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FROM THE EDITOR

The Michigan Counseling Association is in the midst of tremendous transformation. Divisions are shifting and merging, membership continues to go up and down in dramatic fashion, and the administrative structure is in the midst of a major overhaul. Through it all, the Michigan Journal of Counseling, Research, Theory, & Practice remains faithful to the task of reviewing and disseminating quality articles of interest to the profession. This issue is no different.

Dr. Mary Fawcett of Winona State University describes the development of her racial identity as a person, counselor and counselor educator. This provocative piece will provide you with food for thought as you examine your own racial identity development while reading about her journey.

Counseling men is a specialty within the counseling profession. While there is literature in this area, there is not as much as compared with other sub-specialties such as multicultural counseling or counseling women. Travis W. Schermer from Chathan University & East Liberty Center for Counseling provides us with a way to conceptualize masculinity through the use of traditional Chinese ideals of being a male. He offers a step by step application that can be useful in both individual and group settings.

Finally, Drs. Nancy G. Calley and Lisa D. Hawley provide us with an empirically-guided program designed to empower at-risk youth though increasing their knowledge of prevention resources concerning depression. As our youth are our future, any tools that we can provide those working with at-risk youth are much needed and greatly appreciated.

My thanks to the editorial board who worked to provide our authors with valuable feedback about their articles and Laura Hoehn, our editorial assistant, who proofed each article and the entire journal numerous times. Without their help, this journal would not be possible. Additionally I would like to welcome Dr. Colin Ward to the editorial board. I look forward to his contribution.

One White Counselor Educator's Process of Racial Reeducation

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Abstract

Counselor educators introduce racial/cultural identity models in order for students to examine their own racial identity and learn the value of identifying the stage of racial/cultural identity development of their clients. While there is an abundance of literature about the multicultural training of White students, there is very little on training experiences of White counselor educators. It is by focusing on the competency training of White counselor educators that we can determine the cultural competence of trainees. I am a White woman that was raised in a racist community in the 1970's and trained as licensed professional counselor during the 1980's. Through this article, I describe my journey as a developing counselor and educator: mistakes made, struggles overcome and recent experiences that contribute to my increased effectiveness in classroom, advocacy and social justice activities.

Key words: multicultural, training, racial identity

One White Counselor Educator's Process of Racial Reeducation

A positive racial identity is the ability to appreciate one's own race/culture without making judgments about its superiority over that of others (Helms, 1984). I have struggled to teach White counselor education students to 1) believe that examining their race/culture is important; 2) think that they need to do more than simply learn about others' cultural/racial communities, religions, and history, to be multiculturally effective; and 3) commit to lifelong social justice efforts. I thought for many years that I was just dealing with a particularly tough group of students when I realized the problem was not my students, but me. The combination of my upbringing in a racist family and community, and a multiculturally-lacking early masters' training program made it very difficult to understand the importance continuing education on the topics of post culture and diversity. My doctoral program was my first exposure to African American professors, diverse clients and courses in multicultural counseling competency and racial/cultural identity theory. I know my early masters' training was not atypical when I read about Arredondo's (1999) concern that counselor training typically required only one course in multicultural counseling. I also find less shame about my early negative attitudes when I read D'Andrea and Daniels (1999, 2001) findings' during their 16 years of White racism research that common reactions of White counselor educators, practitioners, and graduate students included:

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-anger in having to deal with political correctness

-generalized apathy towards the subject of culture and diversity in general)

-intellectual detachment from their knowledge about societal oppression by taking no action for positive change.

I now know my students were simply reflecting my attitude about cultural and diversity course content by doing the assignments as if they were just completing another assignment.

Despite the development of cross-cultural training models that include exploration of counselor as a cultural being (e.g. Johnson, 1987; Carter, 1995), researchers have found most multicultural training approaches emphasize students' focused research on a cultural group different from their own (Carter, 2003; Utsey, Gernat & Bolden, 2002). It makes sense to me now the ways in which I developed and implemented training models that today reflect most multicultural training approaches. I find it interesting that this focus on other cultures runs counter to the first Multicultural Counseling Competency (MCC; Arredondo, et al., 1996) in which students study their own cultural values, biases and worldview, and have committed to adapting my current training model to include more self-examination by my students. Through this process of redefining my goals in multicultural education, I realized I needed more self-exploration about my own racial identity. Through my racial identity exploration I noticed a parallel process my students were experiencing in terms of new discoveries about their racial identity. Together, as we were each discovering our past racial experiences and current identity development, I found it inspiring to watch my students and I struggle with similar challenges. Additionally, I found my honesty about my process developed a level of mutual trust in our discussions about our biases and how these attitudes would permeate the counseling process in negative ways if we did not address our issues. When I had the realization that I needed self-exploration I was not surprised to find as I developed my own racial identity, I became more effective in training my students to be more culturally competent.

Discussion

I have struggled for years to find the appropriate metaphor for what counselors need to go through to achieve what Janet Helms (1992) calls "re-education" of how we look at equality and become aware of our own racist tendencies and blind spots. The parallel experience for me is learning Spanish. I want to be bilingual and have been a vigilant student for over four years. I also desired to be non-racist and learned how to self-reflect, study multicultural counseling with better comprehension, and apply cultural identity developmental tasks to my everyday living. When I put into words how I struggle with my "re -education" of a racist perspective I realize I have the same difficulty in describing the challenges of learning a new language. This process of putting into concrete terms what exactly my struggle is allows me to determine the next step in my journey. I realize I have two important and significantly difficult goals

in becoming bilingual and non-racist. I realize I will fail at both because I will never be as fluent in Spanish as I wish to be (I simply started studying too late in life), and I will never be as non-racist as I hope to be (I live in a culture that reinforces racism on many levels). However, as long as I keep trying to achieve these goals, I am not allowing the current climate to continue to condition me to give up on my bilingual and non-racist identity goals. If I do not study Spanish with daily tenacity, I forget vocabulary and sentence construction very quickly; if I do not focus my attention on the many continuous incoming daily racist messages through my community and the media, I lose ground on my still fragile non-racist identity. So I practice new Spanish words as I move about my day (e.g., when I see my dog, I say "perro") and I practice non-racist acts during conversations with family, friends, colleagues and students by confronting them on the ways in which they say things or pointing out a joke that denigrates another race. By doing these things, I build a wider bilingual vocabulary and am able to filter out racist messages. I also continue to become aware of ways in which my world reinforces racist ways of doing things. So, learning a new language is like learning to be non-racist for me: I will always speak English better than Spanish, and I will be better at being racist than non-racist. The paradox is that the more I realize I am racist, the more multiculturally competent I become as a counselor educator. I am working on ways to work against my 'grain' and accept these realities and work for social justice in my own life and pass these lessons onto my students.

Racist Lessons

I was raised in a home with culture and gender biased role models. My grandparents were explicitly racist people who were very vocal about their beliefs. My parents were implicitly racist and I think they believed they were achieving non-racist status in comparison to their parents. What I know now is that they taught me an insidious form of racism that is more dangerous than the type my grandparents exhibited. I learned my parents' style of racism well because it was reinforced in all the communities in which I have lived.

