Suggested APA style reference: Freeburg, M. N., & Van Winkle, J. L. (2011). *Increasing intake interview skills: A creative approach.* Retrieved from http://counselingoutfitters.com/ vistas/vistas11/Article_33.pdf

Article 33

Increasing Intake Interview Skills: A Creative Approach

Melissa N. Freeburg and Joseph L. Van Winkle

Freeburg, Melissa, N., is an Assistant Professor as Bridgewater State University. She teaches Assessment, Research, Internship Experiences, and Creativity in Counseling. Melissa is active in professional organizations and has held leadership positions at the national, regional, and state level.

Van Winkle, Joseph, L., is a licensed Mental Health Counselor at Atlantic Counseling in Massachusetts. His clinical focus is in marriage and family, children, and adolescents.

Introduction

Most every professional counseling relationship between a counselor and a client begins with an intake interview. Depending on the clinical setting, the intake process may vary from structured to unstructured models, each with a similar core theme of information customarily gathered. Effective initial intake interviews are considered a balance between gathering information and developing a therapeutic working alliance (Whiston, 2009). Furthermore, research indicates that to become effective in intake interviewing so that a working alliance is fostered, counselors need to follow guidelines and receive training to obtain accurate and valid information (Duley, Cancelli, Kratochwill, Bergan & Meredith, 1983).

Undoubtedly, this need for training to be successful in executing intake interviews is why counseling education textbooks on assessment and appraisal (psychological testing) include chapters dedicated to the intake interview. These chapters include discussions on: the importance of intake interviews, information relevant and typically gathered, defining the client's presenting concern, interviewing and communication skills, and specific techniques (Hood & Johnson, 2007; MacCluskie, 2010; Whiston, 2009).

Occasionally these same text books provide case studies so that counselors may interact with a conceptualized client and how that client's personal information may be retrieved during the intake process. However, these case studies rarely represent a comprehensive exposure to the plethora of client personality and presenting concern dynamics. And the counselor reads such statements as, "A good intake interview will enable you to answer these broad questions and generate a comprehensive, culturally sensitive conceptualization of your client (MacCLuskie, 2010, p. 224)," with little applied understanding that the intake interview is really quite dynamic and that a great deal of skill is necessary to adapt to each individual client's needs.

Recognizing that counseling students, and even professionals practicing in the field, could use an additional set of vignettes to interact with, and more comprehensively express challenges in the intake interview, the current authors pose ten new ones in this article. In Irvin Yalom's book, *The Theory and Practice of Group Psychotherapy* (2005), he includes a chapter dedicated to problem patients. In this chapter he presents general client types with a description, effects on the group, and therapeutic considerations. Modeling his theoretical design, the ten vignettes each represent a "type" of client that represents different and unique challenges in the intake interview process. Furthermore, to reduce anxiety commonly connected to assessment based activities (Centra, 1993), and to make the interaction more creative, the use of commonplace storybook characters have been used.

Storybook Assessment Activity

The intent of the ten vignettes presented here are to challenge students and practicing counselors to reflect on the dynamics and diverseness that different clients may present. This set of ten is not a comprehensive work of all potential client "types," but a solid starting point. Additionally, this material may be useful in a variety of settings, for example, practitioners as a method to refresh and challenge skill sets, at a workshop, and as a classroom experiential activity. The initial design was intended for students to engage in the creative, silly, character activities by acting out their character while their partner/counselor practiced intake skills. A variety of intake instruments (psychosocial, bio-psychosocial, general intake forms, and the Mini Mental Status Exam) were provided for experimentation. Students were told that all characters are based on popular storybook characters so that during the intake process there were no immediate assumptions that each person acting in their role was delusional. Providing the dyads with about 10-15 minutes in each role is sufficient.

One method to debrief the experience is to tackle each character individually. The individual acting as the counselor can be given the opportunity to share what challenges they may have faced when interviewing their client. Probing questions may be used to see what assumptions about the client they may have drawn, what strategy changes did they make in action, what stumped them, and of course, what went well? Following each vignette below is further discussion unique for each character presented.

