Prevention in Counseling Psychology: Theory, Research, Practice and Training is a publication of the Prevention Section of the Society for Counseling Psychology. The publication is dedicated to the dissemination of information on prevention theory, research, practice and training in counseling psychology, stimulating prevention scholarship, promoting collaboration between counseling psychologists engaged in prevention, and encourages student scholars. The publication focuses on prevention in specific domains (e.g., college campuses) employing specific modalities (e.g., group work), and reports summaries of epidemiological and preventive intervention research. All submissions to the publication undergo blind review by an editorial board jury, and those selected for publication are distributed nationally through electronic and hard copies.

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Submission Guidelines
The Prevention Section of the Society of Counseling Psychology publishes Prevention in Counseling Psychology: Theory, Research, Practice and Training. This is a blind peer-reviewed publication presenting scholarly work in the field of prevention that is distributed nationally. Contributions can focus on prevention theory, research, practice or training, or a combination of these topics. We welcome student submissions. As a publication of the Prevention Section of Division 17, presentations and awards sponsored by the section will be highlighted in these issues. We will also publish condensed reviews of research or theoretical work pertaining to the field of prevention. All submissions need to clearly articulate the prevention nature of the work. Submissions to this publication need to conform to APA style. All submissions must be electronically submitted. Please send your documents prepared for blind review with a cover letter including all identifying information for our records. Submissions should be emailed to Julie Koch, Managing Editor, at julie.koch@okstate.edu.
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Sally M. Hage

University at Albany

Prevention Section Initiatives

As Chair of the Prevention Section, I have the honor of working with so many committed, visionary leaders in prevention. Several of these talented leaders have put together this exciting new issue of the Prevention in Counseling Psychology: Theory, Research, Practice and Training. This issue inaugurates a new cycle of the prevention section publication. Our publication will be released twice a year, including a midwinter issue in February and a midsummer issue in July. I encourage you to consider submitting a brief report of a research project and/or a theoretical article or book review on a prevention related topic for one of the next issues!

Another exciting initiative of the Prevention Section is the development of the Prevention Guidelines for Psychologists, which are undergoing final revision as APA practice guidelines. These practice guidelines will provide psychologists with recommendations to facilitate best practices in prevention within psychological specialty areas. The Prevention Guidelines are organized into 4 specialty areas within the field of prevention psychology: a) practice b) research and evaluation c) education and training and d) social policy and legislative action.

Upcoming Events

The section sponsored symposium at APA Orlando this year will focus on the application of the Prevention Guidelines to diverse practice contexts, titled, “An Ounce of Prevention: Applying the Prevention Guidelines to Real World Contexts.” This symposium brings together an amazing group of scholars, including Andy Horne, Rebecca Toporek, Keith Herman, and Stephanie Coard, and the discussant will be Isaac Prilleltensky. These scholars from across specialty areas in psychology will share their ideas and real world examples of how they apply prevention practice, research, training and social action contexts. Don’t miss it!

The Third Annual Prevention Section Social, Award Ceremony and Poster Session will be held at APA. If you are a student, consider submitting a poster proposal to the Prevention Section for the 2012 APA conference in Orlando in August. Your proposal will be considered for both the SCP Poster Session and the Prevention Section Poster Social/Award Ceremony, both in Orlando. Also, consider nominating your favorite prevention scholar for the Lifetime Prevention Award. The recipient will be honored at the APA social event.

Signs of Hope

In closing, I am encouraged by so many signs of hope around us that a prevention orientation is beginning to take hold across the nation. One indicator of this shift was the release of the National Prevention Strategy (National Prevention Council, 2011) on June 16, 2011, by members of the Obama administration, led by members of the National Prevention, Health Promotion, and Public Health Council. Also, a recent poll indicated that 71 percent of Americans favor increasing our investment in disease prevention and making prevention a top priority in future health reform (Trust for America’s Health, 2009). Finally, Healthy People 2020 is now available, providing a comprehensive set of 10-year, national goals and objectives for improving the health and wellbeing of all Americans. Find it at healthpeople.gov/2020.

Thank you to all of the staff, contributors and editorial board members who put together this special issue. See you in August in Orlando!
Greetings from the Editorial Board

Welcome to the Winter 2012 issue of Prevention in Counseling Psychology: Theory, Research, Practice and Training, the publication of the Prevention Section of the Society of Counseling Psychology. The goal of this publication is to promote prevention theory and research. Within these pages, you will find new research that highlights recent efforts in prevention.

Ham and Shea provide an example of prevention in practice. They share their experiences from a pilot project with Latino parents of children who bully, a narrative therapy experiential group held at an elementary school. The authors provide a nice outline of an eight-session group that is replicable and highly relevant for the potential prevention of bullying through parental involvement. In another article, Dickson and Rinaldi review the literature related to health care disparities among LGBT patients. They provide suggestions for counseling psychologists, including ways in which counseling psychologists can promote the welfare of LGBT patients through collaboration with, and training of, healthcare providers.

You will also find five abstracts published here, four of which summarize work that was presented at the Prevention Section Student Poster Session at the APA Convention in Washington, DC in 2011. Ali and Waldo summarize a study about how the use of transformative mediation shows promise in helping families significantly improve their empathic listening and interpersonal learning. Gildar and Gonzalez Castro share a summary of a study of the prevention of drug-use relapse and its relation to self-efficacy. Toale and Brunner provide a review of the literature examining factors related to moral resilience among children at high risk of criminality. Yam summarizes a study of Chinese/Chinese-American and European-American attachment styles and, with Henderson, a study of Cambodian/Cambodian-American attachment styles. We are delighted that we are able to showcase these cutting edge prevention studies. More information on each of them can be obtained by contacting the authors.

Next issue, we would like to publish a description of your prevention work. We accept manuscripts addressing prevention theory, research, practice and training. We believe this is an excellent forum for sharing your work with prevention oriented colleagues. We encourage you to submit your own work for our next issue to Julie Koch, Managing Editor, at julie.koch@okstate.edu. The deadline for our Summer 2012 issue is May 15, 2012.
Message from Your Graduate Student Representative

Erin Ring
*University at Albany*

Special greetings to the students of the Prevention Section! Are you looking to advance your professional development and enhance your leadership skills? We enjoy collaborating with students in the field. I’d like to mention a few opportunities in our section geared specifically for you:

- Submit a proposal for the Division 17 Poster Session at the 2013 APA convention. Note that the Prevention Section also has a conference poster session specifically for our students. The poster session is a great opportunity to present your research, network with other students and professionals in the field, and meet recipients of the Prevention Section's annual research and achievement awards. By submitting your proposal to the Prevention Section for the Division 17 Poster Session, your proposal will automatically be considered for both poster sessions, allowing you to present at one or the other.

- Earn experience reviewing manuscripts by serving as a reviewer of the Prevention Section’s peer reviewed publication: Prevention in Counseling Psychology: Theory, Research, Practice, and Training. Contact Michael Waldo at miwaldo@nmsu.edu for more information.

- Submit your own research or abstracts to be included in our peer reviewed publication. Contact Julie Koch at julie.koch@okstate.edu.

- Help the Section with online media updates, including our website and social networking.

If you are interested in any of the above opportunities, or have additional ideas for your own involvement, please don’t hesitate to contact me at ering@albany.edu and I can provide you with some more information. I look forward to hearing from you!
Schools are being asked to respond to the needs of greater numbers of students with less financial and personnel resources. These needs increasingly include addressing aggressive behavior in children as young as elementary age students. Bullying behavior impacts the physical, mental and academic well being of students including the victim, perpetrator and often the bystander (Swearer, Espelage, Vaillancourt & Hymel, 2010). While there are as yet no best-practice models of school-based interventions targeted to reduce and prevent bullying, evidence suggests the critical need to include parents when attempting to address these and other behavioral issues in children (Cunningham, Cunningham, Ratcliffe & Vaillancourt, 2010; Swearer, Espelage, Vaillancourt & Hymel, 2010). School-based interventions may involve a whole school approach to bullying prevention as well as parental participation. Parents may be more accessible than counselors, and minimize stigma associated with seeking help from traditional mental health settings. However, research has yet to conclusively validate this approach (Hong, 2009; Soriano & Hong, 1997; Swearer, Espelage, Vaillancourt & Hymel, 2010). However, parent information and discussion sessions are a key component of the Olweus Bully Prevention Program, a comprehensive school approach that has spawned many of the current bullying programs (Kallestad & Olweus, 2003). Additionally, in economically austere times, including parents in school-based group intervention allows school counselors to provide comprehensive and integrated services to greater numbers of children and their families. The ideas for the research underlying this paper were an outgrowth of observations by both authors’ and their experiences in the schools. The first author was a researcher and School Counselor for many years in New York City. The second author worked extensively as a researcher in primary and secondary schools. Both authors identified the need for the school community to provide school-based involvement with parents and support for them that could significantly impact the success of their students.