In my youth and on into college, I bought into the belief that if I was 'color blind' I was showing myself to be trustworthy of equal relationships with anyone from any culture or income level. While I was taught to not see skin color in a person, the first thing I noticed when meeting others were the differences (skin color, hair type, facial structure, etc.). I also noticed the cultural accent or English slang used, and the fear and mistrust of me as a White person. I didn't admit my observations because I had never heard anyone else in my "community" of family or friends mention these things and I wanted to fit into my social group. I saw how my family and friends made fun of people who were different. If I was to disagree with anyone about racist ideas, I was shunned. Nowadays, I care little about this reaction from others but I still recognize the looks on people's faces when I try to 're-educate' them. It is not a welcoming, curious look. It is a look that says "what language are you speaking?".

Racial Identity Development

As I move through my own racial development I realize I have really

never completely transitioned from "abandoning my racism" to developing a "non-racist" identity, a process Helms (1992) describes as the two-phase process to a healthy White identity, but I have made great strides in working toward my goal of becoming less racist. I have been slowly advancing toward non-racist status since 2002 when I began to focus my professional development and research on multicultural counseling competency. My greatest progress was in 2007, when one of my graduate students recommended I read *Lies My Teacher Told Me, Everything Your History Teacher Got Wrong* (Loewen, 2007*).* I felt alternately sickened and empowered as I read about the accurate histories (and the concrete evidence of such events) about White oppression beginning with the colonists who arrived in the New World. Sickened because I felt the racial identity stage of Immersion-Emersion that Helms describes as the stage in which "the person assumes personal responsibility for racism and develops a realistic awareness of the assets and deficits of being white" (1992, p. 33). Empowered because in the Immersion-Emersion stage I was beginning to explicitly confront racism in my social group and developing a humanitarian attitude towards all people by learning the accurate contributions of all people in the development of the North America I know.

My gift to myself during this tumultuous time was to realize I could choose to unlearn the history that was fed to me in my secondary school experiences. I reeducated myself about North American history by reading biographies of people from all racial and cultural groups who contributed to the growth and development of the United States. I attempted to re-educate my friends and family (an ongoing project). I also realized I did not have to act on the conditioned racist thoughts in my mind that were planted in my childhood. I believe (and currently teach my students) that racist thoughts are like a recording they will always be there, but we can choose to turn down the volume or select to not listen to them.

In my 12 years as a counselor educator, I have taught in a very similar fashion to how I was taught while a graduate student. Since I work at a Midwest university in a predominantly White population, it is relatively easy to teach my students how to work with White clients and 'mention' race and culture as a second thought. I felt embarrassed the first time I realized I was teaching 90% of a counseling theories course on the traditional "dead White man's theories" and, at best, 10% on multicultural theory. I felt shame when I realized I had prioritized outdated lectures over new multicultural material when pushed for time (because it is easiest to go with what is familiar in a time crunch). When I assigned mock counseling sessions, we hardly ever role-played counseling sessions dealing with cultural differences between counselor and client.

My professional challenges include mishandling difficult discussions about race in my classrooms, ignoring students' rude comments about learning multicultural counseling course content (e.g. "I just don't have the time to learn all this"), and doing little with the multicultural research I conducted other than publishing the data. I began to improve my instruction as I moved from Helm's status of Pseudo Independence to the Emerson status. Incorporating activism in my personal life meant meeting my professional challenges with more courage

and I found myself able to address the aforementioned difficult discussions.

Instructor Competence

In 2005 I began my study of the Spanish language. I had been doing career counseling with students from Mexico and Central America and practicing my Spanish in the process. About the same time, I had been seriously considering a cultural immersion experience in Central America but could find no one to share the journey with me. Out of fear of travelling alone, I put off my plans until I met a colleague who wanted to join me in my cultural immersion in Guatemala. In 2007, with my colleague, I travelled to Antigua, Guatemala to study Spanish and experience immersion in a culture unlike my own. Part of my motivation for this experience was to understand better my Latino/a students' simultaneous appreciation for their secondary education and apathy in furthering their education once they graduated. I could not comprehend the fact that these students were not sharing my White person's value for "education above all else" and I had no effect in my attempts to motivate them to change their belief system.

I had never been out of the United States and certainly never viewed third world poverty up close. I still cannot describe in words the beginning of my personal and professional transformation when I first visited Guatemala, nor can I express the profound sense of being when I return annually. What I can describe are some of the most difficult elements of this experience: physically painful homesickness, shameful inability to speak the language despite my most earnest attempts, awkward self-consciousness about my height and skin color, extreme fear I had about the unknown, maddening frustration during a moment at a bank when the tellers kept me waiting while determining amongst each other whether my travelers' check was valid, fearful shock in seeing armed (semi-automatic weapons) tour guides and policeman, and heart wrenching sadness during moments visiting with and watching four and five-year old children selling jewelry or shining shoes in the parks and streets of Antigua.

I found that the most common mode of income for Guatemalan and Mayan families is money sent from family members working in the US. I was also made aware of the lack of access to clean water in Guatemala. (I realized at home after my first visit that I use more clean water in one shower than most Guatemala and Mayan families have access to in a month.) Additionally, I found most Guatemalan and Mayan families live within their community of extended family members and work together to sustain themselves. Finally, I observed these amazing people experience joy in their lives on a daily basis despite the sad reality of the poverty in which they live.

I can describe my time in Guatemala as an experience of being exactly where I needed to be at the time for many reasons. When I return, I receive validation that I am not only doing something important to bring resources to people who are desperately in need, I am also learning something of value about my level of multicultural competence as a person and educator. Mostly, I learn that it will always be a challenge to understand another person's experience. I can feel deep compassion and respect and awe for the Guatemalan and Mayan

people I met while travelling, but I absolutely felt limits in understanding their experience. I think it is important for me to acknowledge that every time I return to Guatemala, I get a deeper sense of the way my racist upbringing continues to affect my attempts to be non-racist (even though I oftentimes cannot put it into words). Because of this renewed knowing, I am not surprised how hard I have to work to rise above my own limiting experiences, but find that time spent in Guatemala helps me become a little more culturally aware on several levels. Hanley (2005) states that ones' experiences limit their perspective. As I experience more unique moments in another culture, I realize my perspective about my (White) place in the world changes to a more accurate picture of reality. My reality is that I will always be working toward a non-racist identity and the shedding of many years of inappropriate education I received both formally and informally. As I continue to be aware of the white privilege I have been afforded in my life, I realize I can undo twenty-five years of racist conditioning, a little at a time. As I reeducate myself on multicultural counseling competency development and counselor education, I become more likely to live and work from a less racial stance.

Back home, I finally began to appreciate my Latino/a students' immigration experiences. I can empathize more easily when they tell me about the excruciating discomfort they have experienced being in an unwelcoming and foreign place, and the aching of one's soul when separated from loved ones. I appreciate their discomfort in sitting in a classroom and struggling to understand the teacher's language. I appreciate the attempts that some of my students make to "pass" for White. When I share about my travels to Antigua, I find my students more willing to discuss with me their stories about how they came to live in the US. Some of these immigrants came here illegally and risked life and limb while travelling with their family. Others came to this country legally but had to leave family behind. Some of these students were born in the US and worked full-time at jobs while attending school while others had to quit school to work two or three jobs to take care of their parents who had immigrated to the US but remained monolingual and worked on farms and in factories. Post Guatemala, my work with these students continues but I am a better career counselor for them in that I stopped trying to push my agenda of post-secondary education, stayed out of their way, and watched them set realistic and valuable goals for their future. I became a culturally effective counselor and, in turn, am able to be a more culturally effective counselor educator.

