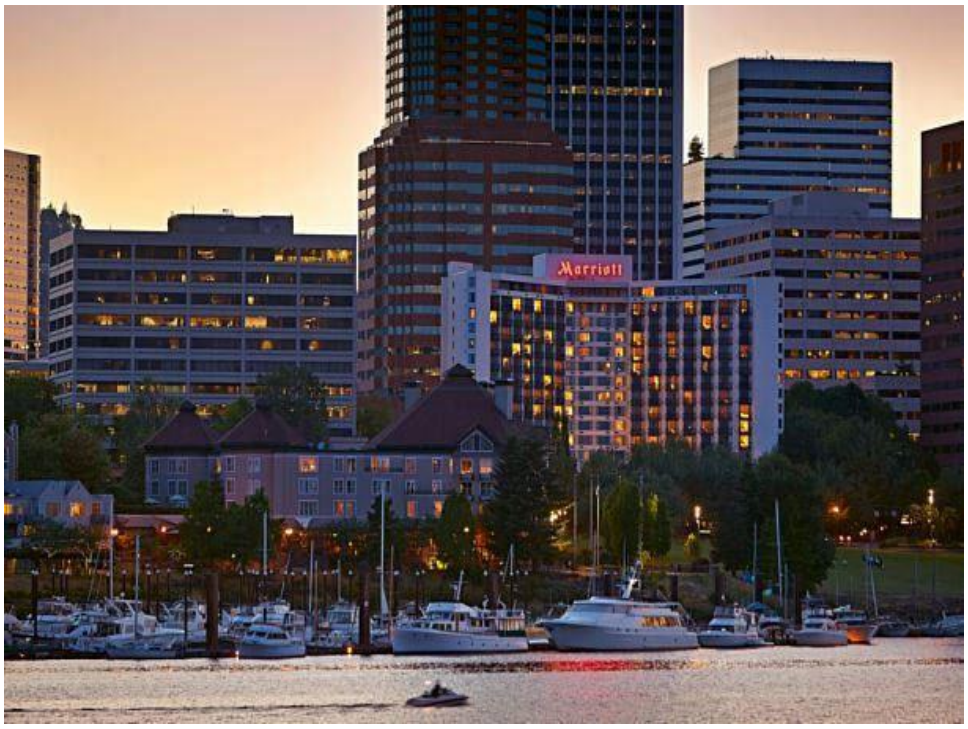

The Association for Humanistic Counseling

InfoChange

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IN THIS ISSUE

President's Letter

Dear AHC,

From my year of service as AHC President, I am glad to have gotten to know many of you more, though there are so many more of our vibrant community still to get to know. We are in a strong place as a smaller division growing faster than ACA and almost all other divisions, a small division that accomplishes member services, service projects, and opportunities to connect beyond what larger divisions do. We are "the little engine that could."

One measure of our strength is the quality of our pool of leaders. We are rolling out candidate introductions in this and upcoming newsletters. We have two highly accomplished candidates for President-Elect that I asked to provide introductory statements for this newsletter. We'll have statements from candidates for Governing Council Representative and for Secretary in upcoming newsletters. We are well to have so many highly-qualified persons ready to lead.

I want to thank our AHC board for their work with me this year. Past-President Brande Flamez has continued to work hard for us, as well as being a great support for me. Our Treasurer Nate Ivers handles complex transactions for us, attending to our monetary needs promptly and with a care that we can count on, plus going beyond in service on our board. Our Governing Council (GC) Representative Michelle Perepiczka not only represents and informs us from GC, but she has also been an active board member and co-chaired our bylaws committee with Brande, which can be tedious and thankless, but essential work. I appreciate our Secretary Belinda Lopez' work and support; and our President-Elect Linwood Vereen's – we are going to have a great year with Linwood as President!

I could not say enough to thank our Conference Coordinator, Kimberly Jayne, and those who have supported her in hosting our conference. To accomplish a conference that satisfies our many needs – that helps us come together as a community to connect and enhance – can be a monumental task when done well – and Kimberly and her supporters have done this. Kimberly, thank you!