The importance of this paper is that it presents the development of a narrative therapy group experiential model that with further development could be part of a larger school-wide bullying prevention program. The experiential group was piloted as a school-based, culturally responsive intervention for the parents of Latino elementary school-age children involved in bullying. The paper presents the curriculum used in the group sessions and explores the challenges of recruiting and involving parents in a bullying prevention intervention. The focus of this paper is the development of the training model. The paper does not provide outcome data evaluating the group intervention.

The Narrative Therapy Experiential Parent’s group on-site at a Los Angeles elementary school was developed to address a critical counseling need for children who bully and their parents, while at the same time providing a fertile training opportunity for graduate level counseling students as facilitators of these groups. The parents’ group took place in the spring of
Narrative Therapy Experiential Group

2011 in a Los Angeles area elementary school. The major tenant in developing the group was to create a bullying intervention and prevention tool for the school that addressed parents' own growth and development, as well as the key role that parents play in children's behavior. The Narrative Therapy Experiential Group provided specific training for graduate student facilitators to add to their repertoire of culturally sensitive skills used to service parents in school communities with limited counseling resources. Graduate level counselors were trained in narrative therapy and conducted the experiential group on-site with Latino parents whose elementary school children had been referred by the principal for aggressive behavior.

Narrative therapy, a post-modern therapeutic approach for addressing problems of individuals and family systems, allows for a divergent perspective on bullying behavior in children. The narrative therapy approach is known for the belief in externalizing the problem; the person is not the problem but the problem is the problem (White, 2007). Furthermore, it expands the discourse from that of the individual or family systems to a larger contextual arena (i.e., society, oppression, internalized belief systems). From this stance, the individual or individuals are not in a position of being blamed and bullying behavior can be explored from multiple perspectives.

Parents or primary caregivers are critical players in shaping the thoughts, behaviors and feelings of the children they raise. Research that implicates the role of adults (e.g., parents, teachers) in children’s bullying, their school experience, and interventions to date has mainly focused on individual characteristics of either the child or parent. That research has proposed resolving bullying on the individual level (Espelage, Bosworth & Simon, 2000). Additionally, numerous studies have found correlations between the bullying behavior of children and the role of the parent, suggesting parenting is an ameliorating factor or one that increases the risk of bullying behavior in the child (Georgiou, 2008; Holt, Kantor & Finkelhor, 2009). And it is likely that this relationship is reciprocal. Parents' thinking, behavior and feelings are also impacted by their children. Parents of children who have been deemed to exhibit problematic behaviors have been reported to demonstrate decreased parenting self-efficacy (Johnston & Mash, 1989). From both perspectives, there is inherent blame that either the parent or the child is causing a disruption in the functioning of the other.

Bullying intervention and prevention programs in schools have had mixed results (Cunningham, Cunningham, Ratcliffe & Vaillancourt, 2010; Hong, 2009; Jenson & Dieterich, 2007; Merrell, Isava, Gueldner, & Ross, 2008; Swearer, Espelage, Vaillancourt & Hymel, 2010). Some schools have addressed student bullying behavior and parental difficulties by offering student skills groups or voluntary or mandated parenting skills classes (Koffman, Ray, Berg, Covington, Albarran, & Vasquez, 2009). A narrative therapy, experiential parents’ counseling group is wholly distinct from a didactic, skill or behaviorally oriented parenting skills group that is commonly used to educate parents about parenting skills. The difference between teaching- and skill- based groups and our Narrative Therapy model is the experiential aspect—namely the focus on social emotional skills and the process of self-reflection, growth and development, as well as the parental peer connection forged by their common experiences. In particular, the emphasis of the Narrative Therapy Experiential Group is to take the blame off of the parents and encourage a collaborative environment where parents can develop alternative and empowered stories with each other that increase their own coping as well as their children’s coping skills. The group aimed to not only promote parents’ coping skills but to help parents understand their child’s experience, and increase their parenting self-efficacy.

Bullying and Parental Connections

Bullying is an age-old problem that today is being more formally recognized as an increasingly problematic and destructive behavior (Esbensen & Carson, 2009; Rigby, 2003). Not only has it extended to younger populations (Hartung, Little, Allen & Page, 2011), but also it has grown in proportion, as the level of violence is more extreme, at times resulting in fatalities (Klomek, Marrocco, Kleinman, Schonfeld & Gould, 2007). In the school context, a bully is defined as a student who has acted aggressively toward another or multiple students. According to the 2001 National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health (NIH), one out of four children have reported being bullied, and one out of five children have reported victimizing another child. The common elements of bullying include repeated, intentional aggressive acts in which there are differences of power between the perpetrator and the victim (Olweus, 1993, 2001). Bullying can take the form of either physical or verbal assaults—ranging from actual contact between perpetrator and victim (i.e., extortion, name-calling, teasing, or threatening with harm)—to psychological or relational harassment (i.e., spreading rumors, refusing to talk to someone, encouraging others to participate in bullying).

Several family and parenting characteristics have been implicated in bullying (Smokowski & Kopasz, 2005). Some studies suggest that bullies come from homes with permissive mothers and absent father figures (Curtner-Smith, 2000). However, blaming parents for their children’s behavior reinforces already engrained beliefs about parenting inadequacies. A more comprehensive view of the role of the parent includes parents as a critical protective factor for children. Research has supported parents’ roles as significant protective factors in children’s developmental trajectories (Masten & Coatsworth, 1998; Werner, 1996). Direct parental involvement has been found to be associated with children’s academic achievement (Epstein, 2001), positive school experience, enhanced social skills (Kohl et al., 2000), and reduced problematic behavior (Burke, Loebel, & Birmaher, 2002). The focus on parenting strengths is critical as positive child/parent interactions increase children’s resilience, self-esteem, communication skills, and peer relationships (Arbona & Power, 2003).

The caretaker/child connection is an important protective factor for all children but becomes even more important to bolster resilience in children who are at risk because of external factors (Masten & Coatsworth, 1998). Fostering healthy
parent communication and reducing parental stressors through a narrative therapy group approach is intended to insulate parents from societal demands that ultimately impact their interactions with their children. The first author noticed during her 8 years as a School Counselor in New York City that differences in acculturation levels between the child and the parent, demanding work schedules, and being an adolescent parent are a few external factors that contribute to the difficulties parents experience in connecting with their children. The protective factor of the caring adult connection becomes compromised in households with difficulty communicating and a lack of parent/child connection (Baldry & Farrington, 2005; McCabe, Goehring, Yeh & Lau, 2008; Perren & Hornung, 2005). Stressors in the home and conflicts with parents increase children's stress levels, decrease coping and lead to behavioral and school performance problems. There is a notable lack of studies that include racial ethnic group comparisons in the examination of the correlation between home stressors and children's behavior. Moreover, although Latinos are one of the largest and fastest-growing ethnic minority groups in the United States (U.S. Department of Homeland Security, 2009), they continue to be underrepresented in bullying research and interventions (U.S. Department of Health and Human Services, 2001). However, group interventions have been found to be an efficacious intervention modality with Latino clients (Rivera, 2003).

