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FROM THE EDITOR

Volume 40, Issue 2 of the Michigan Journal of Counseling: Research, Theory & Practice contains research and topics from counselors and counselor educators across the United States. The authors of the three articles in 40(2) have presented their research topics and ideas related to counseling special populations. It is necessary that counselors have a solid foundation in general counseling skills in order to effectively treat and build a therapeutic relationship with many clients. At the same time, it is important that counselors have a working understanding of the special treatment requirements and obstacles they may face when working with special counseling populations. The authors in this issue clearly delineate the unique needs of three special populations and have included innovative suggestions and ideas to best work with these populations.

In the first article, Killam, Roland, and Weber focus their research on ways in which school counselors can effectively integrate violence prevention programs on school campuses. Killam, Roland, and Weber shed light on the ongoing school violence issue that many school counselors and communities across the United States face on a daily basis. The authors found those middle school students who participated in a violence prevention program reported a decrease in aggressive behaviors and an increase in healthy problem solving skills.

Ms. Smith, Ms. Michero, and Dr. Fineran present a discussion about the ethical treatment of clients struggling with eating disorders. Specifically, the authors highlight the importance of promoting autonomy and preserving the rights and dignity of clients during treatment. In this study, Smith, Michero, and Fineran examine the struggles faced by clients who have eating disorders, effective treatment models, and the ethical dilemmas faced by counselors treating this population. The authors provide a case example and detail the 10 ethical decision making steps a counselor might undergo.

Guo, Wang, Corbin-Burdick, and Statz highlight an important issue facing school counselors today: support systems for students diagnosed with Aspergers. Dr. Guo and her colleagues present an overview of Aspergers and Autism spectrum disorders and the accompanying cognitive and behavioral characteristics. Dr. Guo et al., describe the role school counselors and other mental health professionals play in creating support systems for both the students, family, and community systems.

Sincerely, Jennifer N. Bornsheuer-Boswell

Violence Prevention in Middle School: A Preliminary Study

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Abstract

Violence in schools continues reflecting violence within society. There is a growing need for violence prevention programs within the schools that provide students with the skills needed to cope with interpersonal and relationship issues effectively. This study was conducted at a middle school and there were 345 middle school students (6th to 8th grade) who participated in the study. The students participated in a violence prevention program. In this study, the researchers used a pre-test/post-test design and the results indicated that there were some changes in attitudes towards violence that occurred after the intervention.

Violence Prevention in Middle School: A Preliminary Study

With the growing acts of incivility and violence on today's K-12 school campuses, the need for prevention violence has never been more important. Major problems listed by schools in the United States are fighting violence and gangs (Algozzine & McGee, 2011). School violence continues to be a major problem, with numerous contributing factors which need attention from many different angles. As an example, the lack of close relationships with parents has been linked with an increase in violence in boys such as physical fighting and violence with a weapon during early adolescent years (Stoddard, et. al., 2011). This is an indication that violence prevention efforts need to address family issues as well. Often children learn behaviors at home and then exhibit those

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behaviors in other places such as school, which typically can reflect the dynamics that play out in the home.

Literature Review

The impact of school violence is multifaceted. When violence occurs at school it can lead to victims feeling depressed and isolated. Researchers have indicated that some students who are victims of school violence skip school occasionally due to not feeling safe (Johnson, Burke, & Gielen, 2011). Furthermore, Blossnich and Bossarte (2011) indicated that even low-level violence can result in negative emotional and psychological consequences for the victims. While the focus is often on violence against students, it is important to note that violence in schools occurs within social contexts and can also include violence against teachers, principals, counselors and other school-based personnel who have perceived or real experience with a level of violence in the school (Algozzine and McGee, 2011). In some school districts, teachers and other personnel have left the schools due to not feeling safe and believed violence within the community had impacted the atmosphere within the school (Algozzine & McGee, 2011). Violent events in school are often reported in the news bringing attention to the issue (Espelage, et. al., 2013)

Often people think of extreme physical violence, shootings and rapes when it comes to school violence. However, there are numerous forms of school violence including bullying, intimidation and gang activity. Social and environmental factors can impact whether or not students participate in violent activities. Participation in violent activities increases significantly during adolescence (Stoddard et. al, 2011). For some students, peer pressure may be a factor in getting involved in violent activities. Kerbs and Jolley (2007) indicated that more than 50 percent of students may believe that the victims brought the violence upon themselves and that there is nothing wrong with teasing others who are different. Addressing these issues is a complex task yet too often the focus is merely on changing behaviors. Nadal and Griffin (2011) pointed out that hate crimes begin through language, harassment and incivility toward different youth, are examples of the microaggressions we see in schools and family settings.

Many schools have focused on the changing behaviors and mandating punishment for behaviors using a no tolerance policy. They may combine this approach with conflict resolution skills but for some schools these efforts have not been enough (Johnson, Burke & Gielen, 2012). School environment is an important factor in academic success and violence in schools is negatively impacting the development of students both academically and emotionally (Johnson, Burke & Gielen, 2011). More than half of middle schools use some type of security or surveillance methods but these measures are costly and the research has not supported an increase in school safer or a reduction of fear of violence on the part of students (Gottfredson & DiPietro, 2011). It is also interesting to note that violence may not always be reported. In fact, Algozzine and McGee (2011) found in their study that students were more likely to report school crime and violence than teachers or administrators. School climate has been closely linked to the perception of school violence. School climate can be impacted by having clear policies and procedures that are closely followed and developing positive relationships between all members of the school community

(Bosworth, Ford, & Hernandez, 2011). When a school has a climate with an atmosphere that struggles with a climate of aggression, this impacts how students feel, and many may not feel safe (Leff, et. al, 2010).

School Based Violence Prevention Programs

Violence has become a major problem in schools and over 90 percent of school districts in the United States have implemented policies and procedures to attempt to prevent school violence (Johnson, Burke, & Gielen, 2012). School based violence prevention programs have several advantages over other prevention programs. These programs teach students skills and reinforce skills to prevent violence. The focus on developing skills can help to increase social competencies (Sullivan & Bradshaw, 2012). Also, it has been noted that bullying tends to increase during middle school years and is an area prevention programs can address through character building and teaching empathy (Gibbone & Manson, 2010).

However, it is important to note that prevention and intervention programs have mixed results. The best programs tend to have support from administrators teachers, staff and students and are campus wide in nature (Blossnich & Bossarte, 2011). Additionally, Gibbone and Manson (2010) also indicated that school wide programs that allow for peer mentoring and peer leadership can be effective when students are allowed to be involved in the development of the programs. Algozzine & McGee (2011) suggested that while quite a bit is known regarding juvenile crime, there is a gap in the knowledge and literature in terms of the use of evidence based efforts that address violence within schools. Chambers, Zyromski, Asner-Self and Muthoni (2010) researched perceptions of school counselors for being prepared if and when serious acts of violence occurred. Chambers et al., found that both counselors' years of experience, and community setting contributed to those perceptions. It appears that more research is needed on the attitudes related to violence, as well as creating patterns of behavior change in school settings. In this study, we attempt to begin to help fill that gap.

Purpose of the Study

Given the growing issue with violence in society, additional research is needed to determine if school based violence prevention programs can have an impact in reducing attitudes towards violence and violence occurring on schools campuses by students. Counselors need to consider what steps they can take to prevent and reduce violence among youth. The purpose of this study was to explore how the changes in attitudes of students about violence based on an eight week violence prevention program intervention. A pre-test/post-test design was selected in order to determine if significant changes in thought patterns and behavior patterns may occur as a result of the intervention. Other factors were not considered such as grades, fighting and family environment. These are factors that albeit important were not part of this brief study. This study focused on determining if the intervention may have made a difference and thus a pretest/posttest design was selected.

