, Ehlers, 2013). For example, a loud noise such as a car backfiring or fireworks, replicates the sound of gunfire or an explosion sometimes bringing an individual back to the original event and producing an array of symptoms in the individual. Smells and sights can also be triggers for PTSD sufferers. For example, the smell of alcohol can trigger extreme anxiety, panic and dissociation reactions from an abuse survivor if a perpetrator was intoxicated during the abuse. Visual images also can be triggers. For instance, seeing a particular house where an event occurred, or even a house that reminds the victim of the event can stir up, or trigger, negative reactions. For example, survivors of the 9/11 attacks can be triggered by pictures of the event, smells that remind them of the event, stories from newspapers, and movies that bring up terrible memories and flashbacks from that devastating day. These triggers can produce an array of symptoms as noted earlier.

For some, especially sexual abuse survivors, the victim dissociates in order to survive the event or the horrific memories of the events they experienced. Although this symptom helps the victim get through the immediacy of the trauma, it can have devastating effects on an individual interpersonally (Pathways for Change, 2014). Many PTSD victims will self-medicate with alcohol or other drugs to numb their feelings and emotions from the flashbacks (Pathways for Change, 2014). Whether through dissociation or substance abuse, or some other numbing technique, individuals may go years undiagnosed, not realizing or understanding what is happening to their bodies and their minds and why they feel so out of touch. Finally, there are some victims that resort to suicide, such as the staggering 154 suicides by active duty military members in the first 155 days of 2012 (Thompson, 2014). These statistics are too alarming and disturbing for anyone to ignore.

**Treatment**

Treatment for PTSD has varied over the years. For instance, hypnosis was an early treatment of PTSD and showed some efficacy in helping victims (Mills & Hulbert-Williams, 2012). In more recent years, eye movement desensitization
and reprocessing (EMDR), as well as other neuropsychophysiological treatments became commonplace (Mills & Hilbert-Williams, 2012). These treatments assumed that brain patterning was impacted by the trauma, and that new neurological pathways needed to be developed to help the individual reduce symptomatology (Ochberg, 2011; Shapiro & Solomon, 2015).

More recently, a number of cognitive behavioral therapy (CBT) approaches have become commonplace in the treatment of PTSD (Shapiro & Solomon, 2015). One of these, exposure therapy, is based on a classical conditioning paradigm and has an individual repeatedly exposed to situations (e.g., memories of the event or triggers that bring up symptoms) which would normally induce PTSD symptoms (Labordo & Miguez, 2015). Sometimes using progressive relaxation paired with exposure, clients learn that exposure is not associated with the symptoms and eventually learn to relax to what were formally triggers. A number of other cognitive behavioral therapies that help clients see the connection between their core beliefs and their symptoms have also been used with some success (Herbert et al., 2000).

Relevance to the Field of Human Services

Human Service professionals can contribute a great deal to the understanding and treatment of PTSD. For instance, through their jobs they can advocate for treatment of individuals with PTSD, they can provide interventions and referrals, and they can actively help others understand and be familiar with the symptoms of PTSD so that those who are afflicted with this disorder can obtain appropriate treatment.

It is my hope that this article will deliver some knowledge and “trigger” some compassion for those who suffer from this disorder so that human service professionals can become active in the community and help to increase awareness about PTSD. It is only through awareness and effective treatment that the healing process will occur. In doing so, we can help those with PTSD recover so that they can live healthier and more productive lives.

References


The Human Services--Board Certified Practitioner: A Review of the Current State

Narketta M. Sparkman, Tamikia Lott

Abstract

The Human Services--Board Certified Practitioner (HS-BCP) is the only credential of its kind to govern the field of human services. There is no recent literature on its growth, impact, or status over the last six years. It is beneficial for human service practitioners to remain up-to-date on the credential in order to make decisions on becoming credentialed and achieving the benefits of being credentialed. This brief report gives an update on the current state of the credential in terms of growth and development. This information provides an update to the key components of the exam and requirements for eligibility. Growth in the numbers of certified HS-BCPs since inception of the certification is noted as well as advances in testing and technology as it relates to credentialing requirements. Finally, future considerations in advertising and marketing are thoroughly examined as reported by the Center for Credentialing & Education (CCE).