The origination of the characters stemmed from the creator's creativity but also a desire to provide students with an integration of the Council for Accreditation of Counseling and Related Programs (CACREP, 2009) core areas; helping relationships, human growth and development, social and cultural diversity, and professional orientation and ethics. Within the framework of this one single activity many core counseling elements are weaved throughout, making it comprehensive and miserly of time.

While all of the characters are presented as meeting the criteria of diagnoses, this is simply provided as a framework and does not have the intention of being diagnostically geared. In fact, the diagnoses are simply vehicles to give characters shape. The hope is that individuals may look at the behaviors on a continuum (with the diagnosis being an extreme) and gain an understanding that many of the diagnostic criterion elements may be seen in clients that do not require a diagnosis. However, it is helpful to have students

experience the process of an intake interview and how it integrates with the process of clinical diagnostics.

Case Vignettes

The Case of "Sleepy"

> *Your friends have suggested you seek counseling due to your increased amount of sleep. They think you may be depressed but actually you are suffering from Narcolepsy. Of course you are not aware of this…but hopefully your skilled counselor will uncover the necessary information to eventually correctly diagnose you. According to the DSM- IV-TR manual, "Individuals with Narcolepsy may appear sleepy during the clinical interview and examination and may actually fall asleep in the waiting area or examination room. During episodes of Cataplexy, individuals may slump in the chair and have slurred speech or drooping eyelids" (APA, 2000, p. 612). The purpose of this "character" is to help the counselor learn how to keep their interviewee's attention in an empathic way.*

In reviewing this character, students should be encouraged to contemplate the presentation of clients during the intake interview. For example, depression, narcolepsy, residuals of medications, and even just the general mental health of an individual may present similarly. Encouraging students to understand that symptoms may lie along a continuum may help them to develop a sound base for assessment along with a personal plan of action. Furthermore, students in earlier developmental stages within the profession of counseling may fall into the trap of personalizing the symptoms as a reflection of their own inability and/or lack of clinical experience. A fruitful conversation may emerge if students are challenged to address their own fears within the counseling intake process and how those fears may manifest into assumptions that further hinder the process.

The Case of "Doc"

> *As you know, Doc is the leader of the seven dwarfs. Unfortunately the power has gone to his head, and a well informed counselor will eventually diagnose him with Narcissistic Personality Disorder. According to the DSM-IV-TR, "The essential feature of Narcissistic Personality Disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins by early adulthood and is present in a variety of contexts" (APA, 2000, p. 714). Throughout the interview you may want to show a grandiose sense of self-importance, make your accomplishments larger than life and be boastful. The purpose of this "character" is to help the counselor learn how to use interviewing skills, keep you on track, and have plenty of information to fill in an intake assessment.*

According to the DSM-IV-TR (APA, 2000), the prevalence of Narcissistic Personality Disorder (NPD) diagnoses range from 2% to 16% in clinical population and an overall population rate of 1%. Therefore, Doc, as indicated by the vignette, is not a commonplace type of client. However, introducing this character is valuable for the development of a counselor's understanding of NPD and how certain behaviors

associated with this diagnosis manifest in other clients in a less sever manner. For example, it is possible that clients without NPD may request the "top" provider in a clinic.

Because individuals with NPD feel that they can only be understood by, and therefore should only associate with, other individuals who are unique and special, they may begin to "court" their counselors. Meaning, they attribute superior clinical skills and gifted qualities to their counselor. This allows their fragile egos to reconcile why they engage in counseling. Potentially, a developing counselor may bask in the glow of such high praise, but should be aware of the intentionality and even maladaptive manifestation that is occurring. This reiterates the need for boundary setting in session by the clinician to set the tone for the therapeutic relationship.

The Case of "Bashful"

> *Oh, poor Bashful. It took a great deal of courage for you to even make it to your session. Eventually a skilled clinician will diagnose you with an anxiety disorder. During your intake interview you will be unable to hide your symptoms. For example, you may tremble/shake, wring your hands, indicate that you are having chest pains or discomfort, and you may even feel lightheaded. Your counselor may have to work very hard to make you feel safe enough to share your information.*

Caught between the need to have a completed intake form and the desire to support an individual struggling is challenging for the developing counselor. Hence, Bashful was designed to challenge individuals to think about what elements must be present for them to discard the intake interview process and support the individual before them. In this case, students can be challenged to think about what reactions they may have to a highly anxious client. What specific counseling skills will they employ? What indicators will they look for that guides their decision in shifting away from the comfort of the structured intake form? How will they develop the skill of observing the nonverbal behaviors and the completion of the intake form? How might they honor the success of this client for simply arriving to the session?

