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On Going Beyond Counselling:
When more is needed

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Every counsellor can reflect back upon cases where they have had a positive impact facilitating a client's improvement of his/her life and social wellbeing. These are our 'success stories'! As such, they should be wrapped-up in a velvet cloth and stored away in memory. Because unfortunately, we also encounter discouraging cases when our counselling interventions failed and our client's life continued in a downward spiral. It is in these times that we can become discouraged and self-doubting. This is when we need to un-wrap those success stories and remind ourselves of what is possible.

But, though counselling failures haunt every counsellor, they also provide us the best opportunities for our own professional development as well as the growth of our profession. Failures call upon us to engage in deeper reflection. To reflect on the counseling process and the assumptions upon which we base our practices. What did we miss? What more could have, or should have, been done? Applying a medical analogy, we might ponder whether it was incorrect treatment or the correct 'treatment' but insufficient dosage. Did we treat the wrong patient? Did we take too narrow a focus when a broader, more comprehensive treatment plan was needed? Did we focus only on symptoms and miss key underlying issues? It is out of our failures that we can learn the most to further develop and improve counselling intervention effectiveness!

There are many practices today that undermine counselling needing to be addressed. For example, children ages 5 -17 are all too often receiving daily psychotropic medications (many 3 or more) prescribed by a pediatrician or psychiatrist to 'control' their behavior. The child, parents, and teachers are thus told the problem stems from some unverifiable neurological dysfunction; i.e., there is something 'wrong' with your child's brain. Hardly an empowering 'growth mindset' perspective! The role of environmental and developmental factors are largely ignored!. Similarly, school practices all too often are embedded in moral narratives employing counterproductive, punitive methods that serve to exacerbate problems.

Then, there are adult clients who have been in and out of counselling for decades. Often, they are barely "treading water" and not progressing toward a healthier, more fulfilling life. Such clients often relate long histories of unimaginable adversity, trauma, abuse, and neglect that takes every bit of a counsellor's strength just to listen to let alone endure as the clients themselves have done. But again, they're repeatedly told it is their 'abnormal' brain functioning or chemistry, that accounts for their substance abuse, depression, anxiety, or 'lack of motivation' that needs to be "controlled" by medication. What can counsellors do to actively counter these messages to

clients (and public in general) with more accurate, optimistic, and empirically supported information?

Gabor Mate has noted that there currently exists a great paradox in the mental health field stating that, while scientific knowledge regarding the etiology of mental health difficulties has expanded greatly, the practical applications of this knowledge to treatment lags far behind. The symptom control focused intervention strategies of psychopharmacology and reward/punishment behaviorism have failed. Moreover, their underlying assumptions are not supported by research evidence. Yet, these moral and psychobiological based narratives for mental health difficulties continue to dominate.

This research vs. practice discrepancy is readily observed in the Adverse Childhood Experiences (ACE's) research. Abuse and maltreatment in the home, adverse workplace and community environments, counterproductive judicial institution practices, adverse school and classroom cultures (school to prison pipeline) have all been empirically identified as contributing to psychosocial adjustment difficulties. Can an hour or two weekly of personal counseling adequately address the needs of our most damaged or vulnerable clients? Are we as counsellors sometimes overestimating the potential of our counselling skills alone to help certain clients? Should we not also look beyond counselling to address adverse practices in families, schools, workplaces, medicine, etc. viewing these as also "our clients"?

Reflecting upon counselling failures often leads to recognizing that we need to go further, to broaden our counseling lens! Alfred Adler, one of the founders of modern counselling practice, stated in the early 20th century that, *"The honest [counselor] cannot shut [his/her] eyes to social conditions which prevent the [individual] from becoming a part of the community and from feeling at home in the world, and which allow him to grow up as though he lived in enemy country. Thus, the [counsellor] must work against… unemployment which plunges people into hopelessness; and against all other obstacles which interfere with the spreading of [mental health] in the family, the school, and society at large"*. How do we complement our counselling services with additional resilience, wellbeing promoting experiences to counter the adverse life conditions clients have experienced and to which many when they leave our offices?

Programs that go 'Beyond Counseling'

Fortunately, there are some programs that have achieved great successes by going "beyond counselling". These programs go beyond the healing of social-emotional wounds via counselling alone and also incorporate opportunities for clients to experience themselves as valued, competent people capable of making a valuable contribution to their community. The outcomes are most encouraging!

In effect, these 'Beyond Counseling' initiatives have combined the findings of Alexander's Rat Park Studies with Felleti & Anda's adverse childhood conditions research. All have demonstrated that when opportunities are provided for healthier social experiences, lives can be more effectively turned from risk to resilience and psychosocial well-being. Let's examine just a few examples.

The Icelandic Youth Model: This is an adolescent substance abuse prevention initiative that has succeeded in decreasing teen alcohol and drug abuse by approximately 50 percent. The

focus is on providing access to greater positive extra-curricular activities along with increased school, family and community. This program has now been successfully adapted to over 50 communities across 20 countries. (*www.drugsandalcoholni.info/iceland*)

The Valued Youth Partnership: This internationally recognized model was developed by the Intercultural Development Research Council likewise took a more comprehensive, social wellbeing promotion approach. The focus is on reducing school drop-out rates among "at-risk" youth between13-18 years of age. Key to the program's success has been its philosophy that "*all students can actively contribute to their own and other's education*". Participants are provided tutorial support but also assigned 3 younger-aged students to tutor several hours per week serving as tutor/mentors. The results indicate participant rates of school drop-out dropped to under 2% as opposed to the control group's 20%. Self-esteem, academic achievement and school attitudes among participants also improved significantly. (*www.idra.org/valued-youth*)

Project LIFT: The Life Initiatives for Teens project works with the most difficult youth in the community who present with a history of substance use/abuse, delinquent behavior, poor school performance, poverty, and dysfunctional family environments. While most adolescent intervention programs have only a 20% success rate, Project LIFT achieves a 72% success rate of participants not returning to the juvenile justice system for substance abuse or delinquent behavior and 80% voluntarily continue on in the after-care program. Key elements of the program include counselling support (from licensed counsellors) offered in non-traditional formats, a family-style meal together each evening, life skills workshops, and paid vocational skills training in a variety of trades.

Project LIFT also utilizes a community service model with vocational training program products donated to community members in need. This includes food from agricultural program to local food banks, automobiles rebuilt/repaired and given to families in need, donated construction projects, and refurbished bicycles for needy children. Rather than functioning from a *one-down, "*recipient of services" position, Project LIFT participants experience life from an e*mpowered* "providers of services" position. (*www.projectliftmc.com*)

How then do we work to better assist those clients for whom counselling alone proves to fall into the "*right prescription but insufficient dosage*" category? What resilience-based, social well-being methods need to accompany our counselling services to better counter the profound adverse life conditions they have experienced and may still experience when they leave our offices? This is perhaps the next growth step in the further development of the counseling and mental health fields.