Method and Sample

Middle school students in grades 6 to 8 in East Texas attended a violence prevention program with parental consent. The program was conducted within the schools with the aim of decreasing school violence. In recent years, school violence has become a major concern and the school system wanted to take proactive steps to prevent issues. The study was approved by a community treatment center's institutional review board (IRB). Mental health providers from the treatment center went to the middle school for eight weeks for 50 minute sessions with groups of students to discuss violence and conducted the violence prevention program. The program was a collaborative effort between the middle school and the treatment center. As Farrell (2009) indicated the schools are a way in which a large number of individuals can be reached and continuity can be provided when it comes to violence prevention. This was a major reason why the program was implemented in the schools. In reviewing various curriculum, some curriculum focused only on a small number of high risk students while other curriculum focus on the entire student body (Farrell, 2009). In order to reach as many students as possible, the treatment center used the Second Step: A Violence Prevention Curriculum. This curriculum also has extensive research to support it. The curriculum has been designed to decrease aggressive behaviors and increase social skills. The curriculum focuses on teaching skills in the areas of empathy, problem solving and controlling emotions (Neace & Munoz, 2012).

We focused on determining if changes occurred in attitudes. The questions were designed by the counselors after reviewing the curriculum to be specific for this intervention. A pre-test/post-test design was used to determine if changes in attitudes about various situations occurred. While there are numerous factors that could account for changes in attitudes, the questions were designed to address the information and situations presented in the curriculum. The hypothesis was that there would be a significant change in attitudes after the intervention. The participants were all enrolled in school and parental consent was obtained for participants to participate in this study. The interventions occurred during the regular school day with the counselors coming to the schools. With regards to the participants, the group was diverse and represented the diversity of the local population. There were 345 middle school students who participated in this violence prevention program. Of this number 57 percent were female and 43 percent were male. With regards to race and ethnicity, 43 percent identified as White, 31 percent as Black, 21 percent as Hispanic, three percent as bi-racial and two percent identified as other.

Results

Participants were asked to rate their feelings regarding specific situations that could be classified as violent or bullying behavior using a five point Likert scale. The questionnaire survey was completed before the violence prevention program started and again at the conclusion of the program. On several of the items there were changes in the percentage that were over five percent. This is significant in that it demonstrated that the interventions may have had some impact on attitudes and feelings of participants. The questions along with results of the survey are below in Table 1 with the percentage for each item.

Table 1
Percentage for Questions

| Question | Response | Pretest % | Posttest % |
|------------------------------------------------------------------------------------------------|---------------------|-----------|------------|
| 1. Teasing someone is a violent behavior. | I totally agree | 32.2 | 35.4 |
| | I agree somewhat | 26.4 | 25.5 |
| | I disagree somewhat | 27.8 | 16.2 |
| | I totally disagree | 13.6 | 22.9 |
| 2. Being in a fight is a lot of fun. | I totally agree | 1.2 | 0.9 |
| | I agree somewhat | 25.2 | 5.2 |
| | I disagree somewhat | 14.2 | 30.4 |
| | I totally disagree | 59.1 | 63.5 |
| 3. People don't get seriously hurt in a fight. | I totally agree | 12.2 | 3.8 |
| | I agree somewhat | 7.0 | 3.8 |
| | I disagree somewhat | 25.5 | 37.7 |
| | I totally disagree | 55.4 | 54.8 |
| 4. It's okay for people to slap around boyfriends or girlfriends if they need to keep in line. | I totally agree | 20.6 | 20.0 |
| | I agree somewhat | 3.8 | 1.2 |
| | I disagree somewhat | 14.5 | 4.6 |
| | I totally disagree | 61.2 | 74.2 |
| 5. Sometimes people deserve to be hit or hurt. | I totally agree | 7.0 | 3.5 |
| | I agree somewhat | 15.7 | 11.0 |
| | I disagree somewhat | 24.6 | 19.1 |
| | I totally disagree | 52.2 | 66.4 |
| 6. It's okay for people to encourage their friend to fight if they have insulted. | I totally agree | 3.5 | 0.6 |
| | I agree somewhat | 9.0 | 4.1 |
| | I disagree somewhat | 20.9 | 16.2 |
| | I totally disagree | 68.1 | 79.1 |
| 7. It's okay for children to be hit if they have done something wrong. | I totally agree | 3.5 | 3.2 |
| | I agree somewhat | 9.0 | 9.0 |
| | I disagree somewhat | 44.6 | 14.8 |
| | I totally disagree | 42.9 | 73.0 |
| 8. It's okay to walk away from a fight whether or not you think you had won. | I totally agree | 56.2 | 48.7 |
| | I agree somewhat | 27.8 | 13.9 |
| | I disagree somewhat | 9.3 | 23.8 |
| | I totally disagree | 6.7 | 13.0 |
| 9. If you want to protect yourself, you need to carry a gun. | I totally agree | 0.6 | 1.2 |
| | I agree somewhat | 3.5 | 2.9 |
| | I disagree somewhat | 14.5 | 26.7 |
| | I totally disagree | 81.4 | 68.7 |
| 10. When parents are violent toward each other, they are usually the ones who are affected. | I totally agree | 14.5 | 15.7 |
| | I agree somewhat | 19.7 | 35.9 |
| | I disagree somewhat | 35.1 | 15.1 |
| | I totally disagree | 30.7 | 32.8 |
| 11. People who are good fighters deserve a lot of respect. | I totally agree | 10.7 | 1.7 |
| | I agree somewhat | 24.3 | 6.7 |
| | I disagree somewhat | 17.4 | 11.3 |
| | I totally disagree | 47.5 | 79.7 |
| 12. Fighting is cool. | I totally agree | 0.3 | 1.4 |
| | I agree somewhat | 13.6 | 6.4 |
| | I disagree somewhat | 13.6 | 8.1 |
| | I totally disagree | 72.5 | 83.5 |

Discussion and Implications for the Counseling Profession

There are several different violence prevention programs available. When selecting a curriculum it is important to consider the anticipated outcomes. Within this study, the students showed gains in terms of understanding violent behaviors as evidenced by shifts in the percentages on questions. However, there were some areas where certain percentages did not shift as much. This may be due to a number of environmental factors. Given that nearly 70 percent of the students in this school district are on free or reduced lunches, one must take into account the socio-economic status (SES) factors. Also, roughly half of the students were living with single parents or grandparents. One has to consider how this may impact the students' perceptions of violence especially if the parents often fight. These factors were not asked as part of the demographic background but could have impacted the results.

The results of this study can be used to consider areas in which violence prevention programs can provide students with additional information regarding what is considered violence. Also, programs may want to consider how they can provide students with additional hands-on experiences in handling difficult situations using role-playing and cases to facilitate personal growth in their ability to be prepared to deal with challenging situations.

Limitations and Directions for Future Research

There were limitations with this study. First only middle school students were included in the study. Also, participants were only those who attended a certain school in one state. It would be interesting to see if there are differences between students based upon region of the country. Also, it could be beneficial to see if older and younger students share similar attitudes. Although the sample was diverse in nature it may be beneficial to compare differences based on racial and ethnic groups. These aforementioned comparisons may potentially account for beliefs regarding violence. A study with a larger sample size could compare not only racial and ethnic differences but also gender differences. Additionally, in future studies, it would be important to take into account the SES background of the students if possible and to do some complex comparisons between various groups such as students from single parent families versus those from families with two parents. Another important area for research is the family dynamic and it how may have contributed to the level of behavior that would appear uncivil, mean, or violent that occurs in the school setting. There are also other factors that may have contributed to changes in attitudes that were not measured as well. Furthermore the study did not look at violence records in the schools or academic success. Future studies could take these factors into account. This additional information may assist counselors in providing a more tailored and structured approach to violence prevention, utilizing several avenues of response not researched in this study.

Conclusion

The rate of violence and incivility that seem to be occurring in schools is at an alarming rate. This should be addressed on multiple levels, and dedicated school violence prevention programs are one way to begin to address the issue

of violence within schools and society. By providing children and young adolescents with the knowledge and skills they need to effectively cope with potentially violent and difficult situations, a reduction in school violence may occur. Continuing to work with families of bullied and bullying individuals is important in counteracting the negativity that can be seen in the home, and carried into the educational system, on all levels (Baldry, 2003; Mustanoja, Luukkonen, Hakko, Rasanen, Saavala, & Riala, 2011). Additionally, the skills learned in violence prevention programs can be used throughout one's lifetime (Farrell, 2009). The attitudes and responses of children need to be considered when evaluating violence prevention programs. In this study, we have attempted to begin that process.