And I want to state my appreciation of our 2015-2016 Emerging Leaders: Megan Speciale, Katie Purswell, Kristie Opiola, Vicki Giegerich, Marcia McCall and Chelsey Zoldan. They have done a lot of the work of our division this year, and especially have brought greatly refreshing new energy. Many thanks!

Be sure to take advantage our AHC Members Forum. Our forum is an opportunity to bring together the many of us who live and work far from each other, though we share common ideals and values. It can be new mode to get to know each other more, to connect and support each other for the difficult work that we do. Our Forum Committee: Jeff Cochran (me), Christian Chan, Juliana Carter, Everett Painter and Marcia McCall will start threads to facilitate conversation - We look to you to do the same! Don't be shy – your AHC friends need you to reach out in relationship. Together we make the world a better place for persons in need.

Be well and keep in touch,

Jeff L. Cochran, AHC President 2015-2016

Candidate: Richard S. Balkin, Ph.D., LPC, NCC
Position: President Elect

I am honored to be nominated for President-elect of the Association for Humanistic Counseling. Perhaps more than any other division of ACA, AHC represents the essence of the counseling profession. As the counseling profession has followed national trends toward empirically supported treatments and neurocounseling, AHC focuses on the relationship and interactions with clients. We recognize that the counseling relationship is more central to client-centered outcomes than any other technique, and highlighting this central notion is a cornerstone of humanistic counseling and AHC.

Through collaboration with members and the board, as president, I would seek to support a stronger, more central focus to humanistic counseling in ACA and to professional counselors across the country. I would aim to work with the board to expand our resources beyond our Webinars to provide support, research, and services promoting humanistic practices and principles that compliment or provide alternatives to the trends toward assessment, diagnosis, and treatment planning. In addition we can establish stronger connections with ACA State Branches to emphasize the importance of humanistic principles and practices in the face of external forces seeking to reshape our profession.

AHC can do more to highlight humanistic issues that speak to professional counselors' concerns. Through the development of additional resources, we can further our services for AHC members and broaden AHC membership using a two-tiered approach that occurs on both a national and statewide level. Humanism is what makes counseling distinct from other helping professions. AHC has been a pioneer in ACA since the beginning. Let's make it our collective goal to maintain the integrity of counseling and provide resources for counselors who are focused on humanistic endeavors.

Candidate: Mark Stauffer, Ph.D., N.C.C
Position: President Elect

Dear AHC counselor,

I was reminded of my fittedness with Humanistic counseling and our organization when I read over the presentation summaries for the upcoming AHC conference coming up in Portland, Oregon. The focus of the sessions resonate with me as do the members and focus of AHC. As president, I will clearly represent our tradition and provide strong leadership while I continue with the aspirations and long term convictions of past and present AHC leaders and our members. My goals are to:

- Work closely with divisions, branches, regions, and other humanistic interest groups
- Continue our division's emphasis on service projects (e.g., Empty Plate Project)
- Find more ways for members to be involved and gain professionally from their membership in AHC, including more opportunities for CEU's
- Promote the AHC conference
- Continue to support our Emerging Leaders Program and mentoring transitions to executive boards and committees
- Continue to improve our visibility and the resources that AHC created
- Support our high-quality journal, as well as, the newsletter

Warmly,

Mark Stauffer

Dr. Mark Stauffer is Core faculty member at Walden University. He has served AHC in the past on membership as well as emerging leaders, award, and current affairs committees. He has also provided education sessions on mindfulness and meditation during AHC's Wellness Day at multiple conferences. Dr. Stauffer enjoys scholarship and has co-edited several textbooks: Introduction to Group Work (2006, 2010); Career Counseling: Foundations, Perspectives, and Applications (2006, 2012) and Foundations of Addictions Counseling (2008, 2011), Human Growth and Development Across the Lifespan (2016). As a clinician, he has been a counselor in the Portland Metro Area in Oregon at crises centers and other non-profit organizations working with individuals, couples and families, often with homeless and at-risk populations.

Child Sexual Abuse: Range of Mental Health Services Versus Barriers

by Lauren Chase

There is a range of mental health services available to victims of child sexual abuse. These services include child protective services, law enforcement, child advocacy centers, psychologists, mental health counselors, social workers, and psychiatrists. These professionals are all responsible for protecting children under their care and should be trained to recognize signs of child abuse, neglect, and other maltreatment. According to Fong and colleagues (2016) "Most caregivers reported that they had little knowledge about MHS [mental health services] for child sexual abuse, even if they or their child had prior experiences with services. Despite this lack of knowledge, most caregivers believed that MHS were generally necessary for child sexual abuse." These mental health services have benefits such as someone to talk to the child about what they were going through, teaching how to deal with what they went through, addressing their behavioral issues they may have as a result of the abuse, and preventing them from getting worse (2016). Some caregivers did not think their children needed mental health care after their abuse because "their child was too young, their case was unsubstantiated, they preferred to talk with their children themselves, or they did not receive sufficient recommendations or information about services" (2016).

When the child is too young to understand what is going on, they feel they may not benefit from talk therapy but could benefit from an alternative like play therapy in which a therapist could speak in their own language that the child understands. In a different way, group therapy is beneficial because children are naturally social beings and may thrive off of being in a group to work through issues. Play therapy is effective because the therapist is speaking the language of the child and is able to communicate with them better. Cognitive behavioral therapy is particularly helpful because it teaches problem solving skills and changes poor thinking and behavior. These children may have behavioral issues and act out due to the abuse and may exhibit poor self-esteem because of what has happened to them. This CBT therapy will focus on those key factors in order to improve the child's condition.

An important mental health service particularly focused on this population is the creation of the child advocacy center. These centers are focused specifically on children that are victims of some sort of abuse, mostly sexual, or neglect. In Georgia alone, there are 44 child advocacy centers. These centers offer forensic interviews, medical treatment, victim advocacy, and mental health services to victims of child abuse. The mental health services available include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), and group therapy. These centers offer therapy to the children completely free of charge so that there are no financial barriers for the families to get help.

There are a number of mental health services available to these victims but there are some barriers to getting this help. The main barrier is the parent or guardian failing to seek services. According to Fong and colleagues, "While a few of these caregivers stated that they would have considered services for their child if they had received stronger recommendations or more information about services, others reported that nothing would have convinced them to pursue services for their child" (2016). Children usually have to obtain permission from their parents or guardian in order to utilize these services. Other barriers include: available pediatric mental health care providers, scheduling appointments, lack of coordination and communication around children's multiple providers, and turnover of mental health care providers (Fong et al, 2016). When children can find a pediatric mental health provider, it is sometimes hard to fit it in with their school schedules and parents or guardians may have trouble or lack of transportation to take them to appointments. Also, children may be seeing a social worker, mental health counselor, psychiatrist, and general doctor and all these providers may fail to coordinate with one another regarding the child's care and the quality of care may suffer.

There are also barriers regarding disclosure of child sexual abuse. These barriers include fear of social stigma, threats by perpetrator, burdening their parents, not wanting the perpetrator to get into trouble, lack of trustworthy people to tell, and fear of not being believed (Münzer et al., 2016). Children are afraid of being labeled as "sick" or "gross" or "dirty" for being abused by the perpetrator so they keep the information to themselves. They might also fear that future partners might not want to be with them because they were touched by someone when they should not have been. Victims can also be threated by the abuser not to tell. They may threaten violence or hurting the victim's family if they tell. This threat might keep them quiet because they do not want the abuser to hurt them further.

Children also may not want to burden their parents with the information of the abuse. The abuser could be the breadwinner in the family so if they tell, their money might be cut short. The parents or guardians might not be able to handle the information that their child was hurt and might go after the abuser and the child may fear they will go to jail. The child might also feel there is no one trustworthy to tell. They might fear that person will hurt them or just do nothing about it or worse, confront the abuser. The victim already has trust issues from the abuse so risking telling someone is a big deal. One of the victim's biggest fears is not being believed. The child might tell someone they trust and that individual may believe they are joking or exaggerating. This reaction for a trusted individual will isolate the victim more and make them feel as if they may never be helped out of the situation. There are a range of services available to child sexual abuse victims but there are also just as many barriers keeping them away from getting the help they need and deserve.

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Member Spotlight: Dr. James T. Hansen

By: Blake Sandusky

Dr. James Hansen is a professor in the Department of Counseling at Oakland University in Rochester, Michigan. He enjoys spending time with his wife, two sons, and their dog Niko. He enjoys reading (check him out on Goodreads.com), working out, playing darts, sampling micro-brews and whiskeys, gadgets and technology, and listening to blues and jazz fusion. His main scholarly interests include philosophical issues in counseling, mental health culture, and humanism. His latest book, *Meaning Systems and Mental Health Culture: Critical Perspectives on Contemporary Counseling and Psychotherapy,* was released earlier this year. **Look for the review of this book in the fall 2016 *Infochange*!**

How do you conceptualize or how would you define Humanistic Counseling?

For me, humanistic counseling is defined by two related characteristics: 1) Attentiveness to the whole person; refusal to reduce people to parts; 2) A consistent focus on understanding and appreciating the subjective experiences and meaning systems of clientele. The humanistic relational factors, which have consistently proven to be the key healing elements in the counseling process, naturally grow out of a commitment to the above two values. Unfortunately, these values are the exact opposite of current cultural norms, which strongly emphasize the reduction of people to baser elements (e.g., diagnosis, problem behaviors, etc.) and the superiority of supposed objective truths over personal experience.

What is some advice you would give to current counseling students or practicing counselors wanting to incorporate Humanistic counseling in their practice?

With all the cultural talk of best practices, I think it is useful to remember that relational factors, which are the unique focus of humanistic counseling, have consistently proven to be the most important, evidence-based predictors of counseling outcomes. Therefore, we are in an odd cultural climate wherein the minority humanists are fundamentally correct about counseling and the majority of mental health culture has gone off in the wrong direction. To illustrate the absurdity of this situation, imagine that a minority group of physicians advocated the use of antibiotics to treat infections while, despite the evidence, the dominant medical majority strongly propounded the healing benefits of bloodletting. Consistently incorporating humanistic practices in counseling, then, requires counselors to resist cultural pressures to reduce, objectify, and problematize clients. It is not easy to resist the allures of the dominant culture, particularly since training programs have increasingly tended to teach and model unhelpful reductive practices, such as symptom-based diagnostic training, technical interventions, and an emphasis on the acquisition of micro-skills and competencies instead of holistic student development. Therefore, I recommend that counselors who would like to incorporate humanistic counseling in their practices cultivate their countercultural sensibilities by seeking humanistic supervisors and colleagues; reading classic and contemporary humanistic literature (especially the *Journal of Humanistic Counseling*); and joining, and becoming active participants in, the Association for Humanistic Counseling.

What is something interesting about your life path that has brought you to where you are today?

I began my career as a practitioner, with no plans to become a professor. After a period of dissatisfaction with the conditions under which I was practicing, I suddenly realized that I wanted to become a professor. This realization came to me in a burst one day, and I immediately called the local university looking for a faculty position. In an incredible stroke of luck, a position was available, and I had some of the skills they were looking for. With my wife pregnant with our first child and the ink barely dry on a new mortgage, I quit my job at the psychiatric hospital and anxiously accepted a one-year visiting position, with no assurance of continued employment after the position expired. It turned out to be a good bet. I just celebrated twenty very happy years as a faculty member at Oakland University.

What is your favorite part, memory, or what are you looking forward to being a member of AHC?

My favorite memories of AHC are the wonderful times I have had with fellow members. I am fortunate to have many good friends in AHC, and I look forward to spending time with them at conferences. I have also enjoyed being a long-term member of the editorial board of the *Journal of Humanistic Counseling* because it has offered me the opportunity to support scholars and shape the intellectual direction of the field. All of the editors I have worked under have been outstanding! These editors, Matthew Lemberger-Truelove, Mark Scholl, and Colette Dollarhide, have been absolutely exceptional in their leadership, and I feel lucky to count them as good friends.

Thank you for the opportunity to answer these questions. I would welcome hearing from readers and can be reached at jthansen@oakland.edu I would like to thank Dr. Hansen for being willing to be the spotlight member for this edition of *Infochange*.

We are always looking for members to spotlight, if you know a member of AHC who is doing some incredible work, outstanding teaching, or just an all-around interesting person, Feel free to contact me at wbsooo8@auburn.edu.

Voices from the conference: AHC in Portland, Oregon

By: Kristina M Faimon

What was your experience at the conference? What did you learn? Did you make connections that influence your present practice?

In reflecting back on this experience, I kept coming back to how at home I felt at this conference. In my 15 years of being in the mental health field, I often "conference" in a different manner, this is code for I attend only a few of the presentations. To my own surprise, I attended all day and found myself invigorated by the topics in each session. The presenters were brilliant passionate counselors who invited engagement and inspired me to learn more about the topics they shared! I think the **A**uthentic **H**onest **C**onnections that I felt here made an impact on me and how I approach my education and my future as an educator.

Furthermore, I learned about a wide range of topics that I can incorporate into my way of being. I enjoyed the discussion surrounding desire and then that lead to me attending the existential workshop and processing the anxiety that come up during this exercise. Then the keynote was one of the most authentic speakers I have ever had the opportunity to hear, showing the courage to open herself up. Also she mentioned Brene Brown's work and how it has impacted her life, this connected with me on a personal and professional level, as I am certified in her research and am doing my dissertation on shame and feedback in the education of counselors.

The keynote solidified the importance of this research and of embracing vulnerability instead of making it pathological. In my career, I am now circling back to being a student and I felt that the connections I made at the conference were built on a common desire to cultivate learning and living in a manner that requires deeper reflection on a regular basis. Also exploring how counselors and counselor educators can be authentic in our practice. I feel a sense of gratitude for being a part of this conference and truly enjoyed trying to capture the essence of the experience in writing.

Three Brief Conversations on the Construction of Madness

By: Robert S. Fink, Ph.D.

1
Friday

Mom has spent the past four days in Millard Fillmore Hospital receiving treatment for a debilitating bladder infection. Her admission to the hospital had been precipitated by a crisis at her senior residence. After she missed breakfast and lunch on Monday the staff came to her apartment to check on her. They found her on the bedroom floor, delirious, urine soaked and unable to stand up.

I am primarily responsible for overseeing Mom's medical care. Since I live several hundred miles away her physician, Dr. Barnett, and I have arranged to talk by phone once each day. It is during our Friday conversation that Dr. Barnett mentions in passing that he has prescribed daily use of the anti-psychotic medication Haldol since her admission.

I am stunned. Mom psychotic?

"Haldol? Why?" I quiz Dr. Barnett. "Is she psychotic? She's never been psychotic. And aren't such medications known to increase confusion in the elderly and accelerate their dementia?"

Without a hint of irony Dr. Barnett replies: "Haldol and other anti-psychotics are well-regarded treatments for managing the behavior of elderly patients. The research about dementia is unclear. And surely Dr. Fink, you're familiar with hospital psychosis."

For a minute I do not answer. I feel like shouting fuck you and the horse you rode in on. Instead I speak slowly in a flat, controlled and slightly menacing tone: "Are you saying that she is psychotic? Do you mean that she is not in contact with reality, hallucinating or paranoid? Or are you saying that she's confused, upset easily and tough to deal with?"

Dr. Barnett indicates it is the latter. Then he adds, "She is suspicious and mistrustful. She questions the staff about everything."

My patience is rapidly fraying. "Okay I certainly understand she can be a pain in the neck. But even so take her off the Haldol. Who is benefitting from it anyway, my mother or the staff? She sounds drowsy when we talk. If you want to 'manage' her better why don't you have the nurses sit down and talk with her!"

Two days after stopping the Haldol Mom has regained only a faint semblance of her familiar self: friendly and impatient. Still missing is her talkative nature, ironic stories, humor, restless intelligence and opinionated remarks. In short -- her vitality has been leached out.

Continued on next page.

Three Brief Conversations on the Construction of Madness *Continued*

2
Monday.

After this hospital experience I can't wait to jumpstart more humane treatment at the rehabilitation center where Mom was transferred yesterday. Now Jennifer Hochberg, MSW, ACSW is on the phone. She is the intake social worker. And her first question floors me. Without any preamble she asks: "Is your father dead? And if so how did he die?"

Stunned. Sitting in silence I feel my hope sinking in sloughs of dismay. "Why do you ask?" I question weakly.

Jennifer is insistent. "It would be most helpful if you would just clarify your father's status."

Now I can picture the scenario. Taking her history Jennifer asked Mom about her husband. She explained that he was murdered. Mom's story fell far outside Jennifer's boundaries of plausibility. Consequently Jennifer suspects that Mom is delusional. Again the implied suggestion of psychosis is in the air. Is it dementia or schizophrenia speaking? Jennifer's question is intended to untangle this diagnostic puzzle.

"My father and uncle owned a small clothing store on Broadway in Buffalo. In 1979 they were murdered intentionally although they offered no resistance during a robbery at the store. A salesman and a customer were seriously wounded and traumatized. My mother never married again. Isn't this what my mother said?"

There is a long pause. Then Jennifer thanks me. Yes, my version of events jibes with my mother's. "This is what your mother told me. Very tragic." Quickly she pivots to questions of how Mom has coped with this, as well as medical and social history.

I interrupt her. "You didn't believe my mother. The story of my father seemed too far out. So you assumed she was delusional."

Jennifer insists this is not her reaction: "My job is to gather and clarify data about the life history of our elderly patients so that we can be as understanding and person-centered as possible. You know that your mother has cognitive impairments. Certainly I need to verify what she tells me. You can appreciate that."

Once again I hear the cool dismissive tone of subtle invalidation masquerading as professional objectivity. That's the professional point of view. From the human perspective I feel that I have been blown off by Jennifer, and told that my understanding is so off that it cannot be taken seriously. Was this Jennifer's message to Mom? What did it mean to her? Then I feel the old rumbling of outrage and despair gathering force. Cautionary reminders flash through my mind: Keep your mouth shut. This is about Mom. You need Jennifer to advocate for Mom with the staff. Just answer her questions.

So I do. Jennifer has many questions. I answer them as descriptively as possible, telling stories and trying to make Mom come alive for Jennifer. We talk for 30 minutes. Jennifer seems pleased. She says this will help her to plan for Mom's rehabilitation program. I am relieved and slightly numb. Paradoxically, to stay engaged with Jennifer after our troubled start I needed to emotionally disengage. My comments were channeled from a distant mental galaxy. I can barely remember our conversation.

Finally Jennifer is finished. She asks if I have any questions. I have a few about the various therapies, staff availability and visiting. Her answers are encouraging. Slowly my mind returns to planet earth. As I return the beginning of our interview hits me again as an assault. So I ask her "Why was your very first question about my father's death?" Over the phone I hear a pained exhale of exasperation and then a long silence. Cursing myself I apologize: "Look I'm sorry. I know we need to move forward. We just see it differently."

Jennifer's reply is at once empathic and chiding: "It's okay. I know you want the best for your mother. No doubt this is stressful for you. But we need to move on."

"Yes let's go forward," I agree. "Let me just ask you one more question. It will help me to help my mother. She can be quite sensitive."

Warily Jennifer consents.

"What did you say to my mother after she told you about my father?"

"Nothing. I wasn't sure what to say."

"Thanks. And what did my mother do then?"

Again there is a long pause. "She didn't say anything. She closed her eyes and dropped her chin on her chest."

3
Saturday

I am wandering through the maze of hallways in the rehabilitation center. Where is the activities room? The once bright yellow walls are now faded into a dull pancake beige, courtesy of an imperceptible patina of grime The corridors exude the trace scent of urine commingled with a chlorinated cleanser. The soft lighting seems devoid of energy or stimulation.

Finally I find the activities room. The residents are scattered about, all in wheelchairs. Some are napping and others are staring blankly at the flickering images on televisions mounted high on the walls.

Mom is in the room, sitting across the table from a woman who is shouting. At first her eyes are closed. Then Mom sees me, smiles and waves me over.

For a few minutes we catch up and go over the plans for the weekend. We have to talk loudly to be heard over the

Continued on next page.

Three Brief Conversations on the Construction of Madness *Continued*

shrieks of her neighbor. This woman is screaming about the Nazis, pleading with the staff to release her so she can escape before she is forced into the gas chamber and killed.

Mom motions to me to move closer. In a hushed voice she tells me: "She's crazy. Half the time she's shouting about the Nazis and how they're going to kill her. One day she saw Hitler in the dining room having a bowl of soup. She's frantic to get out. Is this what you call a delusion?"

"Yes. Are you frightened of her?"

"No. Not really. I think she must be terrified, poor woman. Anyway, she's not like this all the time."

"Do you know her at all?"

"Yes. We've talked a bit when she is calm. Actually when she's not upset she is kind of quiet but friendly."

"What do you talk about?"

"Our families or how bad the food is here. But once she told me she was in the camps when she was young."

"Really?"

"Yes. Buchenwald I think. She didn't say much about it. Except that the odor here is like the piss smell in the cattle car that took her to the concentration camp. Do you think that has anything to do with how crazy she gets sometimes?"

I consider this for a moment. "Yes. I imagine it could remind her of all the death she witnessed and the fear for her life in the train and camp. How frightening!"

Mom shook her head sideways. In a louder voice she said: "Not frightening. Terrifying." At the same time she quickly wiped her eyes.

I wondered about her emphatic tone. Did her eyes just get wet? She'd swiped them too rapidly for me to be sure. So I ask her if she feels this way sometimes.

Looking stricken Mom nods. "Yes, Bobby, I'm terrified too. I'm not crazy like her. I know that Hitler isn't here. But I know there's something the matter with me. I'm just fading away. Since I was in the hospital I hardly feel anything. I'm in a haze. I'm not myself. There are large dark spaces in my mind where memories and words used to be. I know you're here for my birthday. When is my birthday? I don't remember. I know I'm old now. But I don't know how old. You know I was always talkative. Now it's too hard. The thoughts and feelings, and the words for them, are gone. When I'm with others I'm leaving only a shell of myself there. I'm empty now. I'm with people but I'm missing. It makes me feel so alone then."

I started to talk but she interrupted me. She couldn't stop now. Her speech was raspy-sounding and urgent. "I know my memory is bad but this is different. Something is the matter with me. I've lost my self. But it's not what Dr. Barnett thinks. Of course I was scared and mad in the hospital. The night before I came in, I couldn't get off the floor and thought I would die there. I was delirious but I wasn't crazy. Sure I was terrified and confused. And it's not what Jennifer thinks. How could someone think I would make up a story so horrible - like Dad's murder - if it wasn't true. That's sick!"

"No, that's not what's wrong with me. But they think this stuff means I'm crazy. And it seems to me that the fact I don't agree becomes another example to them of how I am mentally disturbed. That's how their attitude of concern feels. Sometimes this is so confusing I'm convinced I am crazy.

My mother, always fiercely proud and defiant, now battered into self-doubt and despair. She had become a helpless witness, watching in horror as chunks of her being vanished into a psychological black hole, aided by Haldol and abetted by the discounting of her reality in the service of a diagnostic, objectifying way of treatment. Her sensitive mind no longer could defend itself from these unwitting indignities and hidden agendas. Now she had to absorb and endure it all.

We would love to hear more about you and your experiences. We accept articles specifically related to you and your practice. Here are some prompts that may inspire you:

- How has humanism has impacted your practice?
- How do you describe personal growth?
- How do you incorporate service into your work?
- Are there any aspects of humanism that you struggle with? If so, how do you manage these struggles?

Please submit to InfoChangeAHC@gmail.com.
Submissions should be 1000 words or less.