Society is preoccupied with physical attractiveness. Some may call it a beauty obsession, although the word beauty encompasses much more than a pretty physique. While preoccupation with appearance impacts both males and females, this article focuses on body image concerns of women and girls.

Nowadays, physical beauty for women and girls is inextricably attached to thinness (Choate, 2007; Fox, 1997). However, concerns with appearance are not a peculiarity of modern culture; every historic epoch conveyed a certain standard of beauty (Fox, 1997). For instance, in the 19th century, to reduce the size of their waistline, women wore tight corsets that caused difficulties breathing. Today, women endure grueling diet and fitness regimens that promise an ultimate level of physical fitness and beauty. Although people take after our ancestors in the admiration of an ideal appearance, today, veneration for beauty impacts females in a more insidious way.


The proliferation of mass and social media cause beauty concerns to turn into obsessions (Grabe et al., 2008). Media messages women and girls receive on a daily basis communicate a female image that is air brushed and altered. Frequently, this pursuit for the ideal body image leads to disappointment, preoccupation with appearance, and often self-harm. In addition to media messages, familial attitudes may contribute to increased body dissatisfaction in girls (Choate, 2005). Family can exacerbate negative body perception by modeling behaviors that focus on shape issues, as well as making negative remarks about weight, eating behaviors, general family dysfunction and negative communication (Choate, 2005). While contributing factors of body dissatisfaction may vary, the outcomes of that dissatisfaction are similar and troublesome:

- Research shows up to 90% of adolescent girls are dissatisfied with some parts of their body.
- 13% of 15-17 year old girls suffer from an eating disorder.
- Studies show up to 80% of 10 years old girls are afraid to be fat. Young girls are more afraid of becoming fat than developing cancer or losing their parents.
- 7 in 10 girls believe they do not measure up to their peers in some way, including their looks, performance in school, and relationships.
- 80% of 10-year-old girls have dieted.
- 90% of high school junior and senior girls diet regularly.
- 1 out of 5 girls skip class if she does not feel good about her appearance that day.
- Studies show the more reality TV a girl watches, the more likely she is to focus on her appearance.

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The counseling field emphasizes a wellness and holistic approach to human development and growth (Choate, 2007). Because body image dissatisfaction is a pervasive issue that impacts normal growth and development of many women and girls, counselors should play a role in devising strategies to address these concerns with women and girls (Choate, 2005).

Research on body image consistently shows a successful approach to working with this concern encompasses multiple factors of a girl’s environment (Choate, 2007; Gabe et al., 2008). Therefore, counselors should emphasize wellness and holistic approaches to developing protective factors in adolescent girls’ lives that moderate the impact of social norms related to beauty. According to Choate (2007), these protective factors include: (a) family and peer support, (b) gender role satisfaction, (c) global and physical self-esteem, (d) coping strategies and critical thinking skills, and (e) holistic wellness and balance.

Considering the ubiquity of body image concerns, counselors should be prudent in screening body image issues in all youth. Counselors can focus on fostering a healthy body image by engaging youth and their families in prevention and psychoeducation (Choate, 2005). Counselors can assist girls and women in developing strong social support networks and work with parents to promote family as the foundation for supportive relationships (Choate, 2005). In schools and colleges, counselors can help create curriculums that focus on self-esteem and media literacy education. Recognizing the role of peers during adolescence, counselors can empower girls to develop groups of peers who do not promote restrictive eating practices or pursue the thin ideal (Choate, 2005). Counselors can play a role in discouraging “fat talk” and “diet talk”, and educate girls about the deleterious impact of long-term dieting (e.g. slower metabolism, increased proneness for binge eating, eventual weight gain) (Choate, 2007). Most importantly, counselors can work with girls and women in helping them to embrace a definition of beauty that is not tied to appearance (Choate, 2005; Gabe et al., 2008).