Robinson (1999) states that 'it is rare that a White person has an experience that focuses them to assess their attitudes about being a racial being" (p. 88). I have realized to move meaningfully and intentionally to a non-racist identity I must experience something outside my world on a regular basis and have decided to continue these experiences in Guatemala and other parts of the world. I have gained the realization that the more we realize about the little we know about other cultures, the more likely we are to develop cultural competency. While I can be compassionate and useful in some ways as a counselor and educator, I think the real value in diversity experiences for me is the stark reality that I cannot be "totally" culturally competent and this is a life-long quest. This

does not make me incapable of working with diverse others or teaching students how to work with diverse others. What this does mean is that I need to stay vigilant about the ways in which I am not competent as a counselor educator and teach my students to do the same in their quest for a healthy racial/cultural identity and multicultural counseling competence.

After a recent extensive review of counseling literature, and ten years of conversations with colleagues, I now believe counselor educators are universally poorly trained on how to educate their students how to be culturally effective. I also believe our counseling profession uses rhetoric about cultural diversity and social justice issues to "appear" to be working to answer the professional charge to develop multicultural competencies and social justice skills. I believe we all need to be held accountable for actually doing a better job at teaching and measuring competence. For example, I have conducted pre/post quantitative studies on multicultural competency in a travel immersion course and relied on self-assessment instruments. I thought I had done an excellent job of providing support for other studies in my profession. What I now realize is that I need to do more to measure implicit bias using a non-subjective measurement tool. This type of research is more time consuming, but I believe a serious, valuable journey to cultural effectiveness demands the commitment required of more effective research practices.

My on-going challenge at this time in my career is to begin to be more intentional in my instruction, more courageous in addressing uncomfortable conversations in my classrooms, and more determined to continue to not let my racist conditioning interfere with my growth of a healthy White identity. Some of the ways in which I feel I am working on the second phase of developing a non-racist White identity are to be more vigilant about my own continued study of multicultural professional literature by following my younger colleagues' examples of making time to delve into new research and multicultural literature on a regular basis. I am also finding new methods of integrating multicultural counseling theory in a counseling theories course, requiring my students to do a meaningful cultural immersion experiences in every class I teach. I am maintaining the integration of popular literature such *Nickel and Dimed: On Not Getting By in America* (Ehrenreich, 2002) in my course assignments, and finding more meaningful ways in which to teach my students how to measure their cultural effectiveness.

Conclusion

"It is easy to ignore what you neither feel nor understand" (Hanley, 2005, p. *vi*). The author shares her journey from ignorance about cultural issues to an awakening of humility as she works her way to what Helms (1992) calls an evolution of a non-racist identity. Her continued work is to take notice of times in which she is abandoning racist thoughts and tendencies in favor of developing a healthy racial identity in order to more effectively teach her students how to use current racial/cultural identity models to become culturally effective counselors. Unlike some authors who believe we can undo racism, she believes we cannot undo what has been reinforced for centuries through

insidious and dysfunctional cultural beliefs about equality among people from all races and cultures. However, she trusts that we can continue to become aware of our racist thoughts and tendencies and not allow them to affect our work by taking the leap to visit other communities and cultures, learn new languages and literally put ourselves in a foreign experience. Only by moving outside our own comfort zone can we begin to lose White arrogance and situate ourselves as lifelong learners in non-racist ways of being.

References

Arredondo, P., Toporek, R., Brown, S. P., Sanchez, J., Locke, D. C., Sanchez, J., Stadler, H. (1996). Operationalization of the Multicultural Counseling Competencies. *Journal of Multicultural Counseling & Development, 24(1),* 42-78.

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling and Development, 77,* 102-108.

Carter, R. T. (1995). *The influence of race and racial identity in psychotherapy: Toward a racially inclusive model.* New York: Wiley.

Carter, R. T. (2003). Becoming racially and culturally competency: The Racial-Cultural Counseling Laboratory. *Journal of Multicultural Counseling and Development, 31*, 20-30.

D'Andrea, M., & Daniels, J. (1999). Exploring the psychology of White racism through naturalistic inquiry. *Journal of Counseling and Development, 77, 93-101.*

D'Andrea, M., & Daniels, J. (2001). Expanding our thinking about White racism: Facing the challenge of multicultural counseling in the 21st century. In J. G. Ponterotto, J. M. Cassas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 289-310). Thousand Oaks, CA: Sage.

Ehrenreich, B. (2002). *Nickel and dimed: on (not) getting by in America*. New York: Henry Holt and Company.

Hanley, M. S. (2005). The Dialectics of Roosting Chickens: "Race" in U. S. Education. In S. A. Hughes (Ed.), *What we still don't know about teaching race: how to talk about it in the classroom.* (*pp. i-xvi*). New York: Edwin Mellen Press.

Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: a Black and White model. *The Counseling Psychologist, 12,* 153-165.

Helms, J. E. (1992). *A race is a nice thing to have: A guide to being a White person or understanding the white person in your life.* KS: Content Communications.

Johnson, S. D. (1987). Knowing that versus knowing how: Toward achievement expertise through multicultural training for counseling. *The Counseling Psychologist, 15*, 320-331.

Loewen, J. W. (2007). *Lies my teacher told me: Everything your American history teacher got wrong*. New York: Touchstone.

Robinsin, T. L. (1999). The intersections of identity. In A. Garrod, J. V Ward, T. L. Robinson, & R. Kilkenny (Eds.), *Souls looking back: Life stories of growing of Black.* (pp. 85-98). New York: Routldege.

Utsey, S. O., & Gernat, C. A., & Bolden, M. A. (2002). Teaching racial identity development and racism awareness: Training in professional psychology programs. In G. Bernal, J. E. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.), *Handbook of racial and ethnic minority psychology* (pp. 147-166). Thousand Oaks, CA: Sage.

Wen-Wu in Counseling with Men

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Abstract

Wen-wu is a Chinese conceptualization of masculinity that strikes a balance between wen (i.e., literary strength) and wu (i.e., physical strength). This concept can be readily applied to a mental health setting when working with male clients. The present treatise outlines the concept of wen-wu and provides suggestions for use in clinical work. Applying this concept in counseling promotes the construction of wellness plans and facilitates discussions about masculinity.

Wen-Wu in Counseling with Men

Men do not attend mental health treatment at the same rate as women (Prior, 1999; Vessey & Howard, 1993). Scholars have suggested that men are not attracted to mental health counseling because it does not honor a masculine way of being (e.g., Brooks, 1998; Wexler, 2009). Mental health counseling typically emphasizes that clients share their feelings, explore their problems, admit their vulnerabilities, and utilize a client-counselor relationship for change (Robertson & Fitzgerald, 1992). Traditional masculine ways of being often proffers incongruent qualities such as restricting emotions, establishing superiority, showing strength, and being independent (Levant & Kopecky, 1995).

Masculine ways of interacting and sharing frequently emphasize a physically active orientation (e.g., Brooks, 2010; Glicken, 2005; Kiselica, 2005; Rabinowitz & Cochran, 2002). Mental health counselors may need to honor this way of being in session in order to better facilitate some men's counseling experience. The present treatise is one approach to taking a more active orientation towards counseling by challenging men to conceptualize their health through the Chinese concept of *wen-wu*. This application is not meant to define treatment with men, rather to shape early interactions and facilitate deeper dialogs later in counseling.