A Narrative Therapy Theoretical Orientation

Narrative therapy was chosen as the theoretical framework for training and group facilitation. The fundamental concepts of narrative therapy resonated strongly with the graduate students in training and ultimately with the parents. The graduate students expressed enthusiasm about learning a specific theoretical approach to work with parents, and they valued the postmodern stance of an inquirer seeking to generate alternative perspectives for the clients. Narrative therapy conceptualizes the problem as external to the individual rather than as a defining element of the person's identity, and expands the narrative to include the impact of oppressive cultural and societal forces (White, 2007). By separating and externalizing the problem from the individual and the family, a new, healthier and affirming narrative can evolve and develop (White & Epston, 1990). The focus of narrative therapy on deconstructing problem-saturated stories, re-authoring alternate stories by seeking unique outcomes to problems and preferred realities, uncovering strengths, and identifying internal and external resources. Narrative therapy is thought to be especially beneficial for immigrant parents who may feel helpless and distressed about their child's school functioning (White & Epston, 1990). Moreover, the de-centered, not-knowing inquiry stance of Narrative therapy's postmodern approach views clients as the experts in their life, and signifies a position of respect that is valued by Latino cultures (White & Epston, 1990, Cardona et al., 2009). This is a unique approach to examining bullying behavior and the children who bully by locating the problem in the cultural landscape versus blaming the individual (Winslade & Monk, 2007).

Externalizing the problem (or in other words, including alternative perspectives) helps parents understand their stressors within a larger contextual framework that de-emphasizes individual parental pathology and acknowledges these societal barriers and challenges. Narrative therapy fits perfectly with the basic philosophy and tenets of multicultural awareness and skills, and was hypothesized to work well with disadvantaged immigrant families in that it: (a) embraces the construction of multiple realities and appreciates diversity of voices; (b) helps individuals or families to challenge the oppressive values and beliefs of the dominant culture, including prejudice and discrimination; and (c) is strength-based and emphasizes social justice and advocacy for marginalized groups.

Rationale for the Group

Despite the prevalence of bullying in low-income neighborhoods, research has provided limited information on best practice and effective prevention programs in these often predominantly minority neighborhoods (Hong, 2009). Latino immigrant families, particularly those of low income, are likely to encounter a host of contextual and cultural challenges, such as language barriers, intense work demands, racism and discrimination, and acculturative stress (Cardona et al., 2009). Immigrant parents may also experience parenting difficulties due to long working hours, transportation problems, limited English proficiency, as well as unfamiliarity with the U.S. educational system and American culture. Any of these factors could result in parents’ inability to provide guidance for their children’s school development and their disengagement from the school (Ramirez, 2003; Turney & Kao, 2009). Different levels of acculturation and language preference could further intensify family stress and conflict between parents and child (Costigan & Dokis, 2006; Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002). Children of these immigrants are also more likely to live in low-income families where 50% have income well below the poverty level (Fortuny, Capps, Simms, & Chaudry, 2009).

The Narrative Therapy Parents’ Group was designed as a preventive family intervention intended to serve a large number of parents whose children are at the elementary level. The purpose was to improve family functioning and reduce familial conflict that creates stress in the family system, which impedes the learning at school and at home. It was our premise that by using a Narrative Therapy model, parents who are part of a brief interpersonal experiential peer group will be more able to handle conflict and become better communicators within the family, and thus improve the management of their own stressors. We hypothesized that increased parental awareness of family processes in a supportive peer group will lead to a change in parenting behavior that impacts children’s bullying in school, which in turn will improved academic functioning for their children.

The overall goals of the group were to: (a) help parents explore their own challenges and identify internal and external resources; (b) enhance parents’ social and problem-solving skills to build parenting self-efficacy; and (c) empower parents
Narrative Therapy Experiential Group

in the school community to assist one another and support their children during their educational development.

**Method**

Our narrative therapy, school-based, interpersonal, experiential parents’ group was developed to be part of the services to assist parents of children who have engaged in bullying behavior offered by an urban elementary school. Graduate students in a school counseling program were trained by an invited trainer and the authors to facilitate the group. Sessions took place at an elementary school in the Los Angeles vicinity primarily populated by low-income, ethnic minority immigrant students of Latino and Asian decent. Our group was comprised of Latino parents recruited through a process of self-selection following specific outreach to parents whose children had received referrals to the principal for aggressive behavior. Groups were initially offered in both Spanish and English. Only first generation Spanish speaking parents electing to attend. The focus on parents of children who bully was intentional; it was hypothesized that changes in the behavior of the children would be observable after the parent intervention. Bullying behavior is easily documented, particularly by school personnel who can observe and document changes in students’ behavior.

**Participants**

Parents and primary caregivers of children identified as bullies by school personnel were recruited for the group, with a focus on those whose children had received referrals to the School Principal for aggressive behavior. The parents were informed that they were recruited to be part of a parenting support group because their children had received referrals for services from the Principal for bullying behavior. The parents were also informed that there would be no negative school repercussions for choosing not to attend the group sessions. Those who agreed participated in a total of 8 sessions, which included an orientation session, six group sessions and a summary session. The group was conducted in Spanish by two bilingual facilitators.

**Program Descriptions and Procedures**

Group sessions were held once a week after school in a classroom for 1.5 hours for eight weeks. The elementary school personnel assisted in recruiting and referring parents, providing classroom space, snacks, and staff for after school child-care for participating parents. During the orientation session, the purpose and the structure of the group were explained to the participants.

**Training of the Facilitators**

For the purposes of this project, a cohort of Masters level graduate students was trained as group facilitators in Narrative Therapy Techniques. These students were enrolled in a School Counseling program at a public university on the West Coast. MaryAnna Domokos-Cheng Ham, a Psychologist and Counselor Educator specializing in Family Therapy with expertise in Narrative Therapy, conducted the training. The training included readings, an all day didactic and experiential seminar, an all day experiential workshop in the Tavistock method of the study of group dynamics, and weekly on-site supervision by the first author.

The unique opportunity for graduate students to receive specialized training and skills was part of the project goals. These students were trained as group facilitators in the urban schools where they will eventually work as professional school counselors. The training presented a unique opportunity for the graduate students to receive the specialized training and skills they would eventually use as professional school counselors. The students in California’s urban school system also benefited. This is a population that is traditionally underserved due to lack of consistent access to mental health, psychosocial and other vital support systems. The language ability, race and ethnicity of the facilitators closely mirrored those of the student body at the elementary school. The facilitators were asked to write weekly journals in order to further the learning experience and to receive individual feedback.

**Recruitment and Retention**

Development of the parenting groups at the elementary school was the first experience for the school community and principal in hosting a parents’ group facilitated by practitioners from outside of the direct school community. Recruitment for the groups was challenging. The downturn in the economic situation during November 2010-June 2011—particularly as it related to education in the State of California—greatly impacted recruitment for the group. During the recruitment period, the principal’s attention was diverted from recruitment due to pressure related to California State student achievement scores. This resulted in a relatively small pool of parents to contact, as well as delays in communication and receipt of crucial information to assist in the recruitment process.

Additional difficulties with recruitment were due to our narrow criteria for referring parents, which were intended to target bullying behavior. Instead, the school was referring students with a wide range of behavioral infractions. For example, two parents were originally referred whose children had serious behavioral issues beyond bullying. These students were transferred out of the school after the first group session and thus the parents declined to continue with the group. In another case, a parent was referred for a single incident of bullying behavior. After attending several group sessions, the group facilitators, who had come to know the parent, questioned the referral since it appeared that it was an isolated incident and the child was otherwise a model student.

Being outsiders to the school community was possibly the greatest barrier to recruitment. We tried to forge relationships with parents by establishing a presence on campus. Group facilitators attended parent-teacher conference days, parent assemblies and handed out flyers after school. The first author was on-site before, during and after the group sessions, to meet with parents and build rapport and answer questions. Experience with recruiting for the development group confirmed our intuition and the research findings; establishing rapport with the community of parents and creating a word of mouth...
reputation and network is critical to recruitment and engagement (Rodriguez, Rodriguez & Davis, 2006). After the original group sessions, parent participants enthusiastically volunteered to recruit for future groups and reported interest from parents who had heard about the group. Parents commented that the group was an important opportunity to get feedback from other parents and have a place to share their concerns.