References


Considerations for Counselors Working with College Students

Emily Holden
Masters Student

Mental health clinicians and counselors in training who work in a university setting have numerous considerations to make in terms of providing therapy to a distinct population, college students. While recognizing the myriad aspects that mark college students as a unique demographic of people, clinicians working in a college counseling center may benefit from increased awareness of specific and primary characteristics of university students. This entails an understanding of developmental psychology or the different stages within models of ‘normal’ human development (to comprehend the cognitive, physical, and emotional development of university students), an adherence to confidentiality to protect student mental health information and records, and multicultural competence on the part of counseling center clinicians. This article will focus on the first issue regarding knowledge of adolescent development, as it influences the concerns that college students present and the approach clinicians might take in conceptualizing their college client’s concerns.

Studies indicate that college students are particularly vulnerable to mental health disorders due to their level of cognitive and emotional development, as well as a general lack of experience and autonomy in “the real world” away from their primary caretakers. Considering this, clinicians may benefit from education on the developmental stage of college students, who are widely categorized in the stage of adolescence. While some international agencies define the age bracket of adolescence differently, it is now generally accepted that individuals between 10 and 24 years of age fall within the adolescent stage of human development. For instance, by the standards of The United Nations Population Fund, adolescents are individuals between the ages of 10 and 19, while by the classification of the World Programme of Action for Youth, the World Bank, and the International Labor Organization (ILO), adolescents are described as “youth” between the ages of 15 and 24 (UNICEF, 2005, p.1). Yet, as Casey, Jones, & Hare, 2008 describe, the overarching consensus among international standards is that adolescence is a time characterized by “suboptimal” decisions and actions correlated with an increase in accidental pregnancy, sexually transmitted diseases, unintentional injuries, violence, and substance abuse (p.111). Due to the developing judgment, individual identity, and cognitive ability of adolescents, clinicians can reflect on the risk factors that may impact their college student clients.

Furthermore, in light of recent research on adolescent behavior and advanced imaging studies of neural responses in the adolescent brain, researchers, health care providers, and other experts agree that early, middle, and late adolescence is a time marked by some turbulence and transition related to biological, psychological (cognitive), and social changes (UNICEF, 2005, p.2). Such studies reveal that as early as elementary school, some students present with anxiety and mood disorders, indicating the early onset of psychological distress and mental health treatment for adolescents (Kay & Schwartz, 2010, p.1). Following such psychological distress in early adolescence, recent neurobiological models indicate that risky behavior and emotional “reactivity” in college-age students is the result of “a biologically driven imbalance between increased novelty and positive sensation seeking in conjunction with immature ‘self-regulatory competence’” (Casey, Jones, & Hare, 2008, p.118). This data can inform counselors of the trajectory of mental health of college students and the fundamental impact of adolescent cognitive and emotional development on their behavior, decisions, and presenting concerns.

However, despite statistics showing that mental health disorders are prevalent among the college student population, a substantial number of university students avoid seeking help for their psychological distress because they fear being associated with stigma related to receiving mental health-care. According to the National Alliance on Mental Illness (NAMI), “Mental health issues are prevalent on college campuses,” yet 40 percent of students with potential mental health disorders do not seek help (NAMI, 2014). The NAMI website provides important data, based on research of college student mental health conducted in 2012, which indicates the number of adolescent college students suffering from some form of mental distress. According to NAMI’s research:

- 75 percent of lifelong cases of mental health conditions begin by age 24.
- One in every four young individuals, between 18 and 24 years of age, has a diagnosable mental illness. Over 25 percent of young adults in college have received a diagnosis, and or treatment from a professional due to a mental health condition over the past year.
- In the past year, more that 11 percent of college students have been treated for anxiety and more that 10 percent of college students have reported receiving treatment for depression.

(Continued on Page 4)
• More than 40 percent of college students have experienced higher than average stress levels in the last year.
• Over 80 percent of college students felt overwhelmed by their responsibilities and 45 percent reported feeling hopeless about their situations.
• Nearly 73 percent of students with a mental health condition experienced a crisis on campus. However, 34.2 percent of students reported that their college was unaware of their crisis.
• As college enrollment has increased nationwide, college counseling centers have witnessed an increase in the number of and intensity of mental health issues in college students and a greater number of students taking psychotropic medications. (NAMI, 2014).