Wen-Wu

Traditional Chinese depictions of masculinity have highlighted the balance between wen and wu (Louie, 2002; 2003; Louie & Edwards, 1994). This is a conceptualization of masculinity that roughly translates to English to mean wen, literary/civil/mental, and wu, martial/physical. According to Louie, this concept is most prevalent in China but is reflected in most East Asian cultures. Wen-wu encompasses a duality of mental and physical attainment in masculinity and serves to honor both scholar and soldier as being equally masculine. Louie noted that at one time, having a balance between these two elements might have been as desirable as having one or the other present. The context would have dictated what was needed most, but both elements were considered an acceptable expression of manhood.

Education is the most common representation of wen, which is supposed to depict the strength of mind and civility that an individual possesses. Louie (2003) noted that in East Asian countries many political leaders emphasize their educational attainments to depict their worthiness for leadership. In contrast to wen, wu is oriented towards physical strength and is sometimes tied to the martial arts. Louie noted that many American politicians will distance themselves from their education (wen) and gravitate towards their action-oriented pursuits (e.g., hunting, sports; i.e., wu). This is an example of how Westernized conceptualizations of masculinity tend to prioritize a wu-type of masculine strength, even in contexts when they are not intuitively desirable. When applying these concepts to counseling, the emphasis is placed on balancing these elements rather than having one supersede the other.

Applying Wen-Wu

The first step in using wen-wu with male clients is to introduce the concept in session. Most people are familiar enough with yin-yang that it can serve as a useful comparison. Both yin-yang and wen-wu are dualities that reflect a balance or harmony of forces. Informing the client about this balance between the "scholar" and the "warrior" or the "mind" and the "body" provides a foundation for additional discussion. Also noting how counseling will require wen and wu elements can help frame the counseling process. Early on in counseling, this framework might also facilitate a sense of structure for men who might feel especially vulnerable during initial meetings.

The second step is to help break down the two elements and generate examples of how clients are actively living out these qualities of wen and wu. For example, a man might highlight an interest in history as a wen activity and trail running as a wu activity. Developing a picture of how these forces are already being engaged can help increase a client's sense of agency early in treatment. Additionally, spend time exploring a client's goals for expanding wen and wu in their lives. At this phase, it can be helpful to think big and allow clients to freely explore their ideas for both areas. Examples of strengthening wen might include activities such as pursuing educational goals (e.g., taking a class, pursuing a degree, reading about a topic of interest), increasing emotional awareness (e.g., journaling, reading self-help materials), or engaging in discussion with others (e.g., local interest groups). Examples of strengthening wu might include exercising (e.g., playing a sport, running), learning a form of martial arts (e.g., kung-fu, karate, tai chi), or engaging in a physical hobby (e.g., fishing, hunting, sculpting).

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The third step is creating a plan for achieving the established goals. The client can weigh his wen and wu lists to see which one requires strengthening to move towards balance. He can choose either a wen or wu goal and work towards achieving that goal. Addis and Martell (2004) outlined some of the steps for setting useful goals. They suggested (a) establishing small steps for attaining goal, (b) establishing a logical sequence of steps, (c) address the specifics of *when* and *how* the steps will be taken, (d) anticipate and prepare for barriers to emerge during the process, and (e) create some form of reward for accomplishing each step or goal.

The final step is when clients begin implementing their plans. Early on in implementation, clients might feel a sense of success just by completing some of their steps. Highlighting these small successes is a way to begin building self-efficacy that will contribute to increased self-esteem (Smith, 2006). Continuing to link these behaviors to the wen-wu balance can help facilitate discussions of masculinity in session. This is often a starting point for a more comprehensive discussion about masculinity and about how men want to be in the world. Thereby deepening the counseling process with men.

Clinical Experience

In my own clinical experience I have found the concept of wen-wu to be very helpful in facilitating several important therapeutic insights. First, men begin to see the importance of creating balance in their behaviors to achieve wellness. Wellness is often equated with physicality, however the wen-wu balance provides a more comprehensive picture. Second, men start to set goals that are oriented towards wellness with the understanding that they are becoming the best men that they can become. Linking masculinity to mental health change can have a catalyzing impact on men (Real, 1997). Finally, this is helpful way to catalyze a dialog in session surrounding men's issues. Many scholars have suggested that counseling with men needs to focus on masculinity in order to be effective (e.g., Silverberg, 1986; Rabinowitz & Cochran, 2002). By using wen-wu in session, I have found that men are more open to discussing what it is like being a man than if I broach the subject without the same prompting.

I have only applied wen-wu to individual counseling with male clients. However, there are additional applications that could be useful when working with male clients. Most notably, group counseling settings could benefit from incorporating wen-wu. Whether in therapeutic or psycho-educational groups, the concept of wen-wu could provide a simple yet comprehensive framework to construct a program for change. Similarly to the individual setting, a discussion about masculinity may be facilitated by first discussing wen-wu.

Implications for Future Research

The use of wen-wu in counseling with male clients is based on my own clinical experience. As such, there are several opportunities to assess the usefulness of this construct. First, counselors who utilize this construct could participate in a Q sort about its application. This may elucidate some of the different approaches to using wen-wu in session. Second, qualitative research could be

conducted to examine the views of clients who have experienced using wen-wu in session. This might indicate whether or not they found the concept helpful in meeting their goals for counseling. Finally, as a wellness oriented construct this could be compared with other wellness models in applicability with male clients. While other models may be more comprehensive, wen-wu might offer something unique to male clients.

In summary, utilizing the concept of wen-wu in session is not intended to be the whole of treatment with men. Rather it is a useful tool for framing discussions of wellness and masculinity. Some men might find it a masculine friendly way to begin a therapeutic relationship. As men become more comfortable with the counseling relationship, they may be able to embrace other ways of being in session with another person. As such, counselors may be able to move away from the structure that wen-wu offers and delve into the client's more unique stories of masculinity.

References

Addis, M. & Martell, C. (2004). *Overcoming depression one step at a time: The new behavioral activation approach to getting your life back.* Oakland, CA: New Harbinger.

Brooks, G. R. (1998). *A New Psychotherapy for Traditional Men.* San Francisco: Jossey- Bass Publishers.

Glicken, M. D. (2005). *Working with Troubled Men: A contemporary practitioner's guide.* Mahwah, N.J.: Lawrence Erlbaum Associates, Publishers.

Kiselica, M. S. (2005). A male-friendly therapeutic process with school-age boys. In G. E. Good & G. R. Brooks (Eds.), *The New Handbook of Psychotherapy and Counseling with Men* (pg. 17-28). San Francisco: Wiley & Sons, Inc.

Levant, R. F. & Kopecky, G. (1995). *Masculinity Reconstructed: Changing the rules of manhood- at work, in relationships, and in family life.* New York: Plume Publishing.

Louie, K. (2002). *Theorizing Chinese Masculinity: Society and gender in China.* New York: Cambridge University Press.

Louie, K. (2003). Chinese, Japanese and global masculine identities. In K. Louie & M. Low (Eds.), *Asian masculinities: The meaning and practice of manhood in China and Japan* (pp.1-16). New York: Routledge Curzon.

Louie, K. & Edwards, L. (1994). Chinese masculinity: Theorizing wen and wu. *East Asian History, 8,* 135-148.

Prior, P. M. (1999). *Gender and Mental Health.* New York: New York University Press.