The Human Services--Board Certified Practitioner: A Review of the Current State

The Human Services--Board Certified Practitioner (HS-BCP) credential was established in 2008 by the Center for Credentialing & Education (CCE), in collaboration with the National Organization for Human Services (NOHS) and the Council for Standards in Human Service Education (CSHSE; Hinkle & O’Brien, 2010). The focus of this credential was to establish the human services profession among other professions such as psychiatry, psychology, counseling, and social work, which all meet three primary standards: accreditation, an ethical code, and credentialing (Neukrug & Milliken, 2010). The goal of credentialing is assessing professional’s learned knowledge and experience based on state and national standards. The HS-BCP assesses knowledge, skills, and abilities in the field of human services. The guiding principles are grounded in education, experience, assessment, ethical practice, and continuing education (Hinkle & O’Brien, 2010). The credential has been available in the field for six years and has become a viable part of human services practice. It is the only credential of its kind to head
the field of human services. However, the current state of the credential is unknown. This brief report will give an update on the current state of the credential in terms of growth and development.

**Literature Review**

The establishment of the HS-BCP began in 2008 (Hinkle & O’Brien, 2010) and as a result of the newness of the credential there is a lack of literature that specifically addresses the growth and impact the credential has had in the field of human services. However, literature reveals that prior to the credential there was difficulty in establishing and defining the field of human services. In fact, human service workers were often seen as assistants and not professionals (Evenson & Holloway, 2003). The lack of uniformity in the field possibly lowered the value of the profession, which contributed to the struggle in establishing it among helping professions. There were also variations in how the field of human services was defined. In an effort to define the field, Kincaid (2009) identified four themes in characterizing the field and proposed a universal definition. The foundation of defining the field of human services is rooted in integrated interdisciplinary knowledge, client self-determination, processes to facilitate change, and systemic change at all levels of society (Kincaid, 2009). The National Organization for Human Services (n.d.) adopted a universal definition that has underpinnings of Kincaid’s (2009) themes. In addition, the development of the HS-BCP set universal standards that brought consistency and stability to the field and began to establish it as valuable and relevant among helping professions (Hinkle & O’Brien, 2010). The National Organization for Human Services promotes the HS-BCP and contends that the credential strengthens visibility and credibility among human service careers nationally and internationally (National Organization for Human Services, n.d).

The HS-BCP focuses on verification of standards and experience through education, examination, field experience, and continuing education (Center for Credentialing & Education, n.d.a). Qualification for the credential involves participants having associates, bachelors, and master’s degrees or higher, as well as post degree experience, which varies by degree (Center for Credentialing & Education, n.d.a). At least half of the experiences must be post degree (CCE, n.d.a). In addition, individuals approved must take an examination that covers four defined areas of human services including: (a) assessment, treatment planning, and outcome evaluation; (b) theoretical orientation/intervention; (c)
case management, professional practice, and ethics; (d) administration, program development/evaluation, and supervision (CCE, n.d.a). The HS-BCP is voluntary and acknowledges that practitioners have completed several core human service-related content areas that align with education and experience and it further supports a commitment to growth, education, and constructs that govern the field of human services (NOHS, n.d).

**Current State of the HS-BCP**

The HS-BCP was normed by human service practitioners and students during 2010 (R. Flora, personal communication, April 28, 2014). Flora indicates there have been over 2,200 practitioners credentialed since its inception. This number does not include those who have begun the application process, but have yet to meet all the requirements to obtain the credential. As with any new credential, Flora states changes have been made to the HS-BCP credential in order to ensure it is up-to-date in meeting national standards and guiding principles of the field. For the HS-BCP, these changes include updated assessments, changes in experience requirements, use of the HS-BCP as an assessment tool on college campuses, availability in multiple formats, and increased marketing efforts (R. Flora, personal communication, April 28, 2014).

Vignettes and questions for the exam are reviewed and updated by a diverse committee of industry professionals to provide versions of the exam reflecting current trends in required services and questions comply with current industry trends and are clearly written for those sitting for the exam (R. Flora, personal communication, April 28, 2014). The constant updating of questions also maintains rigor and value of the exam ensuring national and ethical compliance.

Since 2012, the HS-BCP exam has been used as an exit test for many of the 28 human service higher educational programs currently participating with CCE (n.d.b). Students enrolled in programs that mandate the exam are taking a proctored paper and pencil exam at their local college or university to assess their field knowledge prior to graduation (R. Flora, personal communication, April 28, 2014). Flora states other students are allowed to register for the exam at an outside testing center. The passing exam results are held by CCE for five years and can be transferred into an HS-BCP credential at no additional charge (Flora & O’Brien, 2013). Graduates have up to five years to complete the experience requirements in order to become credentialed (R. Flora, personal communication, April 28, 2014). Participating programs are given aggregated data on the
assessment that can be used to improve programming and to compare results across the country (Flora & O’Brien, 2013). CCE is moving towards putting the exam online so that it is accessible via Internet Based Testing (IBT) for participating universities and colleges to administer in their testing labs. This process is in the trial phase and planned to be beta tested the summer of 2014 (R. Flora, personal communication, April 28, 2014). CCE plans to work out any issues that may arise during the beta testing process before offering IBT to those universities currently utilizing the exam on site (R. Flora, personal communication, April 28, 2014).