Given that college students 24 years old and younger are still considered adolescents undergoing cognitive, emotional, and environmental transitions that are considered developmentally “normal,” clinicians working with college students can more thoroughly assess and diagnose clients within this population by using these medical and developmental models of human development to help discern the degree to which their client’s issues are developmentally “normal” or “abnormal” and to respond with therapeutically relevant interventions. Due to the issue of cognitive development and the increasing number of students entering college, who have previously received psychotherapy, and or have taken or require continuing use of psychotropic medications, clinicians aim to provide sophisticated college mental health services to ensure continuity of care for college students and heightened awareness of the continuum of severity of their college clients’ mental health concerns.

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Welcome & Congratulations, Fall 2014 Inductees!

Dr. Gerald Juhnke & CSI officers

Dr. Brenda Jones & CSI officers
According to the Texas Department of State Health Services (TDSHS, 2013) 10,729 refugees and asylees were relocated to Texas in 2013. Individuals and families arrived from 70 different countries, with the largest populations claiming Iraq, Cuba, or Burma as their country of origin (TDSHS, 2013). Approximately 8% of these newcomer refugees resettled in Bexar County (TDSHS, 2013).

Who is a refugee? The US Citizenship and Immigration Services (USCIS, n.d.) defines refugees as a person who is outside their country of nationality or outside any country in which such persons last habitually resided, and is unwilling or unable to return to that country because of a well-founded fear of persecution (or past persecution) due to religion, race, nationality, membership in a particular social group, or political opinion. There are several other immigrant statuses including those who are undocumented, seeking asylum, victims of trafficking, parolees (a special status of Cuban immigrants), and individuals arriving on a special immigrant visa. For the purposes of this article, the term refugee and newcomer will be used to refer to individuals who have been through a process that allows them to reside legally in the US. The process of obtaining refugee status and being resettled to a new country may take year and during that time, asylum seekers may move between various countries and refugee camps. And, this population and their needs are largely invisible to the greater San Antonio community.

Newcomers to the US arrive with many concerns. An initial barrier to meeting those needs may be language. For those arriving in Texas, 91% needed a language interpreter upon arrival in order to complete the screening process (TDSHS, 2013). Many languages are not commonly spoken in Texas, including Arabic, Burmese, and Nepali. This may pose challenges for counselors who work with these populations. Newcomers must learn to navigate in a new home, acquaint themselves with different home appliances, strange food, a new education system, unknown shops, new monetary currency, and unfamiliar transportation systems.

Counselors may encounter newcomer refugees in a variety of settings including: public schools, community clinics, crisis centers, and college campuses. And, counselors may work with this population through certain local agencies including Catholic Charities and the Center for Refugee Services. Life is not easy for immigrants resettled to the US (Y-L. Ling, personal communication, June 21, 2013). Newcomers may face discrimination and prejudice in their communities and schools and may be living in poverty (Y-L. Ling, personal communication, June 21, 2013). Furthermore, many refugees may be disappointed and surprised by the challenges they are now facing.

Surviving traumatic experiences (e.g., physical or sexual assault, witnessing murder, death of family members, torture, loss of a limb) is common among newcomer refugees (Betancourt et al., 2012). Moreover, lack of health care in their country of origin or refugee camps may contribute to long-term health problems. Some of the health concerns refugees face include infections like Tuberculosis, Hepatitis B, Syphilis, and HIV in addition to other concerns such as lead poisoning or parasites. As a counselor, taking a holistic approach with clients is essential and becoming aware of community resources for referrals is key.

Typical client concerns may include career counseling, a need for basic resources (assistance with food or housing), negotiating parent/child conflict, behavioral concerns, depression, anxiety, PTSD, suicidal ideation, adjustment to new circumstances, acculturation stress, and dealing with past trauma (Villalba, 2009). Co-creating goals with clients is important in order to understand which needs the client experiences as most pressing. And, recognizing one’s limitations as a counselor is important; counselors may be in an unfamiliar case management role and need to seek additional support for the client. Working with culturally diverse populations also provides counselors with an opportunity to examine biases and beliefs and may afford opportunities to engage in client advocacy.