Rabinowitz, F. E. & Cochran, S. V. (2002). *Deepening Psychotherapy with Men.* Washington, D.C.: American Psychological Association.

Real, T. (1997). *I Don't Want to Talk About It: Overcoming the secret legacy of*

male depression. New York: Scribner.

Robertson, J. & Fitzgerald, L. (1992). Overcoming the Masculine Mystique: Preferences of alternative forms of assistance among men who avoid counseling. *Journal of Counseling Psychology, 39*(2), 240-247.

Silverberg, R. A. (1986). *Psychotherapy for Men: Transcending the masculine mystique.* Springfield, IL: Charles Thomas Publishing.

Smith, E. J. (2006). The Strength-Based Counseling Model. *The Counseling Psychologist, 34*(1)*,* 13-79.

Vessey, J. T. & Howard, K. I. (1993). Who seeks psychotherapy? *Psychotherapy, 30*(4), 546-553.

Wexler, D. B. (2009). *Men in Therapy: New Approaches for Effective Treatment.* New York: W. W. Norton & Co.

Increasing Self-Empowerment related to Depression among Court-Involved Youth: The Moods Matter Project

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Abstract

An empirically-guided program designed to empower at-risk youth through increased knowledge of depression and prevention resources was developed and implemented. Ninety-three court-involved adolescents participated in the *Moods Matter* project, a four-part psycho-educational group experience rooted in the principles of Rational Emotive Behavior Therapy (REBT). Addressing the disproportionate incidence of depression among court-involved youth and the need for short-term interventions that promote self-empowerment, the program was developed specifically for court-involved youth in out of home placement. The results of this exploratory pilot study found significant gains among participants related to increased knowledge of depression. Additionally, all participants successfully completed an individualized safety plan following the intervention.

Increasing Self-Empowerment related to Depression among Court-Involved Youth: The Moods Matter Project

One of the most prevalent and serious mental health disorders among adolescents is depression. In fact, the 2004 National Survey on Drug Use and Health estimated the lifetime prevalence rate of depression among adolescents at 14% (Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2005). Three to eight percent of adolescents are diagnosed with Major Depressive Disorder making it more common among this age group than other chronic childhood disorder, including asthma (Jackson & Lurie, 2006). Since adolescent depression does not typically occur in isolation, depressed adolescents are at greater risk of co-morbid issues such as substance abuse, educational challenges, problems with social relationships, and conduct

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disorders (Zalsman, Brent, & Weersing, 2006). Moreover, suicide, a byproduct of depression, is the third leading cause of death among individuals 15-24 years of age in the United States (Kochanek, Murphy, Anderson, & Scott, 2004). For court-involved youth, the prevalence of depression and other mental health disorders is even greater. In fact, approximately 40-85% of children within the child welfare system suffer from one or more mental health disorders (Austin, 2005) and between 65-70% of youth in the juvenile justice system meet the criteria for a mental health disorder (Skowyra & Cocozza, 2006) including depression.

The disproportionate incidence of depression among court-involved youth indicates the need for specific interventions designed to meet the needs of this special population. However, whereas several evidence-based practices to prevent depression have been developed in recent years (Garber, Clarke, & Weersing, 2009; Gillham, Reivich, Jaycox, Seligman, & Silver, 1990; Mufson, et al.,2004; Spence, Sheffield, & Donovan, 2005), none have been designed to specifically address the unique needs of court-involved youth. Namely, studies must be designed to address needs related to adolescents with limited, if any, social and family supports, and challenges related to the brief periods of time available to intervene with this population. In response to these needs, the *Moods Matter* project, a brief cognitive behaviorally-based group intervention was designed to increase knowledge and resources related to depression to promote self-sufficiency and empowerment.

Literature Review

Depression among Court-Involved Youth

The increased risk for depression associated with court-involved adolescents is often due to exposure to early trauma (Birhmaher, et al., 2001). In fact, Garber and Flynn (2001) found that individuals with a history of child maltreatment might adopt a negatively skewed cognitive style as a result of the experience of early trauma. As a result, these individuals may possess a cognitive schema that tends to interpret events in a manner that promotes self-blame and negativity, and a sense that the glass is half empty rather than half full. This endorsement of such a negatively skewed cognitive style is thought to contribute to the risk of subsequent depression.

Furthermore, this type of environmental conditioning or sensitization to depression appears to place individuals that were exposed to adversity at an early age at disproportionate risk for chronic depression following life challenges of varying degrees (Monroe & Harkness, 2005; Harkness, Bruce, & Lumley, 2006). As a result, these individuals may be conditioned to continuously interpret events, regardless of their realistic severity, as overwhelming, and thus, experience feelings of helplessness that further contribute to their depression. Additionally, individuals with a history of child maltreatment may experience shorter times of wellness in between depressive episodes (Harkness, et. al., 2006). Thus, the chronic nature of depression compounded by only brief reprieves experienced by these individuals may place them at significant risk of sustaining adequate functional ability, and living healthy, full lives. Conversely,

chronic depression may place these individuals at significant risk of engaging in self-harmful behaviors, including suicide.

Depression Prevention Programs for At-Risk Youth

The majority of adolescent depression prevention programs that have been developed over the past several years have used psycho-educational approaches most often based in cognitive-behavioral therapy (Garber, Clarke, & Weersing, 2009; Gillham, Reivich, Jaycox, Seligman, & Silver, 1990; Spence, Sheffield, & Donovan, 2005; Vernon, 2006). One exception to this, however, is the interpersonal psychotherapy (ITP) model (Mufson, et al., 2004). This approach uses psycho-education to increase knowledge related to depression and prevention, and skill-building techniques to address interpersonal deficits, role conflicts and role transition. In a school-based program using ITP, the intervention was comprised of two initial individual sessions followed by eight weekly group sessions. Initial evaluation of the program by the developers supported the efficacy of the approach in reducing depressive symptoms (Mufson, Dorta, & Wickramarante, 2004) and a more recent study examined the program's preventative effects on depression (Young, Mufson, & Davies, 2006). In this recent study, 41 mostly Hispanic youth, aged 11-16 years, with elevated scores of depressive symptoms were randomly assigned to either the ITP treatment or to a school counseling control group. At six month follow-up, significant improvement was found in the ITP group vs. the control group with the ITP group participants demonstrating a significant reduction in depressive symptoms at six month follow-up.

The Problem-Solving for Life program (PSFL) is another school-based approach and one that is based upon cognitive behavioral therapy. The PSFL was delivered to 12 to 14 year old adolescents in Australia (Spence, Sheffield, & Donovan, 2005), with the intervention consisting of eight 45-50 minute weekly sessions focused on problem-solving and cognitive restructuring. In one of the largest studies to date, 1,500 youth were assigned to either the cognitive-behavioral treatment group or the no intervention control group. There were no significant differences found between students that completed the preventive intervention compared with those who did not from pre-intervention to four year follow up.

The Penn Resiliency Program (PRP; Gillham, Reivich, Jaycox, Seligman, & Silver, 1990), one of the longest used depression programs is another school-based cognitive-behavioral program. PRP consists twelve 90 – 120 minute group sessions in which adolescents are taught the connection between life events, their interpretations of those events and the related emotional consequences. PRP has been evaluated several times over the past two decades with overall findings that adolescents participating in the program report fewer depressive symptoms than those in the control group following the intervention (Gillham, Brunwasser, & Freres, 2008). In a study evaluating the effectiveness of PRP in preventing clinical episodes of depression in those with elevated symptoms of depression (Gillham, Hamilton, Freres, Patton, & Gallop, 2006), self-reported high-risk 11 and 12 year old children participated in the PRP or

control group. Females in the PRP treatment group demonstrated a significantly greater reduction in depressive symptoms than females and males in the control group.