Measures were taken to schedule groups on days of the week and at times that were conducive to parents’ schedules. Childcare and snacks were provided for both parents and children by the school in order to encourage parents to attend. Regardless of the measures taken to facilitate engagement, parents still have to manage external demands, including limited time to attend and life stressors that impede attendance (Dumas, Nissley-Tsiopinis, & Moreland, 2007). Parents were also made aware that the group was confidential and that the principal and teachers would not be informed of the content of the discussions. Despite the attempts to promote attendance, external demands on the parents greatly impacted their group participation for the 8 sessions. The following sections describe the individual group sessions.

Group Sessions

Session 1: Welcome and introduction. This first session was considered to be critical for development of the group as it set the tone for subsequent groups. Presented as a support group intended for parents who are experiencing challenges with their children, parents were told the group would be an opportunity for them to tell their stories and learn new ways to think about their children’s behavior. Facilitators were advised to focus on rapport building during all interactions, whether didactic or process oriented. Logistics were presented and discussed with a focus on including the parents as authority figures and equal members of the group. Facilitators were conscious of the possible power dynamics within the group and members were invited to discuss their expectations and what they hoped to achieve during the sessions. Student facilitators were asked to notice inter-group dynamics (e.g., alliances, ostracizing), along with verbal and non-verbal comfort levels and language issues. The anticipated outcome for parents from session 1 was that parents would be introduced to the group format, the members, and the facilitators.

Session 2: Telling the story: Parents’ narratives of their children’s problem behaviors. In this session we invited parents to identify situations that occurred with their children in school and at home, with a focus on the effect of these situations on the parent/child relationship. The facilitators explored the family constellation, asking parents questions about who resides in the home. Part of the work for the parents included helping them to externalize and map the problem, investigating the length, breadth and depth of the problem (Winslade & Monk, 2007; White, 2007). Examples of questions included: How long have you had this problem? What are its effects, and how deeply has it affected you as parent and/or other members of the family? Other important questions included: What was it like for you to learn about your child’s behavior from the school? What impact is the child’s behavior having on you at home? What actions work with your child? What are your unique strengths that keep you going during this time? Narrative therapy questions and circular questioning such as the examples given were used (Nelson, Fleuridas & Rosenthal, 1986; White & Epston, 1990; Winslade & Monk, 2007). These questions were asked of the parents in the group and they were also asked to consider the questions in relation to other members of the family unit.

The facilitator skills that were emphasized during this second session were continued in hopes of rapport building, assessment of the group dynamics, and exploring the present and future tense of the narrative. For example, what were the parents’ expectations for the future? In this way, the facilitators began the process of externalizing the conversation and looked for themes throughout the different parents’ narratives (White, 2007). Facilitators examined the strengths in the stories, the struggles that were overcome, and the transformations that occurred. Facilitators also attempted to discover what behaviors the parents were interested in changing in their respective situations and talked explicitly about change.

The primary goal of the work in this second session was to help parents conceptualize the parent/child relationship from alternative perspectives. The hoped for outcome was for parents to succeed in articulating issues related to the problem and begin to feel comfortable as active members of the group.

Session 3: Constructing meaning: Parents’ narratives of their story. In session 3, parents were invited to share their narratives, including examples of their own early memories of being parented. Facilitators asked questions such as: What are your early life stories about being parented? Who were your models for how to be a parent? What did you learn about parenting from these models? Who did you go to for support and help? Facilitators continued mapping and externalizing the problem and assessed the connections between the child and parent. The group was encouraged to help other group members evaluate the effects of the problem on the family. A critical question for all members was: What could the problem be if the problem isn’t the child’s bad behavior?

Counselor skills that were the focus of this session were encouraging an expanding narrative of the problem that included historical and familial contexts. The counselor asked parents to think about cultural, historical contexts and possible histories of oppression. Facilitators acknowledged the power of the narrative in parents’ lives and helped parents express curiosity and interest from a new and different stance or perspective. Every story has historical component and the storyteller interprets the events with particular attachments to the story. He or she chooses where to begin the story and what events to communicate, including placing the story in a specific time frame. Counselors assisted group members to examine how the parent/child relationship was situated in history and how it could be retold in the present. Reducing the influence of the problem on the family by heightening other aspects of the parent/child relationship was stressed. Interventions by counselors helped parents become aware of how the bad behavior influenced the structure of the family. Although the problem still existed, counselors explored how to shift the or-
organizing principal of the family away from the problem. Issues of immigration were salient during this session, as were differences between parents’ immigration narratives and those of their children. Immigration was explored as an issue that families could be united around. Expanding the landscape of the problem continued to be the parent outcome from group session 3.

**Session 4: Contextual issues: The impact of the dominant discourse and understanding the context of challenges.** The concepts in this session correlate with White’s concept of re-authoring conversations (2007). In this session the focus was on the inclusion of what members had learned from their participation in the group and from other group members about their stories. They were encouraged to include in their new narratives some of the unspoken parts of the story, recognizing that stories usually connect problems to a person unless the story is expanded (White, 2007). Parental values, decision-making styles, and coping styles were examined through a multicultural lens that included immigration and acculturation issues, as well as race, ethnic, gender and socio-economic factors. Facilitators asked parents to consider if the situation with the child caused the parent to react in a certain way, and what ideas the parent might have about why they reacted this way.

Counselors’ skills in session 4 focused on the inclusion of multiple perspectives and the impact of the diverse perspectives on the system. Facilitators looked at the variety of systems influencing the parents (e.g., family, school, the parenting group, community). A systems versus individual perspective was highlighted, thus the facilitator was encouraged not to evaluate one reality but to allow multiple realities to be expressed. The use of metaphors was an important skill for facilitators as they embraced a “not knowing” stance towards the problem (White, 2007). Parents’ identifying contextual elements related to the problem was the intended outcome of this session.

**Session 5: Continuing to externalize and re-author the problem.** Session 5 examined the influence of the child’s problem on the parents’ confidence. Facilitators asked questions such as: Does the problem make you want to give up? How much do cultural differences between the parent and child impact the problem? Parents were also asked to explore how their own parents and grandparents handled problem situations using memories and stories from the past.

Learning how to track family history themes such as listening for the commonalities over various generations was the counselor skill focused on during Session 5. The intended outcome of this session was to help parents become aware and acknowledge that they have learned parenting skills from other generations, and that parent/child interactions may be similar to those they had with their own parents and grandparents.

**Session 6: Re-authoring, discovering competence and constructing alternate stories.** Session 6 focused on continuing to help parents construct alternate stories and support these stories. Questions emphasized examining areas of the parents’ lives that remain unaffected by the problem. For example: What have each of you noticed about when the problem hasn’t been so bad? What have friends, relatives noticed about your child’s problem? Facilitators stressed helping parents to recognize the special skills and abilities each parent has, and what knowledge helped him or her to overcome the problem. Parents were able to add new people to their stories—providing an opportunity to upgrade some stories and downgrade others. By changing the membership around a problem, the problem can take on a different position in the life of the parent and child.

In session 6, facilitators continued to use circular questioning aimed at helping parents to see that they are parenting within an extended community of people (e.g., extended family, friends, and acquaintances from community activities).

**Session 7: Landscape of action (White, 2007).** This session focused on a summary of the impact of examining problems through the unique perspective of the group. Facilitators used a group focus and asked parents to identify similarities and differences in their parenting stories with those of the other members’ stories they heard. Parents were then asked to identify areas of competence in all of the stories. Parents discussed support systems currently in place in their lives that would help them to continue developing new ways of thinking, feeling and behaving. Parents were also asked to assess their learning experience, and discuss what approaches in the sessions worked best for them.

Group dynamic process skills and clarification of themes were important counselor skills. The desired parent outcome of Session 7 was to help parents identify child, personal, familial and group member strengths. Specifically, facilitators asked members to identify a specific life story of another member and state what he or she was drawn to or moved by in the story.

**Session 8: Termination.** The final session was an opportunity for reflections and goodbyes. At this time parents were given books as a gift for their children. Parents were reluctant to end the group and expressed a desire to continue sessions and help with recruiting efforts for future groups.