One of the most important things to note about refugees is that there is significant diversity within the population in general, and within groups from the same country of origin. For example, refugee English language skills may be non-existent, moderate or excellent fluency. Many refugees have no literacy in their own language (ability to read or write) while others are well educated and have earned advanced degrees in their home country. Some newcomers have never experienced life in an urban area. Many countries have a variety of religious beliefs and practices – some refugees are part of the dominant religious culture, and others may be from a minority group who was persecuted. It is important not to make assumptions about client’s based on their nationality or country of origin.

(Continued on Page 6)
Establishing rapport is important when working with clients; however, this may be especially true when working with newcomers. The concept of counseling may not be well understood, and trusting people in positions of power may be especially challenging for those coming from experiences of oppression and violence. Taking a wellness approach, counselors look for and identify client strengths. Newcomers may possess a variety of potential cultural strengths including: cultural traditions, resilience, family and community cohesion, a strong cultural identity, and healing rituals.

When working with specific cultural groups, it is incumbent on the counselor to become familiar with relevant cultural considerations including: gender roles, political situations, religious and spiritual practices, information about the client’s country of origin, and to be aware of current events that may impact the client. What a US native experiences as a 30 second news spot reporting discord in another country may represent violent, ongoing conflict that puts the client’s family and friends in danger. As a best practice, seek resources and consult with cultural experts. For more information, check out the following resources.


*Cultural Orientation Resource Center* [http://www.culturalorientation.net/](http://www.culturalorientation.net/)

*San Antonio Center for Refugee Services* [http://www.sarefugees.org/index.php](http://www.sarefugees.org/index.php)

*United Nations High Commission for Refugees* (UNHCR) [http://www.unhcr.org/cgi-bin/texis/vtx/home](http://www.unhcr.org/cgi-bin/texis/vtx/home)

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CSI Live Webinars

CSI members may receive free CEUs for participating in the webinars. For webinar descriptions, CEU instructions, and registration information, please visit the main CSI website at www.csi-net.org.

December

Using Social Media as a Professional Counselor
Dr. Stephen D. Kennedy & Mr. Jared S. Rose
Tuesday, September 9, 2014 2:00 - 3:00 PM EDT

CSI Recently Added Recorded Webinars

Winar recordings and materials are posted within 72 hours of the live webinar broadcast and are available for CEUs at the main CSI website at www.csi-net.org.

When It’s not Okay to Grieve: An overview of Disenfranchised Grief
Dr. June M. Williams
Original broadcast November 18, 2014

Strengthening the Counseling Profession: The Role of Counselors’ Professional Identity
Dr. Donna M. Gibson
Original broadcast November 14, 2014

Chapter Leaders Training: Insights from Chapter Annual Reports
CSI’s Leadership Fellows and Interns
Original broadcast November 12, 2014

Enhancing our Role as Leaders: Counselor Community Engagement as the Catalyst for Excellence
Dr. Nicole R. Hill
Original broadcast November 4, 2014

Transformative Leadership in Counselor Education
Dr. Cheryl Holcomb McCoy
Original broadcast October 28, 2014
Congratulations to all those who presented at the SACES 2014 and TCA Professional Growth Conferences!

Cohort 9 at TCA in Dallas, TX

Maria and Marlise at SACES in Birmingham, AL

Yuliya, Joe, and Stacy at TCA in Dallas, TX

Marlise and Angelica at TCCA booth at TCA in Dallas, TX

CSI Fall Deadlines

12/01 Award Nominations
12/01 Leadership Fellow Applications
12-01 Leadership Intern Applications
12-01 Voting by Chapters, CSI Elections
12-01 Professional Forms Contest Deadline

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You can also find us on RowdyLink at https://utsa.collegiatelink.net/organization/none.
Something in the Burn

Kathyne Jones
Masters Student

Something in the burn
Something in the burn
of our scrap metal lives

has me holding a fist of lilies
when only the wind
can begin to explain

the way a vicious cycle, spent
like a broken record,
grinds to a halt.