The Case of "Happy"

> *Happy sounds like one of the best of the seven dwarves, doesn't it? Well, unfortunately, most of the world doesn't know that Happy isn't always happy. In fact, Happy will eventually be diagnosed with having a Manic Episode. According to the DSM- IV-TR, "A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood" (APA, 2000, p. 357). Things you may share with your counselor may include; inflated self-esteem, decreased need for sleep, flight of ideas, distractibility, and involvement in many pleasure seeking behaviors (with a high potential for harm).*

Happy embodies the client that novice counselors may find perplexing. General characteristics of this type of client present as cheerful and may even have an infectious quality. Counselors in training should be encouraged to reflect on the potential client that may seem to have no concerns and therefore seem out of place in the counseling setting.

Furthermore, the infectious quality combined with the description of pleasure seeking behaviors may be misinterpreted as a successful person living life to the fullest. Counselors may view this type of client as "cool," "adventurous," and "inspiring." The pitfall is that counselors may highlight these activities as strengths rather than identifying them as verging on recklessness.

Davis, Chang, and McGlothlin (2005) wrote an article calling for counselor educators to infuse humanistic strategies and activities in the assessment courses. One solution they offered was to use a jigsaw puzzle (without knowledge of the final picture product) as a metaphor for the assessment process. In their activity the students were encouraged to identify parallels about the process of gathering information on a client to puzzle pieces. First, it is common to find the edge pieces, or in this case a general framework understanding of the client. Second, groupings are made of colors and designs that match one another. For a client, that might be themes or patterns. Numerous more possibilities live in this activity. The one most germane to the case of Happy is that of the potential for missing puzzle pieces or pieces that just simply do not fit.

To develop stronger skills for the use of intake interviews it is important to challenge one's self about the likelihood of missing puzzle pieces, or pieces that appear to not fit at all. Furthermore, Happy's given diagnosis increases the possibility of him arriving to future sessions in a completely different state of mind. Students can be encouraged to reflect on how they may react to such a sudden change? How may they find consistency when the client is not? How, or will they, reflect any new information concerning the client (e.g., stark differences in mood) on the previously completed intake form? Additionally, this may be an opportunity for educators to broach the subject of appropriate ink colors for documentation (setting specific) and proper procedures for making corrections on existing materials.

The Case of "Dopey"

> *Ah, many think of Dopey, as the little dwarf that is not very smart. In actuality, you were the smartest one of the bunch until one day you found a funny smelling plant in the woods while gathering flowers for Snow White. One thing led to another and now you have a serious drug addiction. In fact, you have been ordered to see a counselor by the King's Court. Your relationship with the other dwarfs is strained and the beauty of Snow White doesn't even encourage you to shower any longer. Over the course of the last year you have had a real checkered life, smoked with a few trolls, and even broke into the witch's tower to steal some of her "magic powder." Since you are court ordered to see a counselor you might be a little resistant, but be nice to your counselor; after all they are learning too.*

It seems that the trend of current day manuscripts on the phenomenon of court-ordered clients is to compare them to non-court ordered clients in terms of readiness for change. And, these tend to be found in Social Work journals and not counseling ones. Furthermore, a debate on whether or not counseling court ordered clients is ethical circles the peripheral horizon for psychotherapists. Regardless, it is essential to stimulate discussions concerning developing counselor's thoughts on the condition. It is an opportunity to discuss comfort levels working with court-ordered clients, referral

originations, policies and procedures for working with governing agencies/agents, documentation procedures, addressing clients who arrive for session under the influence of drugs/alcohol, and potential for testifying in court. Students may not realize that all of these factors begin to play out immediately, and therefore, during the intake interview as well.