One multi-site study examined the effectiveness of a cognitive behavioral (CB) prevention program for depression in adolescents with a high familial and individual risk (Garber, Clarke, & Weersing, 2009). This study involved 316 youth ranging in age from 13 – 17 years, 58% of whom were female and approximately 25% of whom identified as an ethnic/racial minority. Youth were randomized to receive either usual care or a six month CB treatment that involved eight weekly sessions and six monthly continuation group sessions. Results revealed significant differences between the groups with the CB group demonstrating an 11% lower rate of depressive episodes than the usual care group.

Common to the majority of existing depression prevention programs is the use of cognitive-behavioral theory and a curriculum-based model. In addition, all of the programs have been relatively brief ranging from three to six months in duration, and several programs have been school-based. However, although there has been a modest number of depression prevention programs developed recently for youth, little attention has been given to depression prevention programs for youth of various ethnic and racial backgrounds (Gladstone & Beardslee, 2009). Unfortunately, there is also an absence of programs designed specifically for court-involved adolescents residing in temporary and independent living placements—perhaps one of the highest risk populations and one that requires short-term intervention to address the often limited time professionals have to intervene.

In order to address the strengths (i.e., cognitive-behavioral therapy, curriculum-based model, group interventions), weaknesses (i.e., limited long-term effects of preventing depression), and gaps (i.e., interventions that are effective across ethnic and racial groups, different intervention delivery settings) in the existing research on depression prevention programs, the *Moods Matter* project was conceived. In addition, the program was designed as a short-term secondary prevention program to reduce depression and promote self-empowerment among court-involved youth in temporary or short-term placements—a targeted high-risk special population. To address these issues, the *Moods Matter* program used a curriculum-based group approach based upon a model of cognitive-behavioral therapy--Rational Emotive Behavior Therapy (REBT) (Ellis, 2000). To address the challenge of limited time to intervene with this population, it was believed that the focus of prevention should be primarily focused on self-empowerment. In this context, self-empowerment referred to increasing knowledge and resources related to depression among project participants, thus providing participants with the tools needed for future self-care. This type of intervention was guided by the fact that court-involved youth typically have significantly fewer family and social supports than their non-court-involved peers, and was consistent with increased self-sufficiency that is emphasized throughout the child welfare and juvenile justice systems (CWLA, 2005). Further, promoting self-empowerment is consistent with cognitive-behavioral approaches. To reflect this focus on self-empowerment, the program was designed to increase basic knowledge of depression, introduce self-management skills, and promote the development of individualized safety plans to address future depression.

Because of the inherent barriers to conducting randomized clinical trials with court-involved youth and previous mixed results related to depression prevention programs, this study was exploratory. In the exploratory phase of the study, acquisition of knowledge of depression and ability to develop an adequate safety plan were evaluated.

Methods

Participants

Youth.

Ninety-three youth ages 12 – 20 years participated in the Moods Matter project with 16 and 17 year olds comprising 57% of the total. Sixty-four percent of the participants were male while 31.2% were female. With regard to racial and ethnic backgrounds of participants, 78.5% were Black and all youth identified as Black were African American while 12.9% identified as White and of various ethnicities, including Arab-American, European-American, and Latino. At the time of the project, all of the participants were court-involved in the child welfare or juvenile justice system, and in temporary placements such as semi-independent living, short-term residential care, or at home receiving short-term community-based services. The youth were all receiving services from one private, non-profit human service organization in a multi-county region in a Midwestern state. Of the ninety percent of youth providing placement information, 32% were residing in a residential facility, 37% were participating in a semi-independent living program, and 21% were receiving community-based services. Pre-intervention participant scores on the Beck Depression Inventory II were in the following ranges: 11% (n=10) - severe depression, 16% (n=15) - moderate to severe depression, 16% (n=15) - mild to moderate depression, and 57% (n=53) – normal. This finding was consistent with previous data indicating 40% or greater prevalence of depression among court-involved youth (Austin, 2005; Skowyra & Cocozza, 2006).

To recruit volunteers, all clients in each of the programs were asked to participate. Project facilitators informed youth and parents/legal guardians that participation in the project was completely voluntary, and reviewed informed consent forms identifying risks and benefits with each. One hundred participants volunteered, however, seven (7%) of the initial participants did not complete all four sessions, and were therefore, not included in the results.

Project facilitators.

The project facilitators were clinicians working within the organization with youth in child welfare and juvenile justice programs. All of the clinicians had Master's degrees in Counseling, Psychology, or Social Work and held state licensure. The clinicians were trained as Project Facilitators and were provided

all of the materials to facilitate the project independently. Training of the group facilitators involved: an orientation to the objectives of the project, review of the *Moods Matter* curriculum, instruction in the role of the group facilitator, and the use of brainstorming and debriefing activities as critical to increasing group member self-exploration and promoting interpersonal feedback.

Instruments

Two outcome measures were used to gather initial data on increased knowledge related to depression and the development of an individualized Safety Plan. The *Assessment of Knowledge Related to Adolescent Depression*, a fifteen-item questionnaire consisting of True and False items was developed by the first author to assess basic knowledge of depression. The questionnaire was administered before and following the intervention. The instrument consisted of material covered in the *Moods Matter* sessions, all of which was drawn directly from current research on depression, mood management, and REBT.

The second outcome measure involved completion of an individual Safety Plan. The Safety Plan was the culminating activity of the Moods Matter project, a focused plan to aid youth in future depression through self-management tools and accessing needed resources.

The *Moods Matter* program consisted of four psycho-educational group sessions. The curriculum was designed to be delivered in four sessions over a one-month period, and the group-based curriculum consisted of the following major components: 1) *Understanding your Emotional Self: Moods and Behaviors,* 2) *Why Moods Matter: Risks and Consequences*, 3) *Taking Control of Moods: Assessment, Empowerment, Advocacy, and Treatment, and 4) Safety Planning*. The curriculum consisted of instructional tools that included brief lecture material and video clips interspersed with group-based exercises founded in REBT that were completed by the group throughout the sessions. As the project was designed to promote future self-empowerment, a curriculum booklet was provided to each participant with several sets of additional exercises and instructions for continued independent use of the materials following completion of the group. Additionally, each participant received a wallet-sized information card with telephone numbers for various public health and safety organizations, a reading list of books specifically related to depression and teens, and a *Depression Checklist*, identifying various signs and symptoms of depression. Successful completion of the program was evidenced by participation in all four sessions and completion of an individualized *Safety Plan* that each youth retained following the program.

Ten groups of 6-12 youth participated in the *Moods Matter* project with group composition based upon program placement (i.e., community-based, residential treatment, independent living). The groups took place in either a residential setting for youth in residential treatment or in a community-based site for youth in community-based placement (i.e., home, semi-independent living). All group sessions occurred during a one-month period and consisted of four two-hour group sessions.

Immediately prior to beginning the group sessions, the group facilitator provided instructions to all group members about each of the pre-group assessment activities, including information regarding privacy protections, purpose of the data, and participants' right to refuse completion of any of the documents. Additionally, participants were informed that the results of the depression screening would be reviewed with each of them privately by their therapist (i.e., the group facilitator) during their next scheduled therapy session. After responding to any participant questions, the pre-group assessment materials were distributed to participants for completion (i.e., demographic information, depression screening, pretest).