It’s hard to believe the weather
in Texas could change

at a prayer,

but anything can happen
on a lonely trip down an ashen road;

out of these ashes,
perhaps, a rose.

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Lovingkindness (Metta) Meditation Practice

Joe Avera, MA
Doctoral Student and Treasurer

Lovingkindness, or Metta meditation is a meditative practice to cultivate happiness, self-compassion, compassion for others and unconditioned love. The goal of the practice is to love others and yourself more deeply, and find a greater sense of connection with others (Salzberg, 1995). We can be more effective as counselors, by developing a more compassionate, empathic, accepting and caring attitude toward others, and ourselves. We can also learn to be more loving and connected in our personal lives. Sometimes, we might even show some compassion and love towards ourselves.

The Buddha said, “You can search throughout the entire universe for someone who is more deserving of your love and affection than yourself, and that person is not found anywhere. You yourself, as much as anybody in the entire universe deserve your love and affection” (Salzberg, 1995, p. 31). The idea is to love and have compassion for yourself first. Until you love and care for yourself, with all your wrinkles, flaws, and shortcomings, you are going to struggle with developing unconditional love and compassion for others. The Buddha also believed in first hand experience. He implored us to try it, whatever “it” is, for ourselves and to use our own wisdom and insight to decide whether it worked.

If you have a mindfulness meditation practice or some other type of daily practice, contemplative prayer, yoga, qigong etc., you can easily work Lovingkindness into your existing practice. If you do not have a daily practice of some sort, you can also easily incorporate Lovingkindness into another routine, such as your morning breakfast routine, or your nightly routine before bed. Or you can create a new routine just for Lovingkindness.

The simplest method of practicing Lovingkindness is to take a minute and focus on where you are and what you are doing in the present moment. Take two or three deep breaths and then bring the following phrases to mind:

“May I be free from danger,
May I be happy,
May I be healthy,
May I be free from suffering,
May I live with ease”.

You can say the phrases out loud or in your mind. As you say each phrase, think about what it really means to you. What is free from danger? What is live with ease? It will be different for each of us. It may be different for you each time you repeat the phrase. Give yourself permission to accept each of these ideas into your own being. Remember, you deserve all of this and more. Practice daily for two or three minutes, and see if you don’t become more accepting and loving toward yourself, especially toward the parts of you that you think are less than perfect.

When you are comfortable giving these gifts to yourself, you might try expanding your practice of Lovingkindness to include others. The traditional groups are parents, teachers, family and friends, people you know, people you do not know, people you do not like, and finally, all beings in the universe. See if you can offer these same gifts to others, and again, see if you notice a change in yourself. For more information about Lovingkindness meditation, Sharon Salzberg’s “Lovingkindness, The Revolutionary Art of Happiness” is an excellent reference. May you be well, happy and peaceful!

Reference

Overcoming Weight Stigma this Holiday Season

Emily C. Ciepcielinski, MA, LPC
Doctoral Student

The holidays are rapidly approaching, and everyone knows what that entails. Though the holidays may represent different things for different individuals, one thing is for sure: food will be a centerpiece for many of our celebrations. This is a good thing, right? Not for some of our clients. Along with a focus on food, the holidays may bring an additional and painful emphasis on weight and body image.

One does not have to have an eating disorder to struggle with food around the holidays. For many Americans, the holidays represent a time of overeating, particularly when it comes to tasty holiday treats. For some individuals, a lack of control regarding food and a poor body image can lead to feelings of anxiety, guilt, and shame. Imagine, then, what it would be like if family members, friends, or even strangers made you feel even worse because of your food choices and/or body size? Consider what it would be like to hear the following comments: “I would not eat that if I were you; it’s not very flattering with those thighs”, “I’ll go on a diet with you starting in January”, or “I’m going to have to take those cookies away from you…what a fatty!” Or imagine being ridiculed or even just avoided in public because of your body size. Many clients who struggle with food and weight experience this very type of maltreatment, commonly known as weight stigma.