**Future Directions**

The experiential, Narrative Therapy group for parents was a unique service offered to a Los Angeles area elementary school. The school had never collaborated with a local university to receive such a service. Since schools are pressed for mental health resources—yet the demand for such services is prevalent—school based interventions that target the needs of more than the individual are in demand. Services are particularly needed at the elementary level in the Los Angeles area where schools often do not have a full-time school psychologist or school counselors. Schools are the logical place for an experiential parenting group since they are often conveniently located and parents are familiar with the facility and the personnel. The Narrative Therapy model was a useful model for our experiential group because it helped parents to externalize their respective problems, viewing each from multiple perspectives and rewriting a problem narrative by examining individual strengths and locating networks of support. Parents
bonded with each other through sharing experiences and exploring the narrative of these experiences.

We hope that the outline for the development of our group provides a useful template for others to experiment with implementing experiential focused parenting groups. Whole school prevention programs to reduce bullying have generally had disappointing results, possibly because of the complexity of the issue and lack of an overarching efficacy based theoretical approach (Swearer, Espelage, Vaillancourt & Hymel, 2010). Our efforts were to develop a prototype to evolve and test that could be part of a larger comprehensive school based program. Statistical analysis of the impact of our group was limited due to the small number of participants. Future endeavors to conduct school-based experiential groups need to address recruitment issues, including articulating clearer criteria for participation and enlisting parents’ participation in the recruitment process. Possible future papers based on the development of this group will include analysis of the qualitative content of the group sessions.

Feedback from our participants indicated that our group was helpful to the parents. They expressed gratitude for the opportunity to express their feelings in the group and receive support from each other. The group also provided an enhanced on-site learning experience for our students who will be future School Counselors in the Los Angeles area.

References


Narrative Therapy Experiential Group


Preventing Disparities in Primary Healthcare for LGBT Patients

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The realities of unequal access to healthcare, substandard treatment, and negative healthcare outcomes among minority and marginalized populations have been well documented (Agency for Healthcare Research and Quality [AHRQ], 2003). As sexual and gender minorities, lesbian, gay, bisexual, and transgendered (LGBT) individuals have unique medical and emotional needs that have historically gone unaddressed (Institute Of Medicine [IOM], 2011). Many of the obstacles to adequate healthcare that LGBT individuals face can be attributed to the effects of stigma related to non-heterosexual identities, orientations, and behaviors (IOM, 2011).

Although lesbian, gay, bisexual, and transgender individuals have unique experiences, needs, and issues, members of these distinct groups are often referred to collectively by the term sexual or gender minority or by the acronym LGBT. Despite their differences, individuals from each group share the experiences of marginalization and oppression as a direct result of their sexual identities, orientations, gender identities and/or gender nonconformity (Harper, Jerenewall, & Zea, 2004). Thus, for the purpose of this discussion the term sexual or gender minority and the acronym LGBT will be used to represent members of any or all four of these populations who experience obstacles to equal healthcare as a result of stigma.

Recent models of primary healthcare that coordinate behavioral health and primary healthcare services, integrative models, show promise in assuaging the obstacles that LGBT individuals face in attaining optimal health and wellness (Butler et al., 2008). As members of integrative healthcare teams, counseling psychologists are well situated to aid health care professionals in preventing many of the obstacles faced by LGBT patients (Tucker et al., 2007).

The purpose of this article is to highlight the unique medical and psychosocial needs of LGBT patients as well as some of the obstacles obstructing those needs. Moreover, this article will discuss the roles that counseling psychologists can assume within primary care to help prevent disparities in primary healthcare among LGBT populations.

Unique Needs of LGBT Patients

The healthcare needs of the LGBT population have been historically overlooked by researchers and practitioners alike (IOM, 2011). Recently, however, research into the unique medical needs and experiences of LGBT individuals within the healthcare system has increased. It was not until the third issue of their public health policy document that the United States Public Health Service (USPHS, 2000) issued a call for research examining medical and psychological needs within the LGBT community in an attempt to promote optimal health and wellness among sexual and gender minority individuals. Healthy People 2010 (USPHS, 2000) issued a mandate for medical research to further explore and establish the needs of LGBT individuals, so that they could be addressed in the future policy document that is issued every ten years.

Taking up the call of Healthy People 2010 (USPHS, 2000), several researchers documented the unique medical and psychological needs and risk factors of members of the LGBT community. Perhaps the most effective of these studies have been those that examined data from state and national health and behavior surveys. For example, Dilley, Simmons, Boysun, Pizacani, and Stark (2009) examined data collected between 2003 and 2006 from the Washington State Behavioral Risk Factor Surveillance System, an ongoing, population-based survey administered randomly over the telephone. The researchers found that lesbian and bisexual women were more likely than heterosexual women to have generally poor physical and mental health, asthma, diabetes, to be overweight, smoke, and drink alcohol excessively. Also, in comparison to heterosexual men, gay and bisexual men were more likely to have generally poorer mental health, engage in greater health-limited activities and be more likely to smoke (Dilley et al., 2009).

Conron, Mimiaga and Landers (2010) examined data collected between 2001 and 2008 by the Massachusetts Behavioral Risk Factor Surveillance survey, administered by a joint operation between the Centers for Disease Control and Prevention and the Massachusetts State Department of Public Health. The researchers found that sexual minorities were significantly more likely to report activity limitation, worry, smoking, drug use, asthma, and lifetime sexual victimization (Conron, Mimiaga & Landers, 2010). Additionally, they found that gay men were less likely to report annual prostate exams, while lesbians were more likely to report being overweight and having multiple risks for cardiovascular disease. Finally, they found that bisexual women were more likely to report binge drinking.

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and lifetime physical intimate partner victimization (Conron, Mimiaga & Landers, 2010).

Buchmueller and Carpenter (2010) also examined health disparities between men and women in same-sex versus different-sex relationships using data collected through the Massachusetts Behavioral Risk Factor Surveillance survey between 2000 and 2007. The researchers found statistically significant differences between same-sex and different-sex couples. Compared to women in different-sex relationships, women in same-sex relationships were less likely to have health insurance, less likely to have had a checkup within the past year, more likely to report unmet medical needs and were less likely to have had recent mammogram and Pap tests (Buchmueller & Carpenter, 2010). Similarly, they found that men in same-sex relationships were less likely to have health insurance and more likely to report unmet medical needs than men in different-sex relationships (Buchmueller & Carpenter, 2010).

Healthy People 2020 (USPHS, 2010) summarized the unique health disparities and risk factors within the LGBT population, such as increased prevalence of depression and suicide rates, obesity, substance abuse, and a lack of adequate health insurance. The report identified the goal to “improve the health, safety and well-being of lesbian, gay, bisexual and transgender (LGBT) individuals” (USPHS, 2010). Moreover, it advocated for continued practice of successful efforts to eliminate health disparities, such as physicians inquiring about a patient’s sexual orientation and identity and medical schools providing students and residents with greater exposure to LGBT patients (USPHS, 2010).

Obstacles to Health and Wellness

The Institute of Medicine (2011) identified two types of obstacles, personal and structural, that stand between LGBT patients and optimal medical and psychological wellness. Often, these obstacles can be traced to negative stigma attached to non-heterosexual orientations, identities, and behaviors. Personal-level barriers are the result of stigma and include the attitudes, beliefs, and behaviors of both health care providers and LGBT patients (Institute of Medicine, 2011).

Recent studies have shown that personal-level barriers continue to exist within the medical field. These barriers may take the form of heterosexism, or the belief in the superiority of heterosexuality as a sexual identity; homophobia, or active feelings of dread or hatred against sexual minorities; and heteronormativity, or the assumption that heterosexual relationships and practices are the universal norm within society (Irwin, 2007; Haley-Bailey, Adams, Dickson, Hitter & Luna, in press; Surtees & Gunn, 2010). Although active prejudice against members of the LGBT community has significantly decreased since the early 1980’s (Perrin, 2002; Smith & Matthews, 2007), it has not been altogether eliminated. Smith and Matthews (2007) re-administered a survey from 1982 to assess levels of homophobia and HIV stigma among a sample of practicing physicians. The results did indicate a drastic drop in both measures when compared to the 1982 results, but suggested a continued presence of homophobia and HIV stigma within the medical field (Smith & Matthews, 2007). For instance, 33% of surveyed physicians endorsed disagreeing or strongly disagreeing with same-sex marriage (Smith & Matthews, 2007). Similarly, 42% of those surveyed would not allow an asymptomatic student with HIV into a medical school, while 66% would not refer a patient to an asymptomatic general surgeon with HIV. In addition, the results indicated that homophobia was significantly correlated with HIV stigma. The researchers noted that year of graduation from medical school and level of homophobia predicted HIV stigma (Smith & Matthews, 2007).