There has been a change in the experience requirement for those applying for the credential. Originally, all relevant field experience had to be completed post degree (CCE, n.d.a). The new mandate requires a minimum of half the experience to be completed post degree. Those currently working in the field can utilize their experience prior to obtaining a degree to meet the other half of the experience requirement (R. Flora, personal communication, April 28, 2014). This may present a barrier for students who are attempting to obtain the credential immediately after completing degree requirements; however, students benefit by being allowed to utilize pre-degree and internship hours (R. Flora, personal communication, April 28, 2014).

The CCE has a focus on marketing and promotion of the credential to increase value and recognition (R. Flora, personal communication, April 28, 2014). Efforts are focused on encouraging human service program participation with increased focus on collegiate programs across the United States, according to Flora. The CCE has conducted workshops on local and national levels for students that focus on credentialing and the value of the HS-BCP credential (R. Flora, personal communication, April 28, 2014). Additionally, CCE has conducted workshops that target education administrators. These workshops provide the opportunity for students to test, by incorporating the HS-BCP exam into degree programs, to use on-site test centers, and to utilize the data from aggregate score reports (R. Flora, personal communication, April 28, 2014). In addition to student assessment, participation with the CCE offers other benefits to educational institutions—it builds interest in the value of the HS-BCP credential (Flora & O’Brien, 2013). Student program members of the Council for Standards in Human Service Education receive a discount on exam fees, which also fosters a focus on human service programs becoming accredited (R. Flora, personal communication, April 28, 2014). Future marketing and advertising efforts will
focus on data obtained through a personal survey of the 2,200 credentialed practitioners on their use of the credential, career status, population being serviced, and demographics (R. Flora, personal communication, April 28, 2014). This information will be used to increase advocacy efforts and recognition by local, state, and government agencies (R. Flora, personal communication, April 28, 2014).

Relevance to the Field of Human Services

The HS-BCP was established to maintain high standards in human services and is the only credential specific to the field of human services. It provides quality, value, and integrity for practitioners, employers, and consumers of human services. It further provides distinction to the field of human services by clearly setting it apart from other helping professions. The HS-BCP provides a way of documenting that practitioners maintain standards of integrity and conduct. It provides a means for documenting that practitioners protect the welfare and interests of clients. Furthermore, it offers a way to document that practitioners accept responsibility for their actions, seek to enhance their occupational abilities, and practice with fairness and honesty (Hinkle & O’Brien, 2010).

The HS-BCP has been in existence for six years. During this period, over 2,200 practitioners have been credentialed and several changes have taken place to further advance the value of the credential. Collegiate programs have expressed increased interest in using the exam as an assessment tool and efforts are in place to further advance and promote the HS-BCP credential.

References


Abstract

Students come to human services education hoping to help people and can be disillusioned when they begin to grasp the enormity of social structures and their effects on poverty, the issues people face in their neighborhoods and communities, the poor quality of schools, the lack of employment opportunities, and poor access to health care. These can weigh heavily on students who need to build their own self-efficacy before they enter the world as human service professionals. Teaching them to work in communities as partners participating in community development can help them to build the self-efficacy they need to work toward social change in spite of the weight of social problems. Engaging in community development activities that lead to community action can help students see themselves and community members as partners, cooperating from a strengths perspective, with a common stake in the outcome of projects.

Literature Review

Students enter the field of human services because they have an interest in helping others. They are often energetic and full of an idealism that leads them to believe they can make a difference. The most energetic and idealistic of them want to change the world. As educators of future human service professionals, we would like them to maintain that energy and belief in their ability to make a difference far beyond the walls of academia. However, the combination of the courses we teach on the structural causes of poverty, the problems people have in their neighborhoods and communities, the poor quality of schools, the lack of employment opportunities, and poor access to health care can weigh heavily on students who need to build their own self-efficacy before they enter the world as human service professionals. Once they grasp the enormity of the issues they face in the field, they often ask, “but what can I do?” Translated to mean what can I, just one person, do about this whole big mess?

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The student’s self-efficacy, or the belief that they have the capacity to make a difference in the world, is critical to their future resiliency as human service professionals (Bandura, 1997). Human service professionals’ confidence in their ability to work with others to reach goals effects the quality of services they deliver (Holden, Meenaghan, Anastas, & Metrey, 2002; Nota, Ferrari, & Soresi, 2007; Reich, Bickman, & Hefflinger, 2004). Community practice experiences working in partnership with others helps students see the possibilities of social change when people come together to work on social issues.