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Promoting Client Welfare and Preserving Autonomy: Ethical Treatment of Eating Disorders

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Abstract

Counselors often experience an ethical dilemma when mandating treatment for clients with eating disorders. In this article, the authors will briefly discuss the characteristics of eating disorders, the impact of cognitive impairment on the decision to mandate treatment, and the ethical principles of autonomy, beneficence, and nonmaleficence that counselors must consider when working with clients from this population. To address ethical concerns, the authors will apply Welfel's (2010) ethical decision-making model to a case involving a client with Anorexia Nervosa.

Promoting Client Welfare and Preserving Autonomy: Ethical Treatment of Eating Disorders

Eating disorders (EDs) are complex and often life threatening conditions. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (American Psychiatric Association, 2013), EDs are generally characterized by disturbances in eating behavior. EDs are classified into one of several specific categories: anorexia nervosa, bulimia nervosa, binge eating disorder, and feeding or eating disorder not elsewhere classified. Anorexia nervosa (AN) is characterized by restriction of food intake, refusal to maintain minimally appropriate body weight, intense and irrational fear of weight-gain, and distorted body image. Bulimia nervosa (BN) is marked by the consumption of a

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large amount of food in a short period of time; individuals with bulimia often report feeling out of control during consumption and appear to possess a self-image that is disproportionately influenced by body image. Binge eating disorder (BED) is defined as frequent episodes of eating significantly more food in a short period of time than the average person would eat under similar circumstances. Individuals with BED often experience feeling out of control and may eat too quickly, even when not hungry. Episodes may be accompanied by feelings of guilt or shame, thus individuals with BED may hide binge-eating behavior. BED is associated with marked distress and typically occurs at least once a week over at least three months. The category feeding and eating disorders not elsewhere classified includes eating disorders that do not meet the diagnostic criteria for AN, BN, or BED, including, atypical AN, sub-threshold BN, sub-threshold BED, and purging disorder. The subtypes of EDs share commonalities such as fear of weight gain, body image dissatisfaction, and preoccupation with food.

EDs have a significant personal, familial, societal, and health impact. Individuals with eating disorders often develop medical complications. As reported by Stice, Marti, and Rohde (2013), the lifetime prevalence of AN in American women is approximately 0.8%, for BN, it is 2.6%, for BED it is 3.0%, and for FEDEC, it is 11.5%. The total lifetime prevalence for all EDs is 13.1%. College-age women are at a greater risk for eating disorders than the general population (Schoen et al., 2012). EDs have the highest mortality rate of any mental disorder and are more lethal for women aged 15-24 than any other condition (Sullivan, 2002). Crow et al. (2009) reported the approximate mortality rates for individuals with EDs as 4% for those with AN, 3.9% for those with BN, and 5.2% for those with other eating disorders, including BED. Additionally, individuals with EDs also have an elevated risk of suicide (Apter et al., 1995; Bulik, Sullivan & Joyce, 1999; Pompili et al., 2004; Preti, Rocchi, Sisti, Camboni, & Miotto, 2011), and co-morbid mental health disorders including various types of mood, anxiety, personality, and substance use disorders (American Psychological Association, 2009). Many individuals with eating disorders die of starvation related illnesses and, for individuals with AN, the rate of suicide is up to fifty-seven times higher than that of the general population. The lifetime frequency of suicide attempts in individuals with BN has been estimated to be between 15% and 40% (Bulik et al., 1999; Corcos et al., 2002; Favaro & Santonastaso, 1997; Preti et al., 2011) and in individuals with AN to be between 5% and 22.9% (Favaro et al., 1997; Preti et al., 2011, Pryor et al., 1995). Sullivan (1995) noted that the second most common cause of death in AN sufferers was completed suicide, which accounted for 27% of fatalities.

Clearly, EDs are potentially lethal disorders that may require intensive intervention by counselors. In many cases, individuals with EDs have no inten-

tion of changing their behavior and are often either unaware of or unwilling to accept the physical dangers of their conditions. The purpose of this article is to describe ways in which people with EDs may experience cognitive and decision-making impairments, to highlight the ethical dilemmas that may arise with clients who are unwilling to seek additional treatment, and to provide a case example demonstrating the application of Welfel's (2010) ethical decision-making model as a way to manage and balance ethical issues that may arise during counseling with eating disordered clients.

Cognitive Impairment and Treatment Implications

EDs are often accompanied by thought disturbances, which may lead individuals to actively resist change, be noncompliant with treatment, and value declining weight and health. Individuals with EDs often struggle with cognitive impairment and have difficulty with appropriate decision-making (Boeka & Lokken, 2006; Brand, Frank-Sievert, Jacoby, Markowitsch, & Tuschen-Caffier, 2007; Cavedini et al., 2004, 2006; Tchanturia et al., 2007). Assessing potential impairment is critically important to counselors working with individuals with EDs as it may impact the individual's motivation for change. Impaired decision-making can impact an individual's ability to make rational and independent decisions regarding food and health. As such, people with EDs often lack anxiety about the dangers of their harmful behaviors and the resulting life-threatening symptoms.

Clients, with AN may have impaired mental flexibility and experience difficulty shifting focus. This impaired mental flexibility may contribute to the obsessive focus anorexic clients often have on the avoidance of weight gain (Cavendini et al., 2004; Roberts, Tchanturia, Stahl, Southgate, & Treasure, 2007; Steinglass, Walsh, & Stern, 2006). Additionally, semi-starvation likely contributes to anorexic clients' obsessive focus. Individuals in a state of semi-starvation may fixate on food and develop symptoms that mimic obsessive-compulsive disorder (Goldner, Birmingham, & Smye, 1997). Similarly, clients with BN tend to experience cognitive impairment in the form of increased impulsivity and risk taking (Fisher, Smith, & Anderson, 2003; Peñas-Lledó, Vaz, Ramos, & Waller, 2002; Rosval et al., 2006; Steiger, Lehoux, & Gauvin, 1999) and individuals with BN are less inhibited in their responses, especially when experiencing negative emotions (Bruce, Koerner, Steiger, & Young, 2002; Rosval et al., 2006). Furthermore, individuals with binge eating disorder may experience cognitive impairment, especially deficits related to problem-solving, cognitive flexibility, and working memory (Duchesne et al., 2010).

Individuals with these types of cognitive impairments and impulse control issues often need intensive outpatient or inpatient treatment in conjunction with medical and nutritional consultation. Counseling is vital for individuals with EDs, and individual therapies frequently include Cognitive Behavioral Therapy

(CBT), Interpersonal Psychotherapy (IP), and Dialectical Behavior Therapy (DBT). Family and group therapies may also be useful. However, some researchers (Mehler et al., 2010) believe that counseling cannot be effective for cognitively impaired clients who are in states of self-starvation, and suggest that re-feeding treatment is more appropriate. Re-feeding involves gradually increasing in a client's consumption of food. It is often a risky process due to the possibility of heart failure, seizures, and blood and skeletal muscle dysfunction. When a client's weight is very low at the time of admission, re-feeding can be dangerous. The dangers associated with re-feeding may warrant inpatient treatment for individuals suffering from AN so that the process can be medically monitored (National Institute for Health and Clinical Excellence (NICE), 2004). Again, people with EDs are often unaware of their potentially life-threatening situation. Whereas they are not purposefully attempting to end their lives, AN sufferers have the highest mortality rate of all mental health disorders (APA, 2009; Sullivan, 2002). Individuals with this condition are often reluctant to enter treatment and may require hospitalization, often against their will, to prevent further life-threatening medical complications as impending medical crises are difficult to foresee in clients with EDs (APA, 2009; Goldner, et al., 1997).

Ethical Principles

In the helping professions, codes of ethics exist to provide standards of ethical conduct for practitioners and to provide a system of professional accountability that serves to protect the public. Underlying the codes of ethics are basic moral principles. Kitchener (1984) identified five moral principles that are generally viewed as the foundation for the ethical guidelines of the American Counseling Association's (ACA) Code of Ethics (2005). These principles of autonomy, nonmaleficence, beneficence, justice, and fidelity are considered to be of equal importance. Exceptions occur when one principle conflicts with another or is competing with a greater ethical duty (Herlihy & Corey, 2006; Welfel, 2010). When fundamental principles are in conflict, counselors must seek a well-considered balance. When counselors consider mandating treatment for a client with a life-threatening ED, they must specifically consider the principles of autonomy, beneficence, and nonmaleficence in order to find a critical balance between them.