Each of the four sequential psycho-education sessions was similar in structure, consisting of brief lecture material aided by the use of *Powerpoint* slides. Each slide presentation was brief (i.e., less than 10 minutes) and was followed by a related group exercise (the amount of time allocated for each slide presentation was limited in consideration of participant developmental level). Following each group exercise, the facilitator led short debriefings to allow time for participants to further process the exercise, reflecting on learning that occurred and engaging in further discussion about issues addressed in the exercise.

Session one.

The initial session began with a brief primer regarding the interrelationships between cognitions, emotions and behaviors, establishing the framework for developing an understanding of Rational Emotive Behavior Therapy. This discussion emphasized the effect that events or actions may have on feelings as well as the effect that feelings may have on actions or behaviors. Following completion of the group exercises, the A- B- C model (Ellis, 2000) was presented and discussed. The group then engaged in an ABC model exercise, identifying personal activating events (e.g., failed a test), faulty beliefs constructed as a result of the event (e.g., I am stupid) and the subsequent emotional consequence (e.g., I feel down).

Emphasizing the power of cognitions in emotional consequences, personal language and self-talk was discussed, paying particular attention to the manner in which each can be inflexible and rigid and as a result, can further contribute to creating emotional difficulty. An *extreme vocabulary* exercise was used in which group members identified words and messages used as part of self-talk that are rigid or inflexible (e.g., always, has to). As an adjunctive exercise, group members were then asked to identify personal *extreme messages* (i.e., my life will always be bad). The group further discussed the effects that extreme language has had on the clients' affect and behaviors, and ultimately, discussed the role that such language may have on self-esteem and self-efficacy. The initial session was designed to accomplish several objectives that included the following: educate group participants about the complex relationships between thoughts, feelings, and behaviors, explore personal thinking, feeling and behavior patterns to increase self-awareness, and examine the im-

pact of cognition on self-efficacy. As such, the initial session provided the first potential steps toward prevention and management of depression through increased awareness and knowledge about cognitions, affect and behavior, and the power of thinking patterns to influence feelings and behaviors.

Session two.

Continuing to use Ellis' (2000) ABC model, the D-E-F portion was presented and discussed. Because the *Moods Matter* project was designed for adolescents, the *F* was modified to reflect a more fun, less stressful way of living arising from the adoption of a new, effective philosophy. Using the group's original ABC exercise, the group disputed the original beliefs by replacing each with more flexible, rational thoughts and identifying subsequent feelings that would likely emerge as a result of this new way of thinking (e.g., it's all right if she doesn't like me, I'm OK).

As a means of effectively transitioning between more weighty topics (i.e., rational vs. irrational thoughts to understanding depression) and in order to introduce a wellness-inspired focus to examining the relationship between moods, thoughts and behaviors, a discussion of *Favorite Things* was facilitated. Participants explored their favorite activities and the resulting thoughts and feelings experienced following participation in such activities. Taking this a step further, group members also identified activities that they would like to do but have not yet tried, and finally, group members were asked to identify a time when they could plan to try one or more of the new activities. To ensure the feasibility of each activity, group members were instructed to only identify activities that they could engage in currently and independently, thereby ensuring that the activities were indeed feasible. This type of exercise was viewed as particularly meaningful with this population because so often the experience of being court-involved is one largely marked by loss, either temporary or permanent (e.g., related to degree of freedom, home, family, community, possessions). More significantly, this exercise was designed to potentially prevent depression and manage depression for those experiencing depression. As such, participants were guided to explore ways by which they could engage in meaningful activities and seek out new meaningful activities, thus challenging any possible negative outlook that viewed life as lacking or without meaning or change.

Session three.

The third session, *Why Moods Matter: Risks and Consequences,* focused on increasing understanding of depression through an examination of depression, risk factors, and treatment. The session began with an examination of the clinical symptoms of a depressive episode, as identified in the *Diagnostic and Statistical Manual of Mental Health Disorders – TR* (American Psychiatric Association, 2000), with an emphasis on the role of development in symptom presentation (i.e., depressed mood in adults vs. irritable mood in children and adolescents). The various risk factors for depression were then explored, with specific attention paid to teens and to the unique differences related to the experience of court-involved teens (e.g., not living with parent(s), changing

schools). In order to increase awareness of the burden of depression on an individual, the group then engaged in a brainstorming activity to identify the various costs---including but not limited to, emotional (e.g., friends), achievement (e.g., school), financial (e.g., work) associated with suffering from depression.

Next, methods by which to receive help for depression were discussed. The role of peers, teachers, case workers, caregivers, and other support persons in assisting individuals in seeking professional assistance were discussed as were the various types of professionals that are trained to treat depression. Additionally, the group counselor facilitated a discussion about methods by which to access professional help (i.e., informational cards, telephone, location of local clinics). Finally, the role of medication was briefly discussed as a potential form of treatment, when justified.

Session four.

In the final session, group members worked together to develop a *Safety Plan* brainstorming all of the necessary components. To build the *Safety Plan,* group members identified individuals that cared about them with whom they could talk, individuals that could monitor them when feeling down, professionals from whom they could seek help, types of activities that had helped them previously when feeling down, methods by which they could assess the role that personal thoughts and beliefs could be having on mood, as well as other issues related to self-monitoring and accessing help. Following the development of the group *Safety Plan*, participants developed individual *Safety Plans*. Because the intervention was group-based, the authors believed by having participants first engage in brain-storming the necessary aspects of a Safety Plan, that each participant would be better prepared to develop his/her individual Safety Plan.

Teaching participants about the various forms of treatment available and methods by which to access help for depression, as well as guiding participants in the development of their own action plans to address depression, were each designed to promote self-management and self-empowerment, significant in both primary and secondary prevention of depression. Following the final session of the project, participants completed the post-test regarding knowledge of depression.

Results

An independent t-Test was completed between the pre-test *(n=93)* and post-test scores *(n=90)* to compare project learning outcomes. The *t* test comparing the mean pre-test questionnaire responses (*M*=9.69, *SD*=2.36) with that of the post-test questionnaire responses (*M*=11.36, *SD*=2.53) was significant, $t(181) = 4.578$, $p < .05$, indicating gains in knowledge gained from pre- to post-test. The composition of the groups varied in type of juvenile justice or child welfare program, gender, age, and race. No significant differences were found on the pre-post test scores related to participant program, gender, age, or race.

All 93 participants successfully completed an individualized Safety Plan. Because the Safety Plan was designed to assist participants in identifying po-

tential supports that could be accessed in the future, successful completion of the Safety Plan was defined as the completion of the Safety Plan including the identification of at least two supportive individuals and three community resources.

Discussion

The results of the pre-post test indicate that significant gains in knowledge related to depression were achieved. Providing information and increasing knowledge related to depression is considered the initial step in both primary and secondary prevention of depression, and as such, is essential to any clinical intervention with depression.

Whereas the knowledge related to depression provided one measure of impact, the development of individualized Safety Plans provided evidence that participants were able to identify specific individuals and resources available to them for support. This was viewed as a critical step toward self-empowerment. As a result, the increased knowledge and awareness of depression coupled with the completion of personal *Safety Plans* could indeed indicate increased ability to acknowledge future depression, and to access help for depression.