Weight stigma refers to “negative weight-related attitudes and beliefs that are manifested by stereotypes, rejection and prejudice towards individuals because they are overweight or obese” (Puhl, Moss-Racusin, Schwartz, & Brownell, 2007, p. 347). Clients may experience weight stigma in a variety of settings, including work environments, public settings, and family gatherings. The psychological effects of weight stigma include high levels of depression and low self-esteem (Durso et al., 2012), high levels of binge eating (Ashmore, Friedman, Reichmann, & Musante, 2008), and greater levels of psychosocial maladjustment (Carels et al., 2013). Unfortunately, many people view weight stigma as socially acceptable (Barron & Hebl, 2010), which may explain the rampant rise in weight stigma over the past decade (Andreyeva, Puhl, & Brownell, 2008).

So how do counselors address weight stigma with clients? First, counselors can educate all clients about the complex causes of obesity and weight issues. When individuals erroneously attribute being overweight to laziness or poor choices, this leads to the harmful stereotypes that serve to perpetuate stigma (Weiner, Perry, & Magnusson, 1988). The reality is that weight is influenced by a variety of environmental, genetic, and psychological factors. Secondly, counselors can encourage all clients to adopt a “fat-talk free” stance, for themselves as well as for their families and friends. Essentially, this means individuals will refrain from making body-related comments, particularly those that endorse society’s pressure to be thin (Stice, Maxfield, & Wells, 2003). Counselors can also encourage clients to pursue *Health at Every Size* (Bacon, 2010). This means rather than focusing on weight or body size, individuals choose to focus on healthy behaviors. Have a happy, healthy, and stigma-free holiday season!

References


Counseling students are presented with numerous theoretical orientations while taking Introduction to Counseling Theories. We are told to explore the theories presented to us and pick which one we believe is most accurate in describing how people think, feel, and behave. Unfortunately, some students may not find one theory that makes them say, “Yes! That is reason why people behave the way they do!”

For student counselors who are struggling to find one theory that best resonates with them, I challenge them to try on different theoretical orientation hats. Role-play different counseling scenarios; do not just watch them on a video. By role-playing different counseling techniques based on different theoretical perspectives, it is easier to grasp a better understanding of how these theories are actually used in session. Hopefully, by using different orientations, students will gain a better understanding of what they believe in and how they would like to counsel their future clients. If students are hesitant to choose one theoretical orientation, the use of two or more theories is an option.

Using an integrative approach, counselors use theory to drive their decisions on which techniques to use. Integration is different than eclectic counseling. Counselors who come from an eclectic approach use what may suit the immediate needs of individual clients instead of counseling based on theory (Palmer & Woolfe, 1999). Eclectic counselors use what they believe works best with clients but are not as concerned with why or how the technique can make changes in their client. Integrative counseling, however, establishes there is a relationship between two or more theories and their techniques.

To use integrative counseling, it is necessary to have a solid understanding of the theories you accept as true (or partially true) and how you can integrate them together. There are four routes to integrating theories: Common Factors, Theoretical Integration, Assimilative Integration, and Technical Eclecticism (Norcross & Goldfried, 2005). Common factors approach proclaims there are factors in common among several theories that make counseling successful and the counselor incorporates these common factors in their practice. The theoretical integration approach brings together two or more theoretical approaches and develops one unified theory. Assimilative integration favors one major theoretical orientation but may assimilate some other practices they have found to be effective in producing change in clients. Technical eclecticism uses a diverse set of theoretical techniques without having a clear conceptual framework on how the strategies fit together. As mentioned previously, theoretical integration is preferred over eclectic forms of counseling.

If you find yourself interested in more than one counseling theory, ask a professor how to integrate theories into practice and what that may look like. Read books or articles that discuss how theories have been integrated in the past. As suggested earlier in exploring different theoretical approaches, it may be best to role-play the integrated techniques to gain a better understanding of how they are used together.

References
Are you interested in writing an article for our next newsletter?

Our next submission deadline is January 31, 2014.
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