**Professional Standards and Ethics**

The National Organization for Human Services (NOHS; 2014) described the characteristics of a successful human service professional as including the understanding of human systems. Martin (2014) adds that human service professionals should have competencies to work with individuals and communities to deal with barriers to the quality of life. NOHS (2014) lists ethical standards for the human service professional that include: (a) responsibility to the community and society; (b) an awareness of sociopolitical issues that affect community members; (c) awareness of laws, regulations and legislation; (d) understanding the complex interaction between individuals, their families, and the communities in which they live; (e) acting as advocates; (f) planning and mobilizing to advocate for needs at the local community level; (g) being knowledgeable about the cultures and communities within which they practice, awareness of their own cultural backgrounds, beliefs, and values, and the impact on their relationship with others. Community practice experiences outside the classroom can reinforce learning that happens inside the classroom and provide opportunities to interact with eco-systems, can provide practice for these standards, and can provide observing of the interactions of their own cultural backgrounds, beliefs and values with those of the community.

**Community Practice Education**

Through community practice, students can experience the interrelated nature of the individual and the ecological systems that interact to influence their lives (Brofenbrenner, 1979). They are introduced to the interaction of a broad range of client populations from individuals to families, elderly, kids, and people who are homeless. Cultural competence becomes a necessity rather than something to study in class. They learn about access to health care, the quality of
the schools, local law enforcement and juvenile justice. They identify community structures and institutions, networks, local policy processes and the influence of national policies on the community. Students can see eco-systems in action and come to understand the importance of social networks and social systems in community change (Neal & Christens, 2014; Neal, & Neal, 2013).

There are many ways that faculty and students can become partners in a community project. A widely used method is an asset-based approach to communities (Morse, 2011). Here, students are taught to resist the idea of being heroes, looking for problems to solve, or blaming-the-victim thinking that if only the people would behave right, their problems would be solved. Social change in communities is more likely to be achieved using an asset-based model (Kretznan & McKnight, 1996; Mathie & Cunningham, 2003) by identifying and utilizing strengths and resiliency factors (Norman, 2000) and by becoming co-producers of knowledge and change along with the community (McNall, Reed, Brown & Allen, 2009; Newel & South, 2009). This approach allows students who are eager to become efficacious human services professionals to experience the eco-systems at play and identify resources for promoting the capacity of communities (Warner & Warner, 2011).

**Case Example**

One such example was an undergraduate research project implemented by an Elon University Human Service Studies student and faculty member that resulted in a community supported garden in a food insecure area. The garden was a result of community generated responses to survey questions. Community-based research blends well with an asset-based approach to build a project that has multiple uses and outcomes, one of which is social change (Stoecker, 2012). The sophomore, human services student was interested in designing a community-based research project that would result in a positive experience for the people from whom she collected data. She wanted to know more about people’s attitude toward nutritious food, their perceptions of their right to easily access that food and their willingness to act on that right. This author, a Human Service Studies faculty member, had an ongoing community project that had involved students in the past and provided the right environment for her research.

To begin, the student set out to understand the importance of food in the lives of people—cultural practices, family interactions, emotional well-being, likes and dislikes, experiences with different food sources. She developed a
deeper understanding of the people in the community through discussions about something everyone loves. The student learned that there was much interest among the residents for creating a common vegetable garden. Community gardens are not only ways to alleviate the burden of food insecurity in communities, they are places where neighbors grow food together in a communal setting building their own community capacity through relationships (Comstock, et. al., 2010; Teig, et. al., 2009; Twiss, et.al., 2003). Community gardens are increasingly popular in urban settings and can serve to bring people together to work toward community change (Gray, Guzman, Glowa & Drevno, 2014). This project provided an ideal environment for this student and others to meet community members face to face and work alongside each other for a common purpose.

The research and resulting garden required two years of work and commitment on the part of the original student, the faculty member, community members and additional students. Initially, students and community members involved in the garden planning process were met with considerable resistance from local government since the garden was on city property. Issues surrounding the actual location of the garden, timing, and most importantly funding, slowed the process down. For example, the group had initially planned to have the garden beds constructed by late May to be ready in time for planting, but due to delays they were not ready until the end of July.

Additional students from human services classes got involved to help build the garden. They worked alongside the community members with augers, saws, hammers and nails. They handed out water and snacks, helped haul dirt, compost, and plants. Students experienced the whole community system. They attended planning meetings for the community garden with various community stakeholders, including city government officials and employees, members of the local university, the director and staff of the community center, and residents of the community.