Autonomy

Autonomy is the ethical principle associated with an individual's right to independence and self-determination (Kitchener, 1984). Inherent in the concept of autonomy is the notion that clients are free to make self-directed choices without interference from others. To promote client autonomy, counselors cultivate independent decision-making and encourage client self-reliance by remaining open to values that are different from their own, by refraining from judgment,

and by avoiding imposing goals on clients. Paternalism occurs when one individual attempts to determine the best interests of another person and may take place when counselors choose to make decisions on behalf of clients whom they believe have limited, intermittent, or no competence to make self-directed choices (Beauchamp & Childress, 2001). When counselors exercise paternalism in order to uphold the principle of beneficence – to ensure the welfare of the client – they are infringing on the client's right to autonomy.

Beneficence

Beneficence is the ethical principle associated with the responsibility of counselors to do good in order to promote and safeguard the welfare of their clients (Kitchener, 1984). For counselors, this ethical responsibility requires that they contribute to the mental health, wellness, and growth of clients, engage in professional activities that benefit society as a whole, and work within the limits of their competency and scope of practice. Counselors are duty-bound to put forth their best effort to help clients even though their attempts may not always attain positive treatment outcomes. However, when specific treatments or interventions are attempted and prove to be unsuccessful, counselors must present clients with alternative options. The principle of beneficence requires a counselor to provide treatment that not only improves well-being, but also prevents harm.

Nonmaleficence

Nonmaleficence is the ethical principle associated with doing no harm (Kitchener, 1984). Not only must a counselor avoid intentionally hurting a client, he or she must also avoid engaging in actions that have a likelihood of causing harm. This principle is the basis for the ethical standards of competence to practice, informed consent, dual relationships, and public statements. Some ethicists (Beauchamp & Childress, 1979) have noted that avoiding harm (including threats to autonomy and justice) necessitates a stronger ethical obligation than doing good. Following this logic, taking no action would be considered preferable to engaging in action that is likely to cause harm.

Ethics and Eating Disorders

A counselor must find a critical balance between autonomy, beneficence, and nonmaleficence in treating clients with severe EDs. When considering autonomy, a counselor might conclude that a competent client has the right to make decisions about his or her treatment and level of care. In addition, a counselor may assume that such a client has the freedom and responsibility to determine whether to seek treatment at all. Because the principle of autonomy underlies a client's right to make a decision about initiating treatment, one may surmise that a counselor's role is simply to provide a compassionate, supportive, and educational environment while offering neither encouragement nor dis-

couragement about intensifying treatment. Similarly, some view the decision to recommend intensive treatment as a violation of the client's right to autonomy and as counterproductive to treatment (Dresser, 1984; Rathner, 1998). Some ethicists have argued that loss of autonomy due to coerced treatment can be detrimental to the therapeutic relationship (Griffiths & Russell, 1998). In the case of a life-threatening condition such as AN, client autonomy would be upheld by withholding a recommendation regarding coerced treatment; however, this decision may then infringe on other ethical principles. For example, when considering nonmaleficence, one may infer that a counselor's inaction can harm the client through passive negligence; therefore, the counselor must take action to protect the client's welfare.

When considering the case from the perspective of beneficence, a counselor may argue that because EDs, particularly AN, are undeniably lethal when untreated, interventions such as involuntary hospitalization may be necessary (Griffiths & Russell, 1998; Werth, Wright, Archambault, & Bardash, 2003). Perhaps a counselor would reason that compulsory treatment would not only prevent harm, but also promote psychological well-being in clients with potentially lethal EDs. In the hypothetical case study presented below, we provide an example of the multiple ethical dilemmas counselors working with EDs may encounter.

The Case of Lauren

Lauren, a 20-year-old, Caucasian, female who is sophomore at a private university in the United States, presented to counseling at the urging of her parents and campus life personnel. Lauren had a history of concerns with her weight that became apparent at the age of 15. Attempts at weight loss were coupled with frequent comments about feeling fat and the desire to lose weight. During the summer prior to her sophomore year of college, Lauren lost 25 pounds over the course of two months. When she came home during her next break, her parents noticed that Lauren's weight loss had progressed and they pleaded with her to get help.

After returning to school, Lauren fainted at the campus fitness center and was taken to the emergency room, where she was treated for dehydration, low blood sugar, and low blood pressure. She was told that her condition likely resulted from malnourishment. In addition to alerting Lauren's parents, campus personnel required Lauren to seek counseling before she could resume her classes. Lauren's parents contacted Carol, a licensed professional counselor, and provided her with reports from the hospital, which indicated that Lauren was 5'3, weighed 98 pounds, and had a body mass index (BMI) of 17.36 kg/m².

Lauren reluctantly met with Carol the following week and reported a willingness to attend counseling, if only to stay enrolled in school. Lauren signed

a release-of-information for her parents, but indicated that the information could be released for billing purposes only. She did however list her parents as emergency contacts. During the session, Carol shared her concerns with Lauren about the medical information she had received in the hospital reports. Lauren denied having problems with food or eating and reported feeling perfectly healthy.

Over several sessions, Carol noticed Lauren's face becoming increasingly gaunt and she appeared tired and lethargic. Lauren continued to deny being underweight and expressed frustration with constantly being questioned about her weight. Carol recommended that Lauren have a follow up medical examination and see a nutritionist. Carol utilized psychoeducational interventions with Lauren and emphasized the dangers of her low weight and the potentially harmful impact of maintaining her current behavior. Lauren reluctantly agreed to see her primary care physician and authorized Carol and the physician to share information. The physician notified Carol that Lauren now weighed 89 pounds and that her BMI had decreased to 15.77 kg/m². The physician also reported that she had recommended inpatient treatment to Lauren to ensure her physical safety because she was in danger of severe electrolyte imbalance and cardiac arrest; Lauren told the doctor that she would consider additional treatment. During their next session, Carol asked Lauren if she was willing to engage in more intensive treatment. Lauren refused, saying that the doctor didn't know her very well and that she only intended to placate the physician by telling her she would consider additional treatment options.

Ethical Decision-Making in the Case of Lauren

In her work with Lauren, it is clear that Carol was faced with a significant ethical dilemma. She wanted to promote her client's autonomy, but questioned Lauren's cognitive capability to make responsible and healthy decisions for herself. In the following section, the aforementioned case will be used to illustrate the application of an ethical decision-making model. Although there are many appropriate and useful ethical decision-making models, Welfel (2010) designed a ten-step model for ethical decision-making that encourages consultation, education, and thoughtfulness which is thorough, clear, and highly applicable to the type of ethical decision-making faced by counselors on a routine basis. The ten steps of Welfel's model are: (a) develop ethical sensitivity; (b) clarify and consider facts, stakeholders, and the sociocultural context of the dilemma; (c) define central issues and available options; (d) refer to professional standards and relevant laws or regulations; (e) search out ethical scholarship; (f) apply ethical principles to the situation; (g) consult with supervisors and professional colleagues; (h) deliberate and decide; (i) implement the chosen action and document; and (j) reflect on the experience. In the following section, each of these ten steps will be described as they apply to Carol's dilemma.

Step One: Develop Ethical Sensitivity

Attention to ethical decision making development should not only occur in the context of an ethically challenging situation, but should be developed intentionally over time. Carol's development of ethical sensitivity began when she studied both diagnosis and ethics during the course of her education. She completed an internship at a facility specializing in the treatment of individuals with EDs and attended professional conferences where she received additional training in ethics. Her experience and training were integral to her understanding of ethical questions involving autonomy, beneficence, and nonmaleficence specific to Lauren's case.

Step Two: Clarify and Consider Facts, Stakeholders, and the Sociocultural Context

Clients with EDs may intentionally withhold facts about their weight, eating behavior, and exercise (APA, 2009). Counselors must utilize clinical skills to assess and discern important facts. In this case, Carol made herself aware of the key facts that impacted her eventual decision. She knew Lauren wanted to keep her parents uninvolved in the details of her condition. Carol determined the medical facts surrounding Lauren's weight and health. She was aware of Lauren's tendency to deny the severity of her condition and of her probable path toward physical decline. Due to her weight loss, refusal to eat, continued intense exercise, and physical danger, Carol identified the primary stakeholder in this case as Lauren herself. Lauren's parents also had a stake in her recovery, as they would likely be harmed by her continued deterioration. Carol was aware that ongoing counseling would be essential to Lauren's continued enrollment at the university and that punitive measures could be implemented if Lauren was not successful in her recovery. Additionally, Carol considered the myriad socio-cultural implications on clients with EDs, such as the social pressure to be thin, which is often perpetuated by the media.