Rondahl, Innala and Carlsson (2004) found that 36% of a sample of nurses and nursing students endorsed a statement indicating that they would abstain from seeing a homosexual or bisexual patient if they were given the option. Similarly, Riordan (2004) found a common theme among LGBT health workers in passing, or presenting themselves as heterosexual, in order to avoid potential intolerance from patients (Riordan, 2004). Recently, Wynn (2010) interviewed LGBT medical students regarding their experience of prejudice in medical school. The interviews revealed a high report of active discrimination among students against openly homosexual or bisexual students, the degree of which was found to be preventing closeted students from coming out. In addition, some students reported inadequate training in working with LGBT patient populations (Wynn, 2010).

The impact of heterosexism, homophobia, and heteronormativity within the healthcare system has been evidenced in surveys of LGBT patients. For instance, LGBT individuals have reported experiencing discrimination from health care providers that include rude behaviors, verbal abuse, the provision of inadequate treatment, and even refusal of treatment as a result of their sexual orientation and/or gender identity (Kenagy, 2005; Scherzer, 2000; Sears, 2009).

Previous discriminatory experiences with health care providers, fears of discrimination, internalized stigma and/or prejudice may prevent LGBT individuals from tending to their own healthcare needs. For instance, Willing, Salvador and Kano (2006) found that prevalent social stigma within a rural New Mexico community engendered safety concerns in LGBT residents, resulting in their unwillingness to seek mental health care directly from mental health professionals for fear of having to reveal their sexual identities. Instead, these individuals frequently utilized social support systems, such as family, community, and religious contacts, to attempt to meet their mental health needs (Willing, Salvador & Kano, 2006).

LGBT individuals may also internalize stigma related to non-heterosexual identities and/or behaviors and consequently view themselves as undeserving of optimal health. As a result, LGBT individuals may delay seeking necessary medical care, may not reveal their sexual orientation or other relevant information to health care providers, and may acquiesce to practices and policies that are discriminatory (Ponce, Cochran, Pizer, & Mays, 2010).

Structural barriers to optimal health care can exist in the absence of prejudiced attitudes among individuals. They can include institutionalized policies and procedures that limit LGBT individuals’ access to insurance and to practitioners.
who are knowledgeable and affirming of LGBT issues. For example, Irwin (2007) identified heteronormativity within patient admission forms administered by nurses. These forms included questions that assumed heterosexuality in asking about marital status and in presuming that a patient’s next of kin would be a spouse or biological family member. Kitts (2010) found that a majority of a sample of resident and attending physicians did not report engaging in best-practice techniques when working with adolescents who identified as homosexual or bisexual. For instance, of the physicians surveyed, 29% reported regularly discussing sexual orientation with adolescent patients, 11% reported regularly discussing sexual attraction and only 8.5% reported regularly discussing gender identity. Additionally, of the physicians surveyed, only 14% reported that they would regularly assess whether sexual orientation was a contributing cause if an adolescent patient presented with depression, while only 12% reported that they would do so if an adolescent patient presented with suicidal ideation or intent. Kitts (2010) also found that 22% of surveyed physicians reported that they did not know that there is a link between being an LGBT adolescent and depression, while 33% reported that they did not know that a similar link exists between being an LGBT adolescent and suicide. Finally, 51% of surveyed physicians openly admitted that they did not believe they had acquired the skills needed to work effectively within the adolescent LGBT population (Kitts, 2010).

Studies have shown that health care providers lack essential training regarding the unique needs of LGBT patients and are ill-prepared to provide them with culturally competent care (Makadon, 2006; Tesar & Rovi, 1998). The Association for American Medical Colleges Group on Student Affairs and the Association of American Medical Colleges Organization of Student Representatives {AAMC GSA; AAMC OSR}(2007) recommended specific training to facilitate effective communication with LGBT patients about sexual orientation and gender identity. However, a recent survey of medical school deans indicated great variability in regard to the content and quality of such training across different medical schools (Obedin-Maliver et al., 2010). In fact, over two-thirds of the deans surveyed rated their curriculum related to LGBT issues as “fair” or “worse” (Obedin-Maliver et al., 2010).

Current laws such as those preventing same-sex marriages are also structural barriers that have a negative impact on the health and wellbeing of LGBT individuals. For example, insurance companies extend coverage only to same-sex married partners and families; hence LGBT couples and their families are more likely to be uninsured than married heterosexual couples and their families (Ponce et al., 2010). Clearly, difficulties in obtaining health insurance can limit access to affordable primary health care for LGBT individuals and ultimately result in unmet medical needs.

Integrative Healthcare

Recent models of health care incorporate a holistic approach to meeting the medical and psychosocial needs of patients. Collaborative or integrative models of healthcare coordinate the services of mental health professionals (behavioral health care) with medical professionals (primary care) in order to meet the biopsychosocial needs of patients (Blount, 2003; Weaver, 2008). Research indicates that these integrative service models can be effective in reducing health disparities and improve patient health outcomes (Butler et al., 2008). Counseling psychologists are especially well prepared to make unique contributions to the provision of integrative primary care and the prevention of disparate care for LGBT patients.

Working within a multicultural paradigm is an integral component of the current training model for counseling psychologists. Counseling psychologists are well versed in the tripartite model of multicultural practice; they are aware of their own values and biases, knowledgeable about the populations with which they work and have the skills to intervene in a culturally appropriate manner (Ponterotto, 1997; Haley-Bailey et al., In press). In addition, counseling psychologists have been trained to address the influences of factors such as identity development, culture, family, and social/work environments on patients’ health issues (Suzuki & Ponterotto, 2008). Clearly, counseling psychologists can use their expertise to aid primary care providers in overcoming the obstacles to meeting the health care needs within the LGBT population.

Contributions of Counseling Psychologists

Tucker et al. (2007) outlined specific roles and strategies that counseling psychologists can utilize to augment patient health and prevention. Specifically, Tucker et al. (2007) discussed the roles of health care staff trainer and consultant, patient and community health empowerment coach, health counselor and psychotherapist, and health researcher. Counseling psychologists can provide direct and indirect services within each of these roles to help ameliorate the health disparities experienced by LGBT patients in primary healthcare.

Research has shown that although interventions at the training level, through medical school curriculum and didactic training, are the most effective means of increasing knowledge and skills and reducing prejudice, medical schools have fallen short in providing that training (Lock, 1998; Obedin-Maliver et al., 2010). Assuming the role of health care staff trainer and consultant, counseling psychologists can work on an organizational and individual level to enhance healthcare providers’ knowledge about LGBT issues and how to better address their unique needs. First, counseling psychologists can assist primary health care professionals and facilities in assessing their organizational policies and procedures related to LGBT healthcare equality (Association of Gay and Lesbian Psychiatrists [AGLP] (2007). For instance, counseling psychologists can adapt the rating criteria provided in the Healthcare Quality Index (Human Rights Campaign Foundation, 2010) to evaluate the organization’s policies regarding patient rights, competency training, and equal employment as they relate to the LGBT population. Based on the information gleaned from the assessment, counseling psychologists can develop and implement a plan to help ameliorate any disparities identified.

Second, as health care staff trainers and consultants, counseling psychologists can work directly with students, resident physicians, and other healthcare workers by providing training...
that focuses on LGBT issues and medical needs, multicultural competence, and communication skills. Counseling psychologists can use the on-line training curriculum sponsored by AGLP (2007) to expose healthcare professionals to didactic information regarding the unique risk factors and medical issues of the LGBT individuals and best practices for working with members of the LGBT population (AGLP, 2007). Counseling psychologists can use their expertise in multicultural counseling (Ponterotto, 1997; Haley-Bailey, et al., In press) to coordinate and/or provide workshops and didactic presentations dedicated to engendering knowledge, awareness, and skills specific to working with LGBT patients.