Added to the bundle of concerns listed above is the unfortunate labeling that practitioners have placed on court-ordered clients as “hostile,” “resistant,” “hard to reach,” and “unmotivated” (Rooney, 1992). Thomas O’Hare’s (1996) study on the difference between court-ordered and non-court-ordered clients sheds some important insight into some of these challenges. First, he notes that court-ordered clients have their problems defined for them by some arbitrary body, leaving little chance for the person to buy into, or be vested in, the therapeutic process. This undermines the key element of using the intake interview as a starting point for building a therapeutic working alliance. Second, underrepresented groups/ oppressed groups/ minorities, disproportionately represent the body of court-ordered clients. This implies a strong likelihood that the client enters into the counseling relationship acutely cognizant of a social, physical, and therapeutic power imbalance.

To spotlight the above mentioned elements of a court-ordered client, it would be important to also facilitate discussions on how to empower a court-ordered client. Encourage students to generate a few statements they may use in session that helps a client understand that the counselor works in the service of them and not the governing body (if applicable). How can the counselor align with the client to form a working alliance without being underminding to the originator of the court-order? And, the worst question of all, what will the counselor say if the client challenges them for not understanding their drug addiction when the counselor themselves have never taken drugs (many male doctors deliver babies and have never had one themselves!)? At first sight Dopey appears to be a simple vignette, but in actuality it is one of the more loaded in underlying content.

The Case of “Grumpy”

> *Some think that you are just an unhappy dwarf, but in reality a skilled counselor will eventually diagnose you with Conduct Disorder. You are a gruff person who has been aggressive to people and animals (you got in a physical altercation with Doc), destruction of property (spray painted the wall around the King’s castle), and even had to go before the King’s Court because you and Dopey broke into the Evil Witch’s tower. You have been court ordered to seek counseling so you are a little resistant and will mostly give short answers. Don’t be too tough on the counselor though, you may get in trouble with the court!*

Like Dopey, Grumpy is court ordered. Despite the redundancy, the importance of including this character is profound. Grumpy represents the client that creates a sliver (or more) of fear within the stomach of a counselor. The concern is rooted in the unknowing, the potential the client has for harm towards others, self, the counselor, and beyond. Addressing threatening clients should stimulate a conversation on the limits of confidentiality, importance of adhering to the ethical code, knowing danger assessments, solid record keeping, seeking supervision, and establishing safety in the counseling room

(e.g., never letting the client be between you and the door). Not to mention, there is still the matter of performing an intake assessment on Grumpy. Again, the counselor should be challenged to think about their own personalizations that may arise in this scenario. Furthermore, the conversation should be directed to consider what strategic plan of action a counselor may engage. Will they use transparency and simply state their discomfort?

The Case of "Sneezy"

> *You have been referred to seek counseling by your medical doctor. Your doctor has not been able to help you and has come to the belief that you are not actually suffering from any physical ailments. A skilled counselor will eventually diagnose you with Hypochondriasis. According to the DSM-IV-TR, "The essential feature of Hypochondriasis is preoccupation with fears of having, or the idea that one has, a serious disease based on a misinterpretation of one or more bodily signs or symptoms" (APA, 2000, pg 504). That darn nose of yours really has you convinced you are dying. Your medical history will be long!*

Much like narcissism, hypochondria, is not a popular/typical type of counseling concern; in the general public there is a prevalence of 1%-5% (APA, 2000). Instead, Sneezy represents clients farther down the continuum of extreme. For the purpose of this exercise, Sneezy is the client who arrives with a thick folder containing a cornucopia of medical documents. Such behavior could be hypothesized as a result of an individual that has become accustomed to reporting rather than reflecting. Furthermore, it is speculated that the action of dominantly speaking of medical-like experiences is a way to avoid more interpersonal and hidden self concerns.

Interacting with this vignette could center on gaining skill in determining crucial medical history information and that of a more superfluous nature. Counseling students should be encouraged to have a strong base knowledge of the medical questions included on the formalized intake interview form and why those elements are important. Additionally, a knowledge of the difference of various forms of intakes, and therefore, different weights for medical information, could be addressed. Further facilitation questions could engage thoughts and concerns about limits on scope of practice, where to get a strong basis of medical concerns related to mental health, how to redirect a client away from the medical history to other areas of the intake, and where do the medical concerns and the mental health concerns meet?