Step Three: Define Central Issues and Available Options

Counselors define the central problem by evaluating pertinent issues and assessing their likely impact on the client. The counselor brainstorms available options, remaining acutely aware of personal judgments and the impact of these beliefs on the decision-making process. Counselors may ask themselves whether, because of closely held attitudes, values, and biases, they are averse to any options in particular. In this case, Carol determined that the central issue was Lauren's life, which was likely in jeopardy due to her critically low weight. Carol identified a secondary issue involving the long-term health consequences of Lauren's current behavior. Carol brainstormed possible options, which included informing Lauren's parents of her dangerous condition, seeking involuntary hospitalization, or taking no action. Carol also thoughtfully considered her own

values and how her desire to preserve life may come into conflict with Lauren's autonomy.

Step Four: Refer to Professional Standards and Relevant Laws/Regulations

The ACA's Code of Ethics (2005) does not have a section that directly addresses specific mental health disorders like EDs, but instead provides a framework for promoting autonomy, beneficence, and nonmaleficence when working with clients. Carol found the following articles of the code to be relevant to her case: (a) A.1.a.- the primary responsibility of counselors is to respect the dignity and promote the welfare of clients; (b) A.2.b.- clients have the right to... refuse any services or modality change and to be advised of the consequences of such refusal; (c) A.2.d.- when counseling...persons unable to give voluntary consent, counselors seek the assent of clients to services, and include them in decision-making as appropriate. Counselors recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf; (d) A.4.a.-counselors act to avoid harming their clients...and to minimize or to remedy unavoidable or unanticipated harm; (e) A.4.b.- counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals; and (f) B.2.a.- the general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm...Counselors consult with other professionals when in doubt as to the validity of an exception.

Step Five: Search out Ethics Scholarship

In this case, Carol sought out scholarly books and articles about legal and ethical decision-making in cases of AN in which coerced treatment was de-liberated. Carol found research investigating the risks and benefits of involuntary hospitalization and sought out position pieces written by ethicists about the treatment of EDs. She discovered that coerced treatment does not necessarily serve to advance the progress of clients with severe EDs, but rather merely serves to provide temporary medical stabilization (Rathner, 1998). She also found three studies that investigated the outcome of involuntary hospitalization for clients with severe EDs (Griffiths, Beumont, Russell, Touyz, & Moore, 1997; Ramsay, Ward, Treasure, & Russell, 1999; Watson, Bowers, & Anderson, 2000). Russell (2001) summarized the results of these three studies and found that all of them indicated that clients who were hospitalized involuntarily experienced successful re-feeding on par with clients who were hospitalized voluntarily, although involuntary clients took longer to improve. Ramsay et al. (1999) found that, at approximately six years after admission, clients who had been involuntarily hospitalized had a higher mortality rate than those clients who were

admitted voluntarily. The researchers speculated that the higher rate of mortality was attributable to a higher severity of illness upon hospitalization. Watson et al. (2000) reported that short term treatment outcomes were similar between clients who were involuntarily hospitalized and those who were voluntarily hospitalized. Carol was perplexed by these mixed results; it is important to note that while searching for relevant ethics literature, a counselor may not readily find an answer to his or her dilemma. This is particularly true with EDs because of the controversy surrounding the issues of compulsory treatment and autonomy for clients with cognitive impairment. However, with further research, Carol found that after reaching a stable condition, clients often acknowledge that they did in fact need treatment and express appreciation for the intervention (Anderson, Bowers, & Evans, 1997; Goldner, Birmingham, & Smye, 1997; Guarda et al., 2007).

Step Six: Apply Ethical Principles to the Situation

At this point in the decision-making process, a counselor would examine possible courses of action and determine their fit with fundamental ethical principles. The ethical problem for Carol was finding a balance between promoting good, doing no harm, and maintaining autonomy. Carol was familiar limitations to confidentiality in cases of imminent harm to self or others and deliberated whether Lauren's unhealthy weight constituted imminent harm to self. Because she believed that Lauren would benefit from inpatient treatment and knew that parental or university involvement would likely enforce that recommendation, Carol considered taking this action to promote Lauren's well-being. Carol understood that doing so would infringe on Lauren's autonomy, although she realized that Lauren may have been cognitively impaired to the extent that her decision-making abilities were compromised. Carol weighed the risk of harm to Lauren's autonomy and to their therapeutic relationship against the risk of harm to the client due to further medical decline and even death.

Step Seven: Consult with a Supervisor and Respected Colleagues

In this step, a counselor may seek consultation from colleagues, supervisors, treatment team members, and medical professionals in order to generate ideas, gain objective feedback, and garner emotional support. Because EDs directly impact clients' health and are potentially life-threatening, seeking medical consultation is vitally important. Counselors may also seek ethical consultation by contacting the ACA Ethics and Professional Standards Department (1-800-347-6647, ext. 314; ethics@counseling.org).

Early in the course of counseling with Lauren, Carol sought consultation from a respected colleague who was well-versed in EDs and their medical implications. At a critical juncture, Carol pursued consultation with her colleague once again to consider her options. In addition, knowing that medical profes-

sionals can help counselors evaluate the physical risk and aid in the difficult decision-making process, Carol sought consultation with a physician who specialized in treating EDs.

Step Eight: Deliberate and Decide

Once the facts have been gathered, the counselor independently deliberates and decides on a course of action. Often, in emergency ethical decision-making situations, a counselor proceeds through the previous seven steps rapidly, as he or she must act quickly in order to best serve the client. During this step, even in light of likely time constraints, it is important that the counselor carefully and thoughtfully consider the selected action regarding the fundamental ethical principles.

In the previous seven steps, Carol examined her values, reviewed the facts of the case, applied related laws and ethical principles, and sought consultation. She reviewed research that suggested that in most cases, involuntary hospitalization resulted in immediate physical safety, rather than clinically significant progress for an individual (Carney, Tait, Wakefield, Ingvarson, & Touyz, 2005). Carol found herself agreeing with the assertion that involuntary hospitalization does not guarantee client improvement, nor does lack of treatment guarantee that a client will decline (Dresser, 1984; Rathner, 1998). However, Carol weighed her options carefully and decided that she would indeed inform Lauren's parents, her emergency contacts, with or without Lauren's consent. She determined that Lauren's rapid weight loss did constitute imminent danger and that Lauren's physical decline and continued self-harm required action on her part. She considered the alternative of taking no action and determined that the risks of allowing Lauren to proceed on her current trajectory outweighed the benefits of affording Lauren complete autonomy. Carol deliberated on the ways in which she could follow through with her decision while maintaining the most autonomy for her client.

Step Nine: Implement the Chosen Action and Document

Once the decision has been made, the counselor informs the appropriate people and implements the chosen action. If the counselor is currently working under supervision, the counselor will inform the supervisor of the decision before taking action. If the counselor decides to act against the client's will, such as enforcing treatment, the client may resist or feel betrayed by the counselor's decision. It is imperative that the counselor address a client's concerns and convey empathy even when implementing a decision that is directly against a client's wishes. In Lauren's case, Carol informed Lauren that she believed it was necessary to include her parents in the decision-making process regarding treatment. Carol expressed her fears for Lauren's life and conveyed that Lauren's safety was her primary concern. Lauren once again dismissed Carol's

concerns and minimized her condition. She expressed fear that her parents would be angry and that inpatient treatment would interfere with her life. She expressed disbelief that her condition was severe enough to warrant hospitalization. Carol listened empathically to and validated her concerns. She discussed the possible consequences of not informing her parents or pursuing inpatient treatment, including a possible continued decline in health and potential death. Once Lauren realized that Carol was informing her parents with or without her consent, she agreed to be a part of the process and do so on her own terms. Carol involved Lauren in decision-making as much as possible, including giving her the choice of calling her parents herself, helping her to look through various brochures about available treatment programs, and encouraging her to think about, among the various options, which would be the best fit for her. Carol made every effort to respectfully consider Lauren's feelings during the process. Together, Carol and Lauren decided to inform Lauren's parents by phone that day. Lauren selected a fitting treatment program and agreed to go once arrangements were made. Her parents supported her decision. In her case notes, Carol formally documented her consultation experience, research, decision-making process, and the actions she implemented.