To fully interpret the findings of this study, it is important to note its strengths and weaknesses. Its strengths included an effective sample size, the inclusion of ethnic and racial minorities in the sample, and the inclusion of court-involved youth in the sample. The inclusion of these groups addressed significant gaps in the literature. Moreover, because of the prevalence of depression among court-involved youth, specifically targeting this population served as a first step to exploring potential methods for addressing depression. In addition, because of the often transient nature of court-involved youth, this type of brief and affordable approach may be particularly attractive. In fact, without continued work to address depression among this population, youth that are already marginalized as a result of their court-involved status, may face additional marginalization as a result of their clinical needs not being effectively addressed.

Limitations of the Study

Although the results of the short-term outcomes were well worth reporting and reflect the need for practice-informed research, there were significant limitations to the study that included the lack of a psychometrically sound instrument and the lack of a control group. Both of these limitations will need to be addressed in future studies. However, the ethical obligation regarding withholding treatment from a high-risk youth population will need to be addressed in a control group design.

Because the *Moods Matter* curriculum was based upon current research and the pre-posttest items were drawn directly from the curriculum, the pre-posttest was empirically-guided. However, these results must be interpreted with caution since an existing measure with established psychometric properties was not available for use. Finally, because this project emphasized the use of a brief self-empowerment intervention to high risk youth that often are unable to both participate in long-term interventions and follow-up, the long-term impact of

the intervention is not known.

Implications for Future Research

This study serves as an initial step in addressing depression among high-risk youth through the provision of a brief self-empowerment program. Further, it reinforces the need for continued efforts to design prevention and treatment interventions that can be implemented despite the logistical challenges inherent among these populations (i.e., length of time in care, cost). Whereas the initial project objectives were met, the results of the project indicate the need for further work in this area to more rigorously evaluate the program's efficacy. This would entail the use of an additional pre-posttest outcome measure to assess increased knowledge, the use of a randomized clinical trial, and long-term follow-up to assess long-term gains in knowledge and application of skills.

In addition, regardless of the challenges inherent in practice research, clinicians must continue to engage in this type of research as it has not only scholarly implications, but more importantly, it serves to immediately address existing societal needs, often among marginalized populations and within real-life contexts. Therefore, rather than relying on school-based research or other youth populations that may prove easier to access, greater efforts should be made to involve specific sub-populations of high-risk youth. Doing so can ensure that effective interventions continue to be designed to meet the needs of all youth, and as such, counselors can work to fulfill the mandate to be social justice activists.

References

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th edition). Washington, DC: Author.

Austin, L. (2005). U*nlocking mental health services for youth in care.* Children's Voice. Washington, DC: Child Welfare League of America.

Beck, A.T., Steer, F. A. & Brown, G.K. (1996). *Manual for the Beck Depression Inventory II*. San Antonio, TX: Psychological Corporation.

Birhmaher, B., Brent, D. A., Kolko, D. J., Baugher, M., Bridge, J., Iyengar, S., Ullon, R. E. (2001). Clinical outcome after short-term psychotherapy adolescents with major depressive disorder. *Archives of General Psychiatry, 57*, 29-36.

Child Welfare League of America (2005). *CWLA standards of excellence in transition, independent living and self-sufficiency services.* Washington, DC: Author.

Ellis, A. (2000). Rational emotive behavior therapy. In R.J. Corsini & D. Wedding (Eds.), *Current psychotherapies (7th ed),* (pp. 166-201). Belmont, CA: Brooks/Cole.

Garber, J. & Flynn, C. (2001). Predictors of depressive cognitions in young adolescents. *Cognitive Therapy and Research, 25*, 353-376.

Garber, J., Clarke, G., & Weersing, V. R., (2009). Prevention of depression in at-risk adolescents: A randomized controlled trail. *Journal of the American Medical Association, 301*, 2215-2224.

Gillham, J. E., Reivich, L. H., Jaycox, K. J., Seligman, M. E. P., & Silver, T. (1990). *The Penn Resiliency Program.* Philadelphia, PA: University of Pennsylvania.

Gillham, J. E., Brunwasser, S. M., & Freres, D. R. (2008). Preventing depression in early adolescence. In J. R. Z. Abela and B. L. Hankin (Eds.) *Handbook of depression in early adolescence,* (pp. 309-322). New York: Guilford Press.

Gillham, J. E., Hamilton, J., Freres, D. R., Patton, K., & Gallop, R., (2006). Preventing depression among early adolescents in the primary care setting: a randomized controlled study of the Penn Resiliency Program. *Journal of Abnormal Child Psychology, 34*, 203-219.

Gladstone, T. R. G., & Beardslee, W. R. (2009). The prevention of depression in children and adolescents: A review. *The Canadian Journal of Psychiatry, 54*, 212-221.

Harkness, K. C., Bruce, A. E., & Lumley, M. N. (2006). The role of childhood abuse and neglect in the sensitization to stressful life events in adolescent depression. *Journal of Abnormal Psychology, 115,* 730-741.

Jackson, B., & Lurie, S. (2006). Adolescent depression: Challenges and opportunities. A review and current recommendations for clinical practice. *Advances in Pediatrics, 53*, 111–116.

Kochanek, K. D., Murphy, S. L., Anderson, R. N., Scott, C. Deaths: Final data for 2002. *National Vital Statistics Reports*; 53, 1-116. Hyattsville, MD: National Center for Health Statistics, 2004.

Monroe, S. M. & Harkness, K. L. (2005). Life stress, the "kindling" hypothesis, and the recurrence of depression: Considerations from a life stress perspective. *Psychological Review, 112,* 417-445.

Mufson, L., Dorta, K. P., Wickramarante, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry, 61* (6), 577-584.

Office of Applied Studies. (2005). *Results from the 2004 National Survey on Drug Use and Health: National findings.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Skowyra, K. & Cocozza, J. (2006). *Blueprint for change: A comprehensive model for identification and treatment of youth with mental health needs in contact with the juvenile justice system.* Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Spence, S. H., Sheffield, J. K., & Donovan, C. L. (2005). Long-term outcome of a school-based universal approach to prevention of depression in adolescents. *Journal of Consulting and Clinical Psychology, 73,* 160-167.

Vernon, A. (2006). *Thinking, feeling, behaving: An emotional education curriculum for adolescents (2nd ed.).* Champaign, IL: Research Press. Basic Books.

Young, J. F., Mufson, L., & Davies, M. (2006). Efficacy of interpersonal psychotherapy adolescent skills training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry, 47*, 1254-1262.

Zalsman G, Brent DA, Weersing VR. (2006). Depressive disorders in childhood and adolescence: an overview. Epidemiology, clinical manifestation and risk factors. *Child and Adolescent Psychiatric Clinics of North America*, 15, 827–841.

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Figure 1

My Safety Plan

The purpose of this exercise is to identify the types of activities you can do when you are not feeling in control of your feelings and who can help you during this time.

Activity:	Who/What/Location or Telephone #:
Do Depression Checklist	ME
Who can I talk to that cares about me?	
Who can check in with me or be with me	
What professionals can I talk to? (teacher, school counselor, worker, ther-	
How can I check the role that my thought/beliefs are having on my feeling/	
What kinds of things can I do that usually	
Where can I go for help (community re-	
Who can I ask to help me access re-	
Is there anything else that I need to know	

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