The Case of "Snow White"

> *Everyone thought that life for Snow White, once her prince saved her, was as they say "happy ever after." But, after such a stressful ordeal, there is work for you to do to feel whole again. You have no memory of how you ended up in the coma and it scares you. Eventually your counselor will gain enough information from you to diagnose you with Dissociative Amnesia. To help your counselor do this you will need to provide him/her with information such as: your inability to recall important personal information (especially around your traumatic/stressful interactions with the evil witch), some depression, anxiety, and trance states.*

Clients suffering from psychiatric disorders are often poor historians and are also likely to provide systematic biases in their own world view when reporting to a counselor (Evans & Sullivan, 2002). Counselors in training need to be prepared for the occasion when their new client is completely unable to provide information. Hence, questions in exploring this vignette should revolve around the central concern of limited information. How do counselors assist clients to be better historians? What resources might be tapped into to gain additional information? Is using family members appropriate? If a client's eyes glaze over during an intake, will the counselor possibly take it as a personal reflection of their inadequacies? If a client glazes over how will the counselor re-connect to them? What statements and/or skills might be employed?

The Case of a "Fairy Godmother"

> *Many think that you have a history of helping young women who are threatened by evil witches. In actuality, there was never an evil witch with plans to harm the girls. A skilled counselor will eventually diagnose you with Paranoid Personality Disorder. You are very suspicious of others and their intents, preoccupied with doubts of others' loyalty or trustworthiness, reluctant to confide in others, read into comments believing they are truly negative, and may even be quick to react angrily. During your intake you will probably report numerous tales in which others were out to get you and those you care about.*

The case of the Fairy Godmother lends itself nicely to speak across the continuum of extremes. First, a client that has a paranoid personality disorder will be incredibly challenging during the intake process. The *DSM-IV-TR* (APA, 2000) characterizes them as being very reluctant to share any personal information for fear that it will be used against them. A high potential exists that these individuals will assume that the information gathering process of an intake interview is actually a ploy to demean or threaten. Furthermore, they are generally challenging to get along with and most always have problems with forging close relationships. Completing the intake interview, much less a working therapeutic alliance, will be a colossal feat. Unfortunately, these same symptoms are what keep these individuals from engaging in the process of personal therapy as indicated by the reporting of only 0.5%-2.5% prevalence in the general public (APA, 2000).

Second, and on a gentler end of the spectrum of extremes, are those individuals who are less adamant, but still suspicious, of the questions posed in an intake interview. Contemplating counselors should be asking themselves, how do I get skilled enough in my intake interview skills to be able to support the ideology of each question? How will I explain the reasons for questions while still developing a working alliance? How do I balance being thorough in explanation, competent in interviewing, and fostering support for the client?

Third, the opposite extreme of this vignette is that of the individual who provides an abundance of answers above and beyond the need of the intake interview. Competency in knowledge of the items contained in an intake allows a counselor to navigate through the pages for quick documentation when questions are answered without prompting. However, a profusion of unrequested information may bog down a novice counselor. A

discussion of skills inherent to summarizing large bodies of information coupled with redirection statements is necessary.

The Case of a "Prince"

> *Many think that you are a gallant man that swept Snow White off her feet. Few know that in actuality you have a pattern of instability of interpersonal relationships and marked impulsivity that began in your early childhood. Your skilled counselor will eventually diagnose you with Borderline Personality Disorder. In your frantic effort to avoid abandonment, you were very excited with the possibility of being romantic with Snow White; after all she was in a coma and could never leave you. During your intake session, you might share the following things with your counselor: troubles with your identity, impulsive acts (such as gambling on the joust competitions), self mutilation, mood swings, feelings of emptiness, and even stress-related paranoia. You really want help from your counselor because you are incredibly scared of ever losing Snow White!*

The case of the storybook Prince opens the lines of communication for counselors in training to reflect on the potential for severe fluctuations in the interpersonal dynamics of the dyad. When an individual has an embedded pattern where perceptions of rejection spiral behaviors into frantic hyper-activating strategies, it is easy to become an emotional hostage. Draper and Faulkner (2009) recounted a case study of a college student diagnosed with Borderline Personality Disorder and the experience of her counselor. During the relationship the counselor realized that the client never trusted the counselor's attempts to validate feelings. Instead, the client believed that the counselor was trying to tell her how she *should* feel. Nurturing responses often elicited reactions of anger. On the other hand, the client was prone to purchase gifts and function from the assumption that she had therefore bought affection and commitment.