By assessing the attitudes of healthcare providers toward LGBT individuals, counseling psychologists can help increase awareness of negative attitudes and identify specific areas that need to be addressed through training (Tesar & Rovi, 1998). To increase awareness and knowledge, counseling psychologists presentations might focus on deconstructing biases and stereotypes surrounding the LGBT community and encouraging critical thinking (Haley-Bailey et al., In press). Including panel presentations by LGBT health care professionals can be an effective means of countering stereotypes and misperceptions (GLMA, 2006). To increase knowledge and skills, training could be focused on taking detailed sexual histories of all patients, which include asking about sexual orientation, partner status and sexual partners (GLMA, 2006). In addition, if a patient does belong to the LGBT community, health care workers can be taught to always assess for the specific risk factors unique to the community (American Academy of Family Physicians [AAFP], 2011).

Tucker et al. (2007) suggested that counseling psychologists are, on a most fundamental level, expert communicators. As such, counseling psychologists can teach health care providers how to engage in patient-centered communication by means of using effective verbal and non-verbal interview skills and conveying empathy and understanding (Tucker et al., 2007). As health care staff trainers and consultants, counseling psychologists can teach health care providers how to operate with cultural sensitivity and effectiveness (Tucker et al., 2007). Specifically, counseling psychologists can emphasize the necessity of being non-judgmental of LGBT patients and asking open-ended questions regarding partner status and sexual relations (GLMA, 2006). Additionally, they can inform healthcare providers of the importance of using inclusive and gender-neutral language, such as referring to one’s “partner” rather than “spouse”, and to avoid making heteronormative statements such as asking male patients about their wives or girlfriends (GLMA, 2006).

Consistent with patient-centered communication, counseling psychologists can train health care providers to follow their patients’ leads when it comes to how they describe their gender and sexual identities (GLMA, 2006). Health care providers can also be instructed about indirect forms of communication, such as conveying positive messages through health care settings or within patient forms. For instance, counseling psychologists can suggest the importance of displaying LGBT materials, such as Safe Space posters and brochures, in patient waiting rooms (GLMA, 2006). Additionally, they can assist healthcare workers in modifying patient forms to ensure that they contain inclusive language regarding partner status and gender identity (GLMA, 2006).

Counseling psychologists can also help promote wellness within the LGBT population by acting as patient and community health empowerment coaches (Tucker et al., 2007). Counseling psychologists can educate LGBT clients about their unique health care needs and risk factors and encourage them to utilize resources to advocate for their needs. Counseling psychologists can teach LGBT clients behavioral techniques, such as assertiveness training, to aid them in acquiring empowering communication skills to use as medical patients. These skills would also be useful in empowering LGBT clients to directly address public policy issues, including inequalities regarding health insurance (Buchmueller & Carpenter, 2010; Haley-Bailey et al., In press). Counseling psychologists can familiarize themselves with community resources so that they can connect LGBT patients with social networks, advocacy groups, and organizations from which they can draw support (Matthews & Adams, 2009). Moreover, they can apply for federal grants to establish programs that engender collaborations between LGBT organizations and health care centers (Tucker et al., 2007).

As health counselors and psychotherapists, counseling psychologists can work directly with LGBT clients to promote health and prevention (Tucker et al., 2007). First, counseling psychologists can address psychosocial barriers occluding optimal health in their LGBT patients. For instance, they can help LGBT patients dispute stereotypical myths that may contribute to their internalization of homophobia, which, in turn, may prevent them from seeking necessary medical care (Dickson, 2009). Second, counseling psychologists can help patients explore beliefs and attitudes surrounding health and wellness that may be detrimental to their health. Using techniques such as motivational interviewing, counseling psychologists can help patients change detrimental health behaviors prominent within the community, such as tobacco, drug and alcohol abuse and obesity (Dilley et al., 2009; Conron, Mimiaga & Landers, 2010). Finally, counseling psychologists can help LGBT clients cope with the effects of high risk diseases, such as HIV/AIDS, on themselves, friends, family and loved-ones (Tucker et al., 2007).

Finally, as counseling psychologists are trained as scientist-practitioners, they can help promote prevention and wellness in LGBT patient populations by conducting health research (Tucker et al., 2007). Given the scant research into LGBT health and wellness, counseling psychologists can challenge heterosexism within primary care through research that is affirming of the healthcare issues faced by the LGBT population (Matthews & Adams, 2009). Counseling psychologists can, for instance, conduct outcome research to examine the effectiveness of training in multicultural competency and communication skills for health care providers in promoting LGBT wellness. Such research could also examine the effectiveness of specific elements of this training in reducing disparities for LGBT patients. Counseling psychologists can present this re-
search at academic and medical conferences and publish in peer-reviewed journals as a means of more effectively disseminating conclusions (Turner et al., 2007).

**Conclusion**

LGBT individuals experience multiple obstacles in achieving optimal health and wellness, many of which can be attributed to the effects of stigma related to their sexual orientation and/or gender identities. Counseling psychologists are uniquely qualified to address many of the personal- and structural-level barriers that LGBT individuals face in accessing primary healthcare. Moreover, by assuming applicable roles and strategies, counseling psychologists can be instrumental in preventing healthcare disparities for LGBT patients and promoting primary healthcare services that are affirming, sensitive, and effective.

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Preventing Disparities for LGBT Patients


Enhancing Transformative Mediation to Address Family Conflict

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Poorly managed conflict in the family can lead to destructive consequences for children, such as increased aggression (McCoy, Cummings & Davies, 2009) and decreased ability to adjust to school (Sturge-Apple, Cummings & Davies, 2006). This outcome has been observed across families of diverse races and ethnicities (Chung, Flook & Fuligni, 2009; Emery, 1982). Mediation is a secondary prevention intervention that has the potential to help families constructively manage conflict (Emery, 1982). It has been shown to prevent destructive outcomes associated with family conflict (Pearson & Thoennes, 1989). Despite its benefits, 30 to 40% of family mediation clients complain of not feeling heard or understood (Pearson & Thoennes, 1984). Mediators have also often failed to attend to clients’ discussion of relationship concerns (Donohue, Drake & Roberto, 1994), despite clients’ desire to gain insight into their own and their ex-spouses’ feelings (Pearson & Thoennes, 1989). One form of mediation that holds promise to prevent destructive outcomes associated with family conflict is transformative mediation (Bush & Pope, 2004). However, no published research on the application of this mediation model to families currently exists (J. P. Folger, personal communication, October 19, 2010). In the current study, a traditional transformative mediation model was compared to a version that had two modifications. The enhanced version incorporated exposure to Relationship Enhancement communication skills as a way to improve participants’ feeling heard and understood. It also included guidance in how to give and receive interpersonal feedback as a way to improve participants’ discussion of relationship concerns. Using a true experiment, pre-test post-test control group design, 32 diverse families were randomly assigned to either a control group who received traditional transformative mediation or an experimental group who received enhanced transformative mediation. Sixty-six participants were involved in the study. The majority (n = 34) fell into the 36-55 age category, and 30 were aged 18-35. Males and females were evenly distributed in the sample. The majority of participants (n = 41) were bilingual English and Spanish, and identified as Mexican-American (n = 40). The results showed that no significant differences between the two groups existed in participants’ expressive speaking skills, empathic listening skills, interpersonal learning, agreement rates, or satisfaction with mediation, all p’s > .05. However, the entire sample’s empathic listening and interpersonal learning significantly increased from pre- to post-mediation, (p < .05). These findings suggested that transformative mediation, as practiced in this study, whether traditional or enhanced, showed promise in helping families significantly improve their empathic listening and interpersonal learning.