Step Ten: Reflect on the Experience

After the decision has been made, implemented, and documented, the counselor then reflects on the process. In this case, Carol struggled with the difficult dilemma of balancing autonomy with beneficence and nonmaleficence. Reflecting on the first nine steps, Carol reviewed her actions, assessed the quality of her actions in each of the steps of the ethical decision-making model, discussed the process and outcome with her professional colleagues, and began keeping a journal about her experiences. The process of ethical decision-making in Lauren's case was difficult and stressful for Carol as she feared damaging the counseling relationship and, thus, harming her client. With much reflection, she came to the conclusion that the risk of imminent harm to Lauren necessitated action and that damage to their relationship was a necessary risk. By consulting with colleagues, Carol sought support and learned of others' similar experiences, which she found helpful. While Lauren was in treatment, Carol checked in with her progress and was relieved to learn that Lauren appreciated her decision to compel her to get help and that these actions translated into caring and concern. Although Carol did not do so, counselors may wish to seek additional formal supervision and/or attend personal counseling.

Whereas Carol ranked beneficence and nonmaleficence above client autonomy in her decision-making process in this case, other counselor may have drawn very different, potentially appropriate conclusions after implementing the same decision-making process. Because each client case is unique, conclusions to decision-making processes will likely also be unique. Once

again, there is no one right answer to any given ethical dilemma, including dilemmas involving ED cases.

Conclusion

Providing counseling to clients with eating disorders can be intense, complex, and ethically challenging work, as is evidenced by the case of Lauren. This case serves to illustrate that ethical decisions, even when carried out by experienced counselors, require careful deliberation over multiple steps. It should be noted that counselors who do not have training or experience in treating eating disorders may best serve clients by providing referrals in a caring and empathetic manner. In order to best balance ethical principles, counselors facing ethical dilemmas with any client, including those with EDs, will likely benefit from the use of an ethical decision-making model such as Welfel's (2010) model, which emphasizes training in ethics, utilization of consultation and available research, and reflection after ethical decisions are made.

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Essential Points of a Support Network Approach for School Counselors Working with Children Diagnosed with Asperger's

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Abstract

Asperger Syndrome (AS) presents unique challenges to both families and schools. Children diagnosed with Asperger's possess unparalleled characteristics in cognitive functioning and behavioral pattern. These children need extra attention and assistance in schools. School counselors require a strategy to successfully engage and support these children and to deal with multiple phases of difficulties. A support network approach is proposed in this article to assist school counselors coordinating resources in schools, families, and the community. This approach is discussed with essential points that will help school counselors reach out to families and the community and create a friendly and supportive environment for children diagnosed with Asperger's.

Essential Points of a Support Network Approach for School Counselors Working with Children Diagnosed with Asperger's

Children diagnosed with Asperger's face various types of difficulties. They have displayed dysfunctions in domains such as social interaction, atypical speech and movement patterns, and cognitive and sensory difficulties (Attwood, 2007; Baron-Cohen & Wheelwright, 2004; Boucher, 2009; Gibbons & Goins, 2008; Safran, 2005). Their families have to endure excessive stress because of working with these children (Ben-Sasson, Soto, Martínez-Pedraza, and Carter, 2013; Mori, Ujiie, Smith, & Howlin, 2009). The excessive stress will cause depressive symptoms among parents of these children (Zablotsky, Bradshaw, & Stuart, 2013). When these children enter the community, they are likely to receive unfavorable reactions from peers and adults.

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Children diagnosed with Asperger's are prone to be bullied and show atypical behaviors in social environments (Gill & Liamputtong, 2013; Sofronoff, Dark, & Stone, 2011). All these different phases of difficulties mark the complexity noticeable for school counselors working with children diagnosed with Asperger's.

Living under the harsh reality, children diagnosed with Asperger's demand full attention in schools to help them succeed in education. School counselors, whose main mission is to ensure students' academic success, need an all-around strategy to address the educational concerns, which result from the unique difficulties of Asperger's Syndrome (AS). Many books and articles have provided abundant information on the etiology and symptoms, as well as interventions, of AS (Attwood, 2007; Cao, Shan, Xu, & Xu, 2013; Freed & Bursztyrn, 2012; Hadwin, Baron-Cohen, & Howlin, 1999; Harpur, Lawlor, & Fitzgerald, 2006; Hendren & Martin, 2005; Hull, 2011; Pavlides, 2008; Rubio, 2008; Tsai, 2007); however, school counselors should call for the specifically designed strategy that will help them work effectively with unique difficulties faced by children diagnosed with Asperger's.

Gibbons and Goins (2008) listed major concerns in behavioral, academic, socializing, and transitional issues that are of concerns for schools counselors working with children diagnosed with Asperger's. They had suggested that school counselors should combine resources in schools, families, and the community to serve these children. The authors of this article intended to draw knowledge from literature and to use their experiences in mental health and school counseling to provide essential points that could be used to establish a support network for helping children diagnosed with Asperger's in school education.

Review of Literature

Asperger Syndrome (World Health Organization [WHO], 2010) is also known as Asperger's syndrome (Wing, 1981, 1998), high-functioning autism (Boucher, 2009), and Asperger's disorder (American Psychiatric Association [APA], 2000). Both the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) and the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) have listed AS in the category of the pervasive developmental disorders (PDD) (APA, 2000; WHO, 2010). A trend now is to use the term autism spectrum disorders (ASD) to describe autistic disorder, AS, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) (Shattuck et al., 2007). The new DSM-V has adopted this trend to give the diagnosis of "autism spectrum disorder" to AS (APA, 2013, p. 51). This means AS will not be a standalone diagnosis but become a diagnosis of ASD with a specified severity level.

Categorizing AS to be a subtype of autistic disorder continues to raise debates among scholars because AS demonstrates noticeable functional differences (Boucher, 2009; Ozonoff, Rogers, & Pennington, 1991; Safran, 2005; Wing, 1998). AS was described in DSM-IV-TR to show milder abnormality in language and cognitive development, self-help ability, and adaptive functioning (APA, 2000). Developmental abnormalities in social interaction, language and play are less significant (Frith, 2004; Volkmar, Klin, & Pauls, 1998). Many AS features and symptoms also resemble those of non-verbal learning disability (NLD), pragmatic language impairment (PLI), social phobia, obsessive-

compulsive disorder, and schizoid personality disorder (Boucher, 2009; Szatmari, 1998). The complexity of AS symptoms definitely reinforces the argument against merging AS with autism in ASD.

Etiology of Asperger Syndrome

Hanes Asperger once described AS to be "autistic personality disorder" based on common personality traits among AS patients (Attwood, 2007, p. 13). AS is believed to have multiple causes (Boucher, 2009). Genetic and neurological causes are major contributing factors but with unclear mechanisms (Volkmar et al., 1998; Wing, 1998). Hanes Asperger observed a genetic cause which might explain the phenomenon of AS symptoms existing in both parents and children (Asperger, 1991; Attwood, 2007; Volkmar et al., 1998). Brain imaging has been studied to investigate the neurological dysfunctions in AS (Boucher, 2009; Frith, 2004; Ozonoff, Dawson, & McPartland, 2002; Wicker, 2008). The genetic and neurological factors are crucial in the study of AS (Attwood, 2007).

The Theory of Mind (ToM) has been applied in AS research to explain AS symptoms (Attwood, 2005). ToM describes one's ability to project and exchange mental capacity with others. ToM deficiencies could originate in abnormal brain functioning (Attwood, 2005) and thus explain social impairment of children diagnosed with Asperger's as well as untimely cognitive processing and dysfunctions of empathetic reciprocity (Baron-Cohen & Wheelwright, 2004). Nonetheless, children diagnosed with Asperger's are known to have "average to above-average intelligence, social and communication deficits, obsessive and narrowly defined interests, concrete and literal thinking, inflexibility, problem-solving and organizational problems, difficulty in discerning relevant from irrelevant stimuli" (Myles, Cook, Miller, Rinner, & Robbins, 2000, p. 19-20).

Prevalence. AS is showing a prevalence rate of 26 to 36 in every 10,000 school-age children (Ehlers & Gillberg, 1993). Fombonne (2005) proposed an estimate of 13 in 10,000 for autism, 21 for PDD-NOS, and 2.6 for AS. A smaller prevalence rate and milder symptoms certainly dim the visibility of AS (Fombonne, 2005; Frith, 2004; Volkmar et al., 1998). However, the wide variation and complexity of AS symptoms make it difficult to categorize individuals diagnosed with Asperger's in a homogeneous group (Safran, 2005).

Medical treatment. Contemporary AS treatments focus heavily on reducing emotional and behavioral difficulties. Thus, psychopharmacological medicines are used as the first line of defense to target neuro-psychiatric symptoms (Tsai, 2007). Selective Serotonin Reuptake Inhibitors (SSRIs) "might improve anxiety, compulsive symptoms, repetitive movements, and social features" (Hendren & Martin, 2005, p. 65). Stimulants and mood stabilizers are prescribed for children's psychiatric and behavioral symptoms (Tsai, 2007). However, Tsai (2007) indicated that the combination of psychotherapy and medicines would significantly enhance the treatment process.

Therapeutic treatment. Various forms of therapeutic interventions have been developed to assist children diagnosed with Asperger's in symptom reduction and skills development. Cognitive skills are incorporated in occupational therapy to improve motor performance on daily tasks (Rodger & Branden-

burg, 2009). Intensive therapeutic models have been developed to emphasize on the effects of long treatment hours and structured treatment strategies (Solomon, Necheles, Ferch, & Bruckman, 2007). The applied behavioral analysis (ABA) and the developmental, individualized, and relationship-oriented (DIR) model are among the key modalities in the intensive therapy approach (Solomon et al., 2007). These interventions have been implemented in home environment, community agencies, and the schools to manage and improve AS symptoms.

Mental health treatment. The reduction of problematic behaviors and the improvement of daily functioning in homes, schools, and society have become main emphasis of non-medical treatments (Harpur et al., 2006; Myles et al., 2000; Nikopoulos & Keenan, 2006; Pavlides, 2008; Rubio, 2008; Whalen, 2009). Psychotherapy assists children diagnosed with Asperger's to learn essential coping skills (Bromfield, 2010). It also shows effective treatments on siblings, parents, and peers whom are inevitably impacted by children diagnosed with Asperger's (Harris & Glasberg, 2003). A wide variety of psychotherapy models is available. Cognitive behavior therapy (CBT) delivers effective results in AS treatment (Tsai, 2007). The ToM concepts inspire the mind reading approach to teach children social skills (Hadwin, Baron-Cohen, & Howlin, 1999). Art therapy, play therapy and sandplay therapy are available therapeutic models to treat children diagnosed with Asperger's (Cao, Shan, Xu, & Xu, 2013; Freed & Bursztyn, 2012; Hull, 2011). Using animal-assisted therapy and martial art in AS treatment adds available resources in the community (Pavlides, 2008; Rubio, 2008).

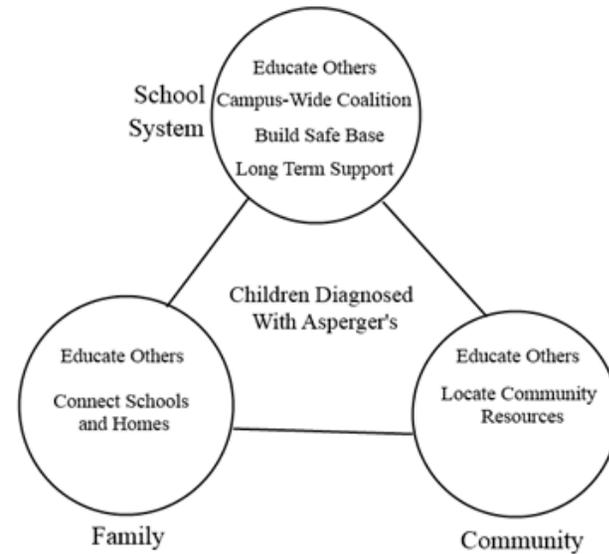
The Role of School Counselors

School counselors play an important role in the educational process of children diagnosed with Asperger's. Although school counselors have not directly involved with the diagnosis and medical and therapeutic treatments, they serve the role to collaborate and coordinate services among the family, community, and school (Gibbons & Goins, 2008). To become a coordinator of various services, school counselors should sketch a strategy gearing toward this function to satisfy the educational needs of children diagnosed with Asperger's. Based on our experiences in serving children diagnosed with Asperger's in the community and schools, we proposed six essential points, which will lay a foundation to a support network approach. This support network approach will be led by school counselors, who play the role of the coordinator to organize the efforts and resources in the schools, families, and the community to better serve these children.

Support Network Approach in School

Children diagnosed with Asperger's will encounter multiple phases of difficulties in schools (Gibbons & Goins, 2008). Considering these children's difficulties in socialization and cognitive and behavioral patterns, their learning process will be jeopardized even more when they face more difficulties in the families and community (Foley et al., 2012). Facing the complex situations these children have to battle daily, school counselors should consider utilizing a

support network approach to fully cover all difficult situations. A support network will reach out to teachers, peers, families, and the community to raise the awareness on AS symptoms. This network can also be connected vertically, from kindergarten to high school, to ensure a smooth transition when these children transit from one school to the other (Gibbons & Goins, 2008). The purpose of the support network is to go beyond the focus on AS symptoms to bring together the schools, families, and community in a collective effort to assist these children learn and grow. We illustrated these essential points and the support network approach in the following figure to explain how school counselors could construct a support network to link schools, families, and the community together.



Support Network Approach

The importance of using a support network approach is to turn the focus from AS symptoms to a networking of resources since multiple factors and situations will cause difficulties to be intensified among children diagnosed with Asperger's (Gibbons & Goins, 2008). These situations, such as the transition of changing schools, should be considered in the strategy to work with these children. Thus, a support network will emphasize on incorporating efforts and resources from teachers, peers, parents, community treatment providers in order to work with these children in schools, families, and the community. Networking certainly brings better benefits by helping these children in different environments and it will cover more grounds than working with these children alone in schools. The six essential points come from the current knowledge and our counseling experiences. These points could be used as the fundamental guidelines to sketch details steps for the construction of a support network.

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Educate others. Misunderstandings about childhood disorders do exist, such as individuals believing children will outgrow their disorders (Young & Gudjonsson, 2008). Children's strengths may be overlooked and difficulties underestimated due to lack of knowledge about AS (Sainsbury, 2009). Educating others will be a crucial action of advocacy for children diagnosed with Asperger's. This educational effort also serves as an outreach to families and the community by providing accurate information about AS and exchanging important knowledge among schools, families, and the community. School counselors could design guidance curricula and in-service presentations to educate school personnel and fellow students about AS, and they can hold meetings and workshops with parents and work with community service providers to advocate for these children.

Form a campus-wide coalition. A campus-wide coalition will provide a platform for all school personnel, who will be in contact with children diagnosed with Asperger's, to help each other on issues relating to working with these children. Children diagnosed with Asperger's can show difficulties "often related to lack of understanding, stress, or a defensive panic reaction" (Myles et al., 2000, p. 20). This coalition should include school counselors, teachers, special education teachers, and other administrators to work together on promoting the awareness of AS symptoms. The existence of a coalition will enhance its members' ability in working with AS since members will be able to share knowledge and skills. School counselors will serve as the coordinator of this coalition to coordinate the efforts and actions taken to help the children. This coalition will benefit the children and the schools by playing the role as a go-to center and crisis response team, which deliver expertise from different school professionals.

Build a safe base. A safe base is necessary for children diagnosed with Asperger's, who are prone to suffer from co-existing emotional deficiencies or mood problems (Baron-Cohen & Wheelwright, 2004; Kim, Szatmari, Bryson, Streiner, & Wilson, 2000). The comorbidity adds uncertainty to the existing difficulties on these children's behavioral and emotional stability. With the possibility of sudden emotional and behavioral outbursts, these children might have to retreat to a safe base where they can re-group and calm down with the help of school counselors. This safe base will be able to reduce unnecessary behavioral or emotional disturbances since these children will be able to receive help instead of escalating the conflicts in classrooms. School counselors could use the coalition to establish several safe bases where each child will receive attention from a teacher or counselor. This safe base will largely reduce the stress in the classrooms and the anxiety of children diagnosed with Asperger's.

Connect schools and homes. Teachers and parents differ greatly in perceptions of the severity of children's AS symptoms (Barnhill et al., 2000). It shows the discrepancy and distance between schools and homes. School counselors should involve parents in the process of helping their children to win parents' support and to assist parents with their difficulties at homes. A school-home connection will serve as a bridge to increase communication between schools and families. Knowing the stress and mental fatigue suffered by the parents of children diagnosed with Asperger's (Ben-Sasson et al., 2013; Mori et

al., 2009; Zablotsky et al., 2013), school counselors could use this connection to assist parents in reducing their stress and anxiety when going through the 504 application or IEP. This school-home connection will also provide an opportunity for school counselors to help parents seek effective treatments for their children and themselves in the community. Building a connection between schools and homes will benefit children diagnosed with Asperger's while they will receive synchronized support both in schools and at homes.

Locate community resources. Children diagnosed with Asperger's will likely receive treatments in the community (Gibbons & Goins, 2008). They also have the potential with comorbid disorders, such as depression, bipolar, attention deficit hyperactivity (ADHD), anxiety, and oppositional defiant disorders (Ghaziuddin, Weidmer-Mikhail, & Ghaziuddin, 1998; Kutscher, 2007). These disorders need community treatment programs to provide necessary medical and mental health interventions. There are also emerging treatment modalities, such as art therapy, play therapy, animal therapy (Freed & Bursztyn, 2012; Hull, 2011; Pavlides, 2008) and martial arts therapy (Rubio, 2008), which school counselors can refer children for effective treatment. School counselors want to obtain an updated knowledge about available treatment interventions in the community and to maintain an effective communication and collaborative relationship with these treatment programs. Collaborating with community resources will help school counselors cope with comorbid disorders of children diagnosed with Asperger's. This collaboration brings school counselors further understanding of these children's conditions and it also provide community resources where school counselors refer children and parents for effective treatment programs.

Establish long term academic support. Children diagnosed with Asperger's have the potential to achieve their goals when they receive help and support in each step of their education (Graetz & Spampinato, 2008; Palmer, 2006). These children will be able to attend colleges and become successful in various professions when they have been helped and guided all the way through the educational systems. School transition has been one of the problematic factors that will trigger negative reactions from children diagnosed with Asperger's (Gibbons & Goins, 2008). How to connect the support networks in different grade schools will become a primary task for school counselors to help these children smoothly transit to new schools. School counselors should expand their on-campus network to connect with other networks in pre-school, elementary, middle, and high schools. When networking becomes vertical, the networks will connect to each other and deliver synchronized assistance through grades. This vertically connected network structure will carry the support for these children all the way until they graduate from high school. The benefit of such connection is that children diagnosed with Asperger's will be familiar with the function of the network and build trust with adults in schools early in education. Thus, they will encounter less intensive difficulties when they have to change schools or go to a new school after graduation.

Implication

Considering the complexity of AS (Barnhill et al., 2000; Safran, 2005), school counselors will need a well-designed strategy to assist children diagnosed with Asperger's and to deliver advocacy and counseling services to them. In addition to assisting teachers' classroom behavior management, school counselors should realize that other situations will significantly impact these children's learning in schools (Gibbons & Goins, 2008). They will need a framework that will cover different needs of these children. The proposed support network approach aims to help school counselors establish a framework to provide all-around support to children diagnosed with Asperger's. A network becomes more effective because it involves people in different positions and setting to work together for these children. It is also beneficial when it will help school counselors reach out to parents and community service providers. This outreach will give school counselors opportunities to assist parents in home environment and to exchange knowledge with community service providers.

The objective of this network approach is to provide school counselors a blueprint to collaborate with on-campus and out-of-campus resources for creating an AS friendly environment. A support network will serve as a platform for professionals in school settings, parents of children diagnosed with Asperger's, and community service providers to find mutual support and expertise exchange for taking care of these children and to promote these children's success in education. The network will also acquire the ability to connect to treatment programs in the community and to build the collaboration between grade schools. The six essential points are proposed to help school counselors construct a support network among schools, families, and the community. This network will be grounded on campus but also garner resources from communities and homes. School counselors will find this concept of a support network beneficial to their work with children diagnosed with Asperger's because they can use this network to deliver services beyond classrooms and to connect with families and the community to provide these children various resources. School counselors can use the six essential points to sketch detailed plans for a support network. These points serve as guidelines that point to directions where school counselors will be able to connect to resources and individuals that are crucial to be included in the support network. A well-established network provides mutual assistance to all partners and supports children diagnosed with Asperger's to succeed in education.

Conclusion

Encountering children diagnosed with Asperger's in community and school counseling settings brought us challenging tasks. However, our experiences in serving children diagnosed with Asperger's raise the awareness on the lack of a well-connected support system existing among schools, families, and the community. There were times when these children and their parents were caught in the bureaucratic process and misdiagnoses. Although these children will receive the 504 plan or Individualized Education Program (IEP) in schools (Gibbons & Goins, 2008), not all of them will get it without a fight. Knowing these uphill battles faced by children diagnosed with Asperger's in the educational system, parenting, and community treatments, school counselors will be

able to anchor a role in this imperfect system and try to improve the situations for these children.

The essential points proposed in this article will be better used as guidelines for planning detail steps in the support network construction. These points lead to domains where detailed action plans will be created and later connected to form a network. We will need to suggest to readers that the essential points and the support network approach have not been empirically tested. It is important to further this discussion by constructing experimental networks to examine the integrity of these points and this approach. Future research will be needed to study the procedures of the network construction and to validate the effectiveness of such a support network in empirical experiments.

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- **The Michigan Counseling Association** is a not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession.

Founded in 1965, MCA is the state's largest association exclusively representing professional counselors in various practice settings.

By providing leadership training, publications, continuing education opportunities, and advocacy services for all members, MCA helps counseling professionals develop their skills and expand their knowledge base.

The central mission and purpose of the Michigan Counseling Association is to enhance human development throughout the lifespan and to promote the counseling profession. Additionally, the association purposes shall be:

- to promote and advance the interests of counseling services in the State of Michigan;
- to provide an organization through which those engaged in counseling services can exchange ideas, seek solutions to common problems, and stimulate their professional growth;
- to establish and improve standards of professional services in counseling services;
- to assume an active role in helping others in educational institutions and in the community to understand and improve counseling services;
- to conduct activities designed to promote the professional growth of counseling services in the State of Michigan;
- to disseminate information and to focus public attention on and promote legislation affecting counseling services in the State of Michigan; and to encourage the formulation and growth of Chapters and Divisions.



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OUR EDITOR

Dr. Jennifer Bornsheuer-Boswell is an Assistant Professor in the Counseling Department at the University of Houston-Victoria. Previously, she was an Assistant Professor at Oakland University in Rochester, Michigan. In 2005, she received her B.A. in Psychology from the University of North Texas and then her M.S. in Counseling and Development from Texas Woman's University in 2007. Recently, she completed her Ph.D. in Counselor Education from Sam Houston State University in 2012. The title of her dissertation was "Conservative Christian Parents Perceptions of Child Parent Relationship Therapy."

Dr. Bornsheuer-Boswell has over 5 years of clinical experience working with children, adolescents, and families in community settings. Her research interests include the use of Child Parent Relationship Therapy (CPRT) with children and parents, the use of play therapy and filial therapy with children who have experienced trauma, the inclusion of religious and spiritual beliefs in the counseling process and counseling programs, qualitative methodology, application of Adlerian theory and methods in supervision, and mentorship of women in graduate counseling programs. Dr. Bornsheuer-Boswell has authored and co-authored numerous articles; made professional presentations at national, state, and local conferences; and has been very active in state and national counseling organizations. She has received several awards including the Emily Oe Counseling and Development Play Therapy Award and Scholarship, the Outstanding Practitioner Award from the Beta Kappa Tau chapter of Chi Sigma Iota, the Outstanding Counselor Educator Award – Doctoral Student, and the Excellence in Writing Award from Sam Houston State University.