The students who participated in these projects were able to interact with community members in such a way that the local residents acted as teachers and students, seeing their strengths rather than their problems. Seeing communities as groups of people with strengths led the students to dismantle the blanket assumption that people of color do not know about and are not interested in nutritious food, or growing and cooking vegetables. They found that there was a long history of people in the community who grew up on farms, worked on farms,
or had mostly vegetables to eat, already eating locally, all the things we thought we could “give” them when we entered the community.

Another benefit was that the local residents saw the strengths of the students. Students, having their own strengths, skills and abilities reflected back to them, developed confidence in their ability to effect social change. Future students were more willing to participate in the project having seen the positive experiences of past students. Building self-efficacy is critical to their success as future human services professionals (Bandura, 1997; Holden, Meenaghan, Anastas, & Metrey, 2002; Nota, Ferrari, & Soresi, 2007; Reich, Bickman, & Heflinger, 2004).

Building ongoing community projects such as this provides opportunities for groups of students to participate over time. Lasting relationships are built between the faculty and community that ensure strong learning experiences. Once the garden was completed, sustaining its presence and success provided opportunities for new students to work with community residents to build relationships and plan new projects. For example, students helped establish a farmer’s market, started a project to enable the market to accept SNAP or WIC credit, or provide vouchers and coupons to low-income people so that they can afford fresh, healthy food. One class even wrote a grant that was funded to hire a garden coordinator for the summer.

**Relevance to the Field of Human Services**

Through this community project opportunities were created for students to experience the importance of the competencies and ethical standards set by NOHS. Responsibility to the community, sociopolitical issues and institutions, advocacy, and cultural competence all came to play in this experience. Struggles with the city officials helped students to see the barriers that were present for people in the community, reducing the tendency to blame the victim. As co-producers of knowledge and change, both residents and students learned the art of working towards change requiring negotiation with each other and those in power. Enabling the students to see and experience the effects of ecological systems on the functioning of communities and the lives of the people within means that when they are human service professionals, they will have experience to draw on, an understanding of the humanity of every person, and the confidence that, along with others, they really can change the world.


Guidelines for Authors

The Journal of Human Services (JHS) is a national refereed journal. Manuscripts judged by the editors to fall within the range of interest of the journal will be submitted to reviewers without the names and identifying information of the authors. The principal audiences of JHS are human service faculty members, administrators, practitioners, and undergraduate and graduate students. Sample areas of interest include teaching methods, models of internships, faculty development, career paths of graduates, credentialing, accreditation, models of undergraduate and graduate study, clinical issues in human service treatment, and supervision of human service practitioners.

JHS publishes three types of submissions: 1) articles, 2) brief notes, and 3) critical reviews of instructional materials and scholarly books of interest to human service educators.

Directions for each type of submission include the following:

1. Articles. Manuscripts for articles should not exceed eighteen (18) typed pages. The page limit includes all pages of the manuscript excluding the title page (i.e., abstract, reference pages, tables, and graphs). Manuscripts may not exceed this page limit. Following the title page include an abstract of not more than 100 words. This statement should express the central idea of the article in non-technical language and should appear on a page separate from the text.

2. Brief Notes. Submissions appropriate for this format include brief reports of research projects or program innovations. Manuscripts should not exceed four (4) double-spaced typed pages; it is recommended that the results and implications occupy at least half of the brief note. A 50-word capsule statement should accompany the note.

3. Critical Reviews. JHS accepts reviews of textbooks, other instructional materials, and scholarly books of interest to human service educators and practitioners. Manuscripts should not exceed three (3) typed pages unless two or more related books are included in one review in which case manuscripts should not exceed five (5) typed pages.
The following instructions apply to all three types of submissions:

1. Manuscripts should be well organized and present the idea in a clear and concise manner. Use headings and subheadings to guide the reader. Avoid the use of jargon and sexist terminology.

2. Manuscripts should be typed in 12-point type with margins of at least one inch on all four sides. All materials should be double spaced including references, all lines of tables, and extensive quotations.

3. All material should conform to the style of the sixth edition of the Publication Manual of the American Psychological Association.

4. Avoid footnotes wherever possible.

5. Tables should be kept to a minimum. Include only essential data and combine tables whenever possible. Each table should be on a separate sheet of paper following the reference section of the article. Final placement of tables is at the discretion of the editors.

6. Figures (graphs, illustrations) must be supplied in electronic format and must be in black and white with a minimum of gray shading. Use of submitted figures or a re-rendering of the figures for clarity is at the discretion of the editors.

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