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Self-Efficacy in Relapse Avoidance:  
A Model of Prediction Using Drug Use History, Resilience, and Depression

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Substance use relapse rates are exceptionally high for people in treatment, ranging from 50% - 80%, depending on the drug and population studied (Moos & Moos, 2006). Self-efficacy in relapse avoidance is defined as a drug user’s belief that they have the ability to abstain from substance use after treatment. Higher self-efficacy to avoid substance use is predictive of better treatment outcomes, and is a factor in preventing relapse (Tate et al., 2008). Velicer, DiClemente, and Prochaska (1990) developed an integrative model of self-efficacy among cigarette smokers, which suggested that Positive/Social, Negative/Affective, and Habit/Addictive, are the types of situations that determine a user’s confidence in avoiding relapse. Further analysis is warranted to explore contributing factors that predict self-efficacy in relapse avoidance among drug users based on Velicer et al.’s categories. Drug use history, resiliency, and depression were used to represent these categories and research has demonstrated that each is related to self-efficacy in relapse avoidance. For a sample of drug users in treatment, we hypothesized that: 1) level of education would be positively associated with self-efficacy in relapse avoidance, and 2) lifetime and past year use of marijuana, heroin, cocaine, and methamphetamine, resilience, and depression would predict self-efficacy in relapse avoidance.

The current study draws on a subsample (N = 131) from the Corazón Life Journeys of Drug Users in Treatment study, which examined the lifetime trajectories of illegal drug users. Toward the end of their treatment, patients participated voluntarily in an extensive semi-structured interview, which consisted of multiple measures. The all-male participants’ ages ranged from 18 to 59 (M = 35.81; SD = 8.79). Participants were of varying ethnic identities, with 79.2% who reported being born in the United States, 15.3% indicated that they were born in Mexico, and 1.9% reported they were born in another country. For the present study, the Demographic Survey, Drug Use Survey, CD-RISC (Connor-Davidson Resilience Scale), CES-D (depression scale), and Self-Efficacy in Substance Abuse Scale were used. Variables in domains identified by previous research as predictors of self-efficacy in relapse avoidance were entered into a hierarchical multiple regression analysis. Constructs were entered in planned blocks: (Block 1 – control variable; Block 2 – past year drug use variables; Block 3 – resilience; Block 4 – depression).

This hierarchical regression analysis showed that a linear combination of these constructs accounted for 7.7% of the variance in predicting self-efficacy in relapse avoidance two weeks after treatment, F(7, 123) = 2.546, p = 0.018. Level of education, ΔR² = 0.044, F(1, 129) = 5.920, p = 0.016, past year marijuana use ΔR² = 0.042, F(1, 125) = 1.426, p = 0.035, and resilience, ΔR² = 0.037, F(1, 124) = 5.253, p = 0.024 were significant predictors of self-efficacy in relapse avoidance.

After controlling for levels of education, greater frequency of past year marijuana use was associated with lower self-efficacy in relapse avoidance two weeks after treatment. Depression was not a predictor of self-efficacy in relapse avoidance. Yet, prior studies have shown that depression among users significantly decreases after exposure to treatment (Harvard et al., 2006). Conversely, greater resilience was a significant predictor of greater self-efficacy in relapse avoidance. Future studies should expand on this finding.

The results of this study also have clinical implications for preventing substance use relapse. Clinicians could use these findings to identify patients that may be at the highest risk for relapse. Finally, there were limitations to our study, including data based solely on self-report inventories, a cross-sectional analytic design with post-hoc recall on some questions, design issues that should be addressed in a future investigation regarding the role of self-efficacy in relapse prevention.

References

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Factors Correlated with Moral Resilience among Children at High Risk of Criminality: A Review of the Literature

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This literature review examined a subsection of criminological literature by asking the central question: “What factors are correlated with children who exhibit ‘moral resilience’ (i.e., moral hardiness or persistence) even though they - due to risk factors in their lives - are more likely to commit crimes?” A compelling body of research indicates that children who grow up in certain conditions (e.g., low socio-economic status, being raised in abusive homes, or having incarcerated parents) are at significantly greater risk of engaging in behavior that is illegal. By examining the subgroup of youth who are exposed to these risk factors and yet still exude “moral resilience,” we can add to the existing literature identifying protective factors. Our review of the literature revealed multiple positive factors that seem to have a positive moral impact upon high risk youth. This review summarizes identified biological, perceptual/cognitive, and environmental “protective factors domains” that seem to deter or minimize the chances of criminality. Because the body of literature assessing factors associated with youth moral resilience is so small, there are not many clear data based trends currently. However, this review analyzed each of these three domains separately and found that prevention programs targeting all three of these domains had significantly better results in shoring up moral resilience among high risk youth than those that were more narrowly focused. It is worth noting that the largest scale study of moral development and resilience indicated that presence and strength of an internalized moral value system is a leading predictor of what we call “moral resilience.” The literature indicates that moral resilience is significantly affected by the environmental domain. Given our review, we suggest future directions for studies of moral resilience.

References


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Parent and Romantic Partner Attachment Styles Among Chinese/Chinese-Americans and European-Americans

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The study examined anxious and avoidant attachment patterns to both parent and romantic partner across two groups, 75 Chinese/Chinese-Americans (ages 18 to 55; mean = 28.32, SD = 8.8) and 75 European-Americans (ages 20 to 65; mean = 34.40, SD = 13.04). Participants were recruited from the San Francisco Bay Area to participate in an online self-report survey, the Experiences in Close Relationships-Revised (ECR-R: Fraley, Waller, & Brennan, 2000). The research questions were: (a) Are there differences between parent and romantic partner attachment styles in Chinese/Chinese-Americans and European-Americans? (b) Are parent attachment styles associated with romantic partner attachment styles among Chinese/Chinese-Americans and European-Americans? The hypotheses were: (a) There will be differences in the relationship between anxious and avoidant attachment to parent and to romantic partner among Chinese/Chinese-Americans and European-Americans; and (b) Anxious and avoidant attachment style to the parent will be positively correlated with the same attachment style to romantic partner among both Chinese/Chinese-Americans and European-Americans. Significant differences were found between the ethnic groups. Chinese/Chinese-Americans endorsed higher attachment anxiety and avoidance with both parent and romantic partner than did European-Americans. Though anxious attachment to parent and romantic partner were positively correlated in both ethnic groups, a positive correlation was found for avoidant attachment between parent and romantic partner only among European-Americans. Significant differences might imply cultural differences in how individuals relate to their parent and romantic partner, suggesting the need for more cross-cultural research on parent and adult attachment. Results from additional research could inform preventive interventions focused improving couples’ relationships and parenting.

Reference

Parent and Romantic Partner Attachment Styles Among Cambodian/Cambodian-Americans

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This study sought to evaluate parent and romantic partner attachment among Cambodian/Cambodian-Americans, building on a previous study with Chinese-Americans and European-Americans (Yam, 2007). Ninety-three Cambodian/Cambodian-American participants (ages 18 to 63; mean = 30.80, SD = 10.97) were recruited from a Buddhist temple in the Northwestern United States during a celebration. Two versions of the Experiences in Close Relationship-Revised Scale (a 36-item self-report instrument, ECR-R: Fraley, Waller, & Brennan, 2000) were utilized, one pertaining to anxious and avoidant feelings toward a parent, and one pertaining to these feelings toward a romantic partner. The research question was: Are there differences between parent and romantic partner attachment styles in Cambodian/Cambodian-Americans? The hypotheses were: (a) Anxiety and avoidant attachment style with the parent would be correlated with anxiety and avoidant attachment with the partner; and (b) Gender differences would be apparent for both parent and romantic partner attachment. A positive correlation was found between anxiety and avoidance with parent and with romantic partner. Chi-square analyses indicated a significant interaction effect between gender and attachment to partner, but not to parent. The results suggested that parent attachment patterns may tend to be transferred to the romantic partner relationship, consistent with Bowlby’s (1973) attachment theory. The study also found that women felt less secure in romantic relationships than did the men. One might speculate that war trauma may have been passed down inter-generationally, disproportionately affecting women over men. These findings do not support assertions of causality, but instead provide data for the formation of new hypotheses. The results may inform the focus of preventive interventions designed to improve relationships for this population.

References

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