The intentionality of including the Prince in this sequence of vignettes is not to wrestle with the intricate dynamics involved in Borderline Personality Disorder treatment, but rather as a stimulus for an interpersonal dynamics discussion. This particular disorder inherently embodies another continuum of potential client dynamics that might be best conceptualized by the title of the famous Kreisman and Straus book, *I Hate You – Don't Leave Me* (1989). While discussing the important skills needed to develop a working alliance with an individual with Borderline Personality Disorder is valid and important for any developing counselor, a more global approach was intended by this character.

Specifically, what does it look like when the client strives to be too enmeshed or too rigid with their counselor? How should a counselor react when a client tests the counselor's overall acceptance of them by relaying wild and traumatic stories while maintaining a flat affect? How does a counselor foster a relationship with a client who has a rational hesitation to allow themselves to be vulnerable with the counselor during the intake interview? How does a counselor maintain professional distance from a client that is actively and visually in acute emotional pain during the intake process? What strategy will a counselor engage in when faced with a highly emotional interpersonal experience with a client?

Conclusion

Once a counselor becomes accustomed to the elements contained in the structured intake interview at their professional practice, it is human nature to develop a certain “flow” and procedure for accomplishing the task. One concern is that the very flow that allows the counselor to feel confident and competent in their intake interview may also breed atrophy in recognizing the unique nuances of clients. This highlights a need for more dynamic and creative strategies in the learning and the relearning, or refreshing, of interview skills.

Counseling is a profession of perpetual change and variety that ebbs and flows with the unique presentation of each client. While it is difficult, if not impossible, to prepare clinicians for the differences they will likely face throughout the entirety of their careers in the profession, there is great value in introducing and discussing some of the potential dilemmas. And when this is done with an approach that is fun and disarming, it can hopefully reduce the already elevated stress levels of future clinicians and increase their confidence and skill.

References

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

Council for Accreditation of Counseling and Related Educational Programs. (2009). *The 2009 standards.* Alexandria, VA: Author.

Centra, J. A. (1993). *Reflective faculty evaluation: Enhancing teaching and determining faculty effectiveness.* San Francisco, CA: Jossey-Bass.

Davis, K. M., Chang, C. Y., & McGlothlin, J. M. (2005). Teaching assessment and appraisal: Humanistic strategies and activities for counselor educators. *Journal of Humanistic Counseling, Education and Development*, 67, 94-101.

Draper, M. R., & Faulkner, G. E. (2009). Counseling a student presenting borderline personality disorder in the small college context: Case study and implications. *Journal of College Counseling, 12*(1), 85-96.

Duley, S. M., Cancelli, A. A., Kratochwill, T. R., Bergan, J. R., & Meredith, K. E. (1983). *Training and generalization of motivational analysis interview assessment skills. Behavioral Assessment, 5*, 281-293.

Evans, K., & Sullivan, J. M. (2002). *Dual diagnosis: Counseling the mentally ill substance abuser.* (2nd ed.) New York, NY: The Guilford Press.

Hood, A. B., & Johnson, R. W. (2007). *Assessment in counseling: A guide to the use of psychological assessment procedures.* (4th ed.). Alexandria, VA: American Counseling Association.

Kreisman, J. J., & Straus, H. (1989). *I hate you – don’t leave me.* New York, NY: Avon Books.

MacCluskie, K. (2010). *Acquiring counseling skills: Integrating theory, multiculturalism, and self-awareness.* Columbus OH: Pearson.

O’Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness for change. *Social Work 41*(4), 417-422.

Rooney, R. H. (1992). *Strategies for working with involuntary clients.* New York, NY: Columbus University Press.

Truscott, D., & Evans, J. (2001). Responding to dangerous clients. In E. R. Welfel & E. Ingersoll (Eds.), *The mental health desk reference: A sourcebook for counselors and therapists* (pp. 271-276). New York, NY: Wiley

Whiston, S. C. (2009). *Principles and applications of assessment in counseling.* (3rd ed.). Belmont, CA: Brooks/Cole, Cengage Learning.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.

Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm