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Supervision for Counselors Working With Eating Disorders Groups: Countertransference Issues Related to Body Image, Food, and Weight

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Because of similarities in age, education, and background, group counselors and members of eating disorders groups may easily identify and connect with each other. Although it can be positive, such overidentification may also create countertransference issues and demand attention in supervision. A model of supervision based on parallel process is presented to address these issues. The article describes (a) societal values related to eating disorders and countertransference; (b) specific themes in eating disorder groups and their impact on group process; (c) examples of countertransference related to body image, food, and weight; and (d) guidelines for supervision of female counselors working with eating disorders groups.

Bulimia nervosa and anorexia affect a substantial number of young women. Up to 5% of all women experience bulimia (Grange, Telch, & Agras, 1997; Pyle, Halvorson, Neuman, & Mitchell, 1988; Wade et al., 1996), which is often associated with serious medical complications (Kaplan & Woodside, 1987) and psychological distress (Katzman & Wolchik, 1984; Mizes, 1988; Williamson, Kelley, Davis, Ruggiero, & Bloudin, 1985). In addition, subthreshold bulimics make up 17% to 27% of college women (Scarano & Kalodner-Martin, 1994), and 15% to 18% of high school students manifest some bulimic symptoms (Crago, Shisslak, & Estes, 1996; Hsu, 1990; Stein et al., 1997). Women with anorexia make up a smaller but still significant percentage of the population with estimates ranging from less than 1% to 4% (Selzer, Hamill, Bowes, & Patton, 1996; Wade et al., 1996).

Group treatment for women with eating disorders is an efficient use of resources (Brownell & Foreyt, 1986; Fettes & Peters, 1992; Yates, Sieleni, & Bowers, 1989). The sizable number of individuals requesting treatment for eating disorders makes group work cost efficient in that several clients can be seen at the same time. Furthermore, the curative factors of groups may be especially useful in helping clients work through issues typically associated with eating disorders. For example, the secret, shameful, and chronic nature of an eating disorder contributes to the client's sense of isolation, whereas groups offer the support of peers, multiple models of competency, reality testing, and opportunities for altruism (Oesterheld, McKenna, & Gould, 1987; Zimpfer, 1990).

In addition, because of similarities in age, education, and culture, counselors and members of eating disorders groups are often able to identify with each other (Hamburg & Herzog, 1990), which increases connection and cohesiveness. Bilker (1993) commented that female therapists "like their patients, have a greater awareness of body image and a firsthand understanding of the emotional, physical, sexual, and spiritual experiences of being female" (p. 402). He concluded that the experiences "facilitate empathy and give the therapist more credibility with the female patient" (p. 418). Simply stated, female counselors may be able to connect with their clients because of similarities in goals, aspirations, and interpersonal style.

Although a relationship between client and counselor is essential, Zerbe (1993) and Saloff-Coste, Hamburg, and Herzog (1994) have warned that female counselors may overidentify with their clients who have eating disorders, which may interfere with therapeutic progress. Frankenburg (1984) suggested that female counselors with experiences and conflicts similar to those of their clients may avoid certain conflicts and issues in therapy. Bilker (1993) specu-

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lated that such similarities may lead to pain avoidance, being overly nurturing, and feelings of competition toward their clients with eating disorders.

Several surveys of health care providers have documented the difficulties related to working with clients who have eating disorders (Wooley, 1991; Zerbe, 1992). Of the health care professionals surveyed, 28% reported being greatly affected by their work with these clients (Shisslak, Gray, & Crago, 1989). Anorexic patients engendered more feelings of anger, helplessness, and stress for medical residents than did those with diagnoses of obesity or diabetes (Brotman, Stern, & Herzog, 1984). Franko and Rolfe (1996) used clinical vignettes to assess countertransference toward anorexic, bulimic, and depressed clients. They found that therapists felt significantly less connected and engaged and more frustrated with anorexic and bulimic clients than with clients with depression.

Although countertransference issues related to working with clients who have eating disorders have been discussed elsewhere (Hamburg & Herzog, 1990; Zerbe, 1992, 1993), these discussions have focused on countertransference issues in general and not specifically on those countertransference issues related to body image, food, and weight. It is essential to examine these countertransference issues in depth, because working with clients who have eating diorders affects counselors' perceptions of themselves, which in turn affects their ability to serve as a reality check for their clients with eating disorders. Shisslak et al.'s (1989) study emphasized that not only were health care professionals surveyed greatly affected by their work with clients who have eating disorders, but specifically their relationship with food was affected. This included a heightened awareness of food and their physical condition, which led to changes in eating habits, body image, and appearance. As a case study, Zerbe (1993) described how she was unconsciously influenced to change her eating and exercise habits as a reaction to two clients with eating disorders. Thus, it seems essential that counselors who work with eating disorders must be comfortable with their bodies and have realistic perceptions of healthy body weight, eating habits, and relationship with food because of the continual need to serve as a reality check for their clients about these matters. If counselors are not aware of the impact of culture on their beliefs about self-worth, body image, and attractiveness, they may inadvertently communicate or reinforce such unrealistic beliefs and values to their clients.

In addition, the literature indicates that counselors working with clients who have eating disorders are frequently influenced by the irrational and faulty belief systems of their clients (Baumann, 1992; Zerbe, 1993). Zerbe stated that counselors will "commonly find themselves reverting to concrete modes of thinking and becoming 'containers' of their patient's bodily preoccupation. One understanding of this process is that the patient, via the mechanism of projective identification, has successfully deposited discomfort and pain within the therapist" (p. 173). (See Ginter and Bonney, 1993, for a detailed explanation of the projective identification process.)

Thus, supervision for counselors leading an eating disorders group is essential to deal with countertransference issues that may arise related to body image, food, and weight. When therapists were asked what helped them to cope with these kinds of feelings, nearly all (98%) cited supervision or consultation with colleagues as most helpful (Franko & Rolfe, 1996). The therapists concluded that the opportunity to ventilate their feelings and have them validated seemed critical to ensure that they did not act on them. "Feelings of frustration, fear, anger, and lack of connection are potentially powerful countertransference reactions for a therapist to contend with under the best of circumstances" (Franko & Rolfe, 1996, p. 114).

Supervision is essential to counselors as a source of support and as a reality check. As Hamburg and Herzog (1990) noted, "the supervisor is faced with the challenge of distinguishing between forms of mutual identification that promote the progress of therapy, and those that may halt it in its tracks" (p. 374). As Zerbe (1993) so eloquently stated:

> Along the way, all members of the treatment team are potential crucial sources of new identification figures for the patient. Those who care for eating disordered patients are no doubt at greater peace with their own body, having achieved some semblance of psychological and physical unity. But full psychosomatic integration and ease with one's body is always more an ideal than a reality for any of us; treaters must be attuned to their own potential psychosomatic vulnerabilities and body image struggles. (p. 173)

If this is indeed true, then supervision is imperative to help counselors continue to have a realistic sense of body image, food, and weight so that the unrealistic expectations and perceptions of women with eating disorders are not supported.

This article focuses on the potential countertransference issues related to weight, food, and body image that female counselors may encounter when leading counseling groups for women with eating disorders. The article describes (a) sociocultural influences related to eating disorders and countertransference; (b) common themes in eating disorders groups; (c) two brief examples of countertransference related to body image, food, and weight; and (d) a supervision model for female counselors working with clients who have eating disorders in group. My experience with leading and supervising groups for women with eating disorders (for both anorexic and bulimic women), together with findings from the literature, serves as the basis for observations discussed and suggestions offered.

SOCIOCULTURAL INFLUENCES RELEVANT TO EATING DISORDERS AND COUNTERTRANSFERENCE

Orbach (1978) discussed cultural myths that continue to be destructive to women in our society today, several of which strongly encourage the irrational beliefs of women with eating disorders (e.g., I must be thin to be attractive; my body size determines my worth as a person). These myths influence how women approach their lives and see value in themselves. Steiner-Adair (1986) suggested that

certain sociocultural influences make anorexia, bulimia, and anorexic-like behavior "a seemingly adaptive response to the developmental demands of growing up female in certain populations at this time in history" (p. 95). She further stated "what is put forward in the cultural ideal of physical and mental health for contemporary female adolescents is tied to the emergence of psychopathology in the form of eating disorders" (pp. 95–96).

One myth is that women should be caretakers and nurturers, unselfishly giving to others at all times. This belief interferes with the ability of women to attend to their own needs and may lead to the denial of their own needs in order to please others. Women may value taking care of others more than themselves. Another myth is that women's bodies are imperfect and impure. This alienates women from their bodies and yet simultaneously propels them into an increasing focus on how thin they are as a means of achieving perfection (e.g., the infamous quote "one can never be too rich or too thin"). This perpetuates the idea that thinness is an answer to all of women's problems—that if they just lose weight, they will be more popular, be more assertive, obtain a good job, and so forth. Such thinking actually detracts from looking at other ways to improve oneself and focuses on the body as the major source of improvement. Related to this is the idea that a woman's appearance is valued above everything else, which again focuses the woman on her body and its imperfections and suggests that if she does not possess her culture's ideal body shape, then her worth as a person is essentially nonexistent.

Steiner-Adair (1986) suggested that not only is appearance valued above all else but self-acceptance is based on the approval of others. Again, women are not paying attention to themselves and their opinions. The idea that the feminine personality defines itself in terms of relationships and connectedness to others creates unrealistic expectations and situations for women. The problem is not so much the connection to others but that women often think that to connect and achieve successful relationships, they must be thin and look good; again, the focus is on their bodies. Separation and individuation as developmental tasks of adulthood are made more difficult for women because they assume the role of caretaker and nurturer in relationships, and because of their need to connect and their need for external validation and approval to feel good about themselves. Although all women do not develop eating disorders, these sociocultural influences are present in our society and affect all women to some extent. These influences also help foster countertransference issues.

COMMON THEMES IN EATING DISORDERS GROUPS

Although each woman with an eating disorder and each group for women with eating disorders is unique, common themes are likely to emerge. Among these themes are striving for perfection, dichotomous thinking, diminished awareness of internal standards, external reinforcement, desire to please others and caretaking, a sense of being out of control and helplessness, and avoidance of affect, particularly negative feelings (Boskind-White & White, 1983; Steiner-Adair, 1986). Each of these common themes is discussed in the following sections in terms of how they may be manifested in behavior and in the group. Counselor interventions will be suggested. Although these themes may be viewed as existing independently of countertransference, they frequently can be linked to countertransference issues experienced by the group leader.

Perfectionism

Perfectionism is often manifested in women with eating disorders and leads to unrealistic expectations toward counseling: to feel better immediately in treatment, to maintain an unhealthy or unrealistic body weight, or to stop bingeing or purging immediately. They often view one mistake as total failure. In the group setting, they may have difficulty asking for what they want or need because they do not want to be seen as needy or less than perfect. Because they view themselves as failures, they may not report relapses or instances when suggestions from the group did not work for them. A counselor must deal with expressions of perfectionism with support, understanding, and encouragement. Early in the group, counselors must directly point out unrealistic goals (e.g., I will never binge again) and help members set more realistic expectations based on current performance (e.g., I am currently bingeing every day, so my goal for next week is to not binge every day). They must also be supportive and help members to reframe cognitive distortions so that they begin to think more realistically about how change occurs (e.g., I have engaged in this behavior for 3 years, so I am not going to change overnight).

Dichotomous Thinking

Dichotomous patterns of thinking are often related to perfectionism. Everything is all or nothing, with foods either good or bad, a person either totally in control or out of control, or eating behavior of either starving or bingeing. Group members often talk about thin being good and fat bad. Baumann (1992) noted "the fear of fat or feeling fat is prevalent in the group. The idea of not eating is associated with being good" (p. 96). Coupled with unrealistic expectations of what they should weigh, group members almost always perceive themselves as fat and, thus, bad. This dichotomous thinking manifests itself in group in that members may make decisions about other members based on their weight and size, not their contribution to the group. For instance, they may decide that an overweight member is bad, out of control in her eating, and thus nothing she says is valuable. The counselors must address such misperceptions and help members to recognize the positive and negative aspects of all people and situations. It should be noted that dichotomous thinking can also interfere with the group members' ability to perceive the group counselors as helpful and supportive and, at the same time, challenging and confrontive.

Diminished Awareness of Internal Standards

Members of eating disorders groups may also display diminished awareness of internal standards related to hunger, satiety, and feeling states. They may describe not knowing they are full until they feel bloated or not noticing they are hungry even though they have not eaten in 24 or 48 hours. Related to feeling states, they may not realize that they are depressed or that something made them angry unless asked specifically how they were feeling or what happened before a binge started. In the group setting, members may not recognize that they are upset by something that happened but react nonverbally.

External Reinforcement

Women with an eating disorder usually do not have a good sense of themselves, and so they are often looking for external sources of reinforcement. Being thin is one such reinforcement: If I can just be thinner, I would be more popular, feel better, and so on. In the group setting, members will often look to leaders and other members for advice and answers to solve their problems. They often want to know the "truth" about an eating disorder and exactly what they need to stop (even though they have read numerous publications on the subject, including professional literature). Because of this, they ask a group counselor for the answers instead of examining for themselves how the eating disorder helps them cope personally. Group counselors need to be able to provide information without providing answers. They may make suggestions and ask other group members to make suggestions regarding a particular situation. They must then take the next step and teach and assist group members to evaluate which solution might work for them as an individual, rather than basing their decision on group consensus or the opinion of the most verbal group member.

Desire to Please and Caretaking

Two other closely related themes are a strong desire to please others and to act as a caretaker for others. Because of the desire to please others, group members are often very accommodating in group, do not verbalize negative feelings, acquiesce regardless of their inner feelings, give advice rather than focus on affect, and do not challenge group counselors or members. To help group members learn to balance their needs with the needs of others, group counselors must encourage members to speak up even if they have different opinions, teach group members about the importance of expressing feelings, and point out when verbal and nonverbal behaviors do not match.

A Sense of Helplessness or Being Out of Control

Feeling out of control is another common theme. Women with eating disorders will often describe the use of binges, purges, and restriction of food intake as a means of control. They may also focus on food and body weight as the one area in their life that they can control. Attendance at group sessions may be irregular, an expression of their feelings of helplessness and lack of control. Group counselors must encourage clients' examination of the relationship between their eating behaviors and other issues in their lives, dispute the irrational belief of having no control over life, and facilitate problem solving about how to feel more in control and to cope with feeling out of control.

Avoiding Affect

Women with eating disorders may also avoid affect. They have difficulty tolerating silence and give advice to divert attention from feelings. If a group member is crying or about to cry, others may rush in to give advice or tell her that it will work out. Group counselors can help members to see the importance of acknowledging feelings, how to express them positively, and the relationship of feelings to their eating disorder.

EXAMPLES OF COUNTERTRANSFERENCE RELATED TO COMMON THEMES

The following two scenarios are provided to the reader as examples of countertransference related to body image, food, and weight that may occur for leaders of an eating disorders group.

Example 1

A very petite member of the group comments, "Everywhere I go, I look at other women's thighs and compare them with mine. I look to see whose are bigger. I feel better about myself when I see that someone else's thighs are bigger, but more often, I notice someone with smaller thighs and I feel bad."

Therapeutic issues. How can I approach this individual about her biased sample of comparisons? How can I get her to look at physical appearance as just one aspect of an individual, not a total determinant of her worth?

Potential countertransference issues. She is comparing her thighs with mine, and mine are bigger. I know how disgusted she feels about fat. What must she be thinking of me? Am I fat? Do I need to lose weight? Do I sometimes judge people based on their physical appearance and size? Am I not paying enough attention to my body? Am I sending out messages to others that I do not care about myself?

Example 2

In the past, a particular group member has reported very dysfunctional behaviors and cognitions. She has used laxatives and vomited on a regular basis to control her weight. She exercises several hours each day without fail. She consumes up to 3000 calories in a binge, including whole cartons of ice cream, whole boxes of cookies, and whole loaves of bread. She occasionally steals food from her roommate to supply her binges. Now the group member states, "I weigh myself every day. If I am up a pound or two, I get angry at myself and depressed. I consciously eat less that day, maybe skipping a meal or exercising extra hard."

Therapeutic issues. How can I help her to acknowledge the tremendous progress demonstrated by the decline of extreme behaviors and still encourage further improvement in healthy weight control behaviors? How can I use some of my imperfection to help this client?

Potential countertransference issues. I weigh myself every day and I experience negative feelings if I gain weight. What is dysfunctional and what is not? Am I dysfunctional because I think and do some of the same things this client does? Will I ever resort to some of the behaviors this client has (behaviors that sometimes shock and disgust me) in my efforts to control my weight? Because there are similarities between us, how can I maintain a balance of identification in which I do not treat her as an object (inferior to me) but I do not overidentify with her? (Or, I never weigh myself. I am not like this client. I am better than she is.)

When the group counselor is touched by such issues, she may react personally. She may distance herself and deny any association with the members, thereby separating herself from the group's symptomatic thoughts and behaviors. She may become overwhelmed with the similarities experienced and feel inadequate to help the members. Her reaction may fall somewhere between the extremes, still hindering her sense of well-being and effectiveness as a group counselor. Like her clients who may become isolated in the shame of their thoughts and actions, the group counselor may become isolated in the shame of her perceived inadequacies as a counselor. Conversely, if a group counselor can be encouraged to acknowledge, examine, and discuss such feelings, her effectiveness as a counselor is likely to be greatly enhanced. Competent supervision and use of coleaders are vehicles for increased counselor and group effectiveness.

POTENTIAL COUNTERTRANSFERENCE ISSUES FOR LEADERS OF EATING DISORDERS GROUPS

Several countertransference issues have been raised regarding working with eating disorders. Each of these has been discussed in the literature. They are now discussed with particular regard to body image, food, and weight.

Overidentification

A strong countertransference issue when working in a group with clients who have eating disorders is overidentification. Overidentification with a client or several clients in a group may block the counselor's ability to serve as a reality check for clients. When clients struggle with issues of self-esteem, assertiveness, and relationships, counselors may be able to identify with them. As suggested earlier, this identification with clients may at first facilitate connection and a common base of experience; later, it may interfere with the group counseling process.

> These dilemmas of overidentification have in common the perils of walking a line between an alliance that allows the patient to experience the therapist as genuinely alive, interested and involved, and the zone without boundaries that the therapist as the fantasy of 'just like me' becomes the only way to experience the patient. It is especially easy for the therapist to be overidentified with these patients concerning issues of gender, generation, power, twinship, or obsessiveness. (Hamburg & Herzog, 1990, p. 374)

Overidentification with clients may make it harder for counselors to confront their clients if they perceive themselves as having the same issues. The reality is that most counselors are at least a step or two beyond their clients in terms of self-awareness and their resolution of such issues. However, if they overidentify with clients, they may not perceive their own competence and may have difficulty helping clients to see their situation differently. Furthermore, if counselors also identify with clients in terms of values about body image and size and feelings of confidence, then it may be difficult for them to confront clients' irrational beliefs (and their own) on these topics. Saloff-Coste et al. (1994) described countertransference issues for dietitians that have obvious implications for female counselors:

> [She may] share some obsessiveness related directly to food, eating patterns, and body image. The cognizant dietitian can use that special personal and professional understanding to validate the patient's process of recovery and to develop rapport, but she must guard against validating inappropriate assumptions or cultural values, and must remain flexible and unbiased. (p. 52)

Control

Counselors' countertransference when working with clients who have eating disorders may also be a reaction to a member's issues about control. If the counselor overreacts to the client's perceptions of control, albeit high or low, then the counselor may become overly responsible for the member, bored, or engaged in a power struggle with the member. It is the counselor's function to set limits and conduct therapy as she would with other clients and not react to a particular member's issues about control. Zerbe (1993) suggested that

> firm limit setting and an ability to refrain from being swayed, corrupted, or seduced by pleas to cast a blind eye to the eating disorder itself may be a crucial step in helping the patient learn modes of self-regulation. Although patients will frequently test the therapist they will often feel relief with a treater who states and then reinforces weight criteria. (p. 175)

If a member presents as being out of control, the first instinct of a counselor may be what Hamburg and Herzog (1990) described as the need to "do it all" for the group member and respond with a level of structure and control of the situation that causes the member to react with anger or passive-aggressive behavior.

Alternatively, the members may come to depend on the counselor to structure the session and their lives. It is essential that the counselor provide clients enough structure to benefit from counseling without stifling the group members with too much structure. Conversely, group members may exert control over the food they eat, how much they exercise, and how and when they binge or purge. Attempt-

ing to take this perceived control away may also engender anger or passive-aggressive behavior.

Saloff-Coste et al. (1994) emphasized finding an appropriate level of activity with clients. Relating this to food, weight, and body image, counselors must have clear beliefs about how to work with clients about their eating disorder without being intrusive and controlling. For example, a group member who weighs herself every day and determines what she eats based on her current weight may not be willing to give up these behaviors easily. The counselor must work with the member on a plan to change such behaviors. Extremes of counselor behavior, either not asking the member at all about what she has eaten or what she weighs or focusing on such topics every session, do not model a balance of control for the group members.

Secrecy

Related to control, counselors may also react to members' secretive behaviors (Hamburg & Herzog, 1990). Clients with an eating disorder often do not volunteer information about how much they eat, binge, purge, or exercise. To them, it is a secret. When asked questions about these topics, they may be vague or change the subject. For example, a group member may state that she eats three meals a day when asked about eating habits. However after further questioning, the counselor may learn that the client ate ½ cup of dry cereal for breakfast, an apple for lunch, and a bowl of rice for dinner. On the basis of such information, the counselor may discuss with the group members why they are not eating adequately. It should be noted that some clients with eating disorders may react with anger to this discussion and claim that what they eat is their business. In addition, some counselors may react to this by demanding more information or by not asking about eating behaviors unless a group member brings it up. Hamburg and Herzog postulated that "some therapists feel compelled to go after secret material, either out of curiosity or from the conviction that the truth will free the patient from the shame she feels" (p. 371).

Counselors must strike a balance about how much information they need to work effectively with group members. It is imperative at times for a counselor to know specifics to assess medical safety. They need to know enough to intervene but should not be intrusive without reason. If the counselor reacts to the secrecy about food and weight by demanding more information, members may in turn respond by being more secretive. In contrast, if the counselor reacts by not asking for some specifics, some members may feel neglected or may hide a condition that requires medical attention. Similar to the issue of control, "the therapist must find an appropriate level of activity for each patient and at each stage of therapy" (Hamburg & Herzog, 1990, p. 372).

Helplessness

Counselors working with clients who have an eating disorder may react with feelings of helplessness, ineffectiveness, and inadequacy (Baumann, 1992). Some of these feelings may be realistic in that women with eating disorders are difficult to work with and progress is slow. Countertransference issues are apparent when the counselor views the resistance to getting better as an injury to the counselor (Hamburg & Herzog, 1990) rather than as a symptom of a long-standing and deeply rooted condition. Saloff-Coste et al. (1994) described a common phenomenon for dietitians working with eating disorders: The dietitian may feel excessively responsible for a client and then feels professionally wounded when the client says she gets no help from her but will continue to see her because she likes her as a friend. This is probably more of an example of the client expressing her hopelessness and feelings of lack of progress about her treatment, but it is phrased in such a way as to make the dietitian (or counselor) also feel helpless and ineffective. It is imperative that the counselor be able to accurately assess the members' progress in therapy, commitment to therapy, ability to progress, and time frame for progress, and to separate these from the counselor's efforts to help members.

Avoidance of Affect

Counselors working with clients who have an eating disorder may also exhibit countertransference in reaction to a member's avoidance of affect (Baumann, 1992). Clients with eating disorders tend either to be overly expressive of feelings such that their whole life is chaos and they cannot do anything about it (the histrionic client) or to work very hard at keeping all emotions under tight control. In either situation, it is important that group members learn to express their feelings appropriately and directly and to be comfortable with a range of feelings.

> It is often said that the eating-disordered patient needs to learn to sit with her feelings rather than avoid them by bingeing and purging, and through other symptoms . . . The therapist treating eating-disordered patients needs to be able to sit with and work with his/her feelings that are evoked in responses to the patients in the room. As the therapist is able to bear the dysphoric feelings, so the patient may increase her capacity for bearing her own unbearable feelings rather than aborting them by bingeing, vomiting, self-starvation, overexercising, or laxative abuse. (Baumann, 1992, pp. 98–99)

Thus, it is important that the counselor be comfortable with a range of feelings and be able to direct clients on how to express them appropriately. The counselor must encourage group members to examine their feelings when they say they have none and to role model for members ways to identify and express their feelings verbally and nonverbally. In addition, the counselor must be able to avoid overreacting to any member's overwhelming sense of depression, inertia, or lethargy and rush to rescue by providing suggestions or taking control. Alternatively, the counselor must not become numb to strong emotions and neglect reacting to them because they are constant for a member. The general aim is for the counselor to model affective expression in a way to better enable group members to display the full range of emotion in an adaptive manner.

A MODEL OF SUPERVISION

Based on my 11 years of supervising female counseling graduate students who lead weekly (1½ hours per week) outpatient eating-disorders groups, the following are recommendations to enhance the supervisory process and the effectiveness of group counseling.

Theoretical Framework

DeLucia, Bowman, and Bowman (1989) described the parallel process that occurs in supervisory and group counseling sessions. They suggested that "counselors are able to facilitate resolution of similar tasks in their clients to the extent they have addressed those tasks in the supervisory relationship" (p. 233). Thus, as group counselors for an eating disorders group become aware of how they deal with imperfections in their bodies, separation and individuation from their families, and issues of independence and interconnectedness, they can then help group members resolve these issues. DeLucia et al. discussed the parallel process between group counselors and members in terms of the group stages. Group counselors must first experience and learn how to form a trusting relationship with their coleader and supervisor before they can facilitate trust and cohesiveness in group members. As coleaders learn how to successfully resolve conflict and disagreement, they can then facilitate similar behaviors in the group. Next, as group leaders learn how to give and receive interpersonal feedback and examine their relationships with others, they are able to facilitate similar exploration on the part of group members. Last, as group coleaders experience and learn how to say "good-bye" in relationships, they are able to help group members terminate their relationship with the group in a positive manner.

This parallel process occurs in all groups (DeLucia et al., 1989). Group counselors for eating disorders groups must learn skills to facilitate trust, cohesiveness, openness, conflict resolution, and ending to be effective. In addition, they must have skills to help clients examine and change their beliefs about their bodies, food, weight, and their relationships. Following from the ideas of DeLucia et al., the premise of this model is that a counselor's ability to successfully facilitate change in clients is based on their own successful examination of these issues. Thus, it is essential that counselors working with clients with an eating disorder have a healthy body image and relationship with food (Zerbe, 1993).

Structure of Leadership and Supervision

A coleadership model and weekly supervision for group leaders are the basis of this model. This coleadership model follows the piggyback model of group leadership (McRoy et al., 1991). In this model, coleaders meet weekly for 1½ hours to plan and debrief. They also meet with a faculty supervisor weekly for 1 hour as a team. Each group counselor makes a commitment to colead the eating disorders group for two academic terms, serving in the apprentice role during the first term and then in the experienced role during the second term. It is highly recommended that the prospective counselor serve as the process observer to the group for an entire academic term before taking on leadership responsibilities to learn about the process of eating disorders groups.

Initial Examination of Beliefs About Body Image, Food, and Weight

Before leading an eating disorders group, counselors need to examine their beliefs and feelings about their bodies, coping styles, and interactional patterns. Several books may be helpful in understanding the key issues in bulimia and anorexia and helping to formulate potential interventions. I recommend the following resources. Boskind-White and White (1983) described the disorders of anorexia and bulimia and the behavioral patterns and cognitive distortions that can occur. *Fat Is a Feminist Issue* I and II (Orbach, 1978, 1982) and "The Body Politic: Normal Female Adolescent Development and the Development of Eating Disorders" (Steiner-Adair, 1986) challenge the group counselor to think about the impact of societal beliefs on women's bodies and self-image and the development of eating disorders. Weiss, Katzman, and Wolchik (1985) suggested specific, concrete cognitive-behavioral interventions that are useful with women with eating disorders. Thompson and Sherman (1989) in "Therapist Errors in Treating Eating Disorders: Relationship in Process" discussed common errors counselors may make with women with eating disorders that result in resistance, and gave practical alternatives to confront resistance. Hamburg and Herzog's (1990) article "Supervising the Therapy of Patients with Eating Disorders" is useful for obtaining an understanding of general countertransference issues toward clients with eating disorders.

After learning about bulimic and anorexic clients, group counselors need to examine similarities with and differences from their group clients. The issue of body image is an essential part of this self-examination. *Body Love* (Freedman, 1988) and *What Do You See When You Look in the Mirror: Helping Yourself to a Positive Body Image* (Cash, 1995) contain a variety of exercises that may help counselors examine their body and self-image and the maladaptive beliefs and perceptions they may hold (e.g., people will like me better if I lose 10 lb., I would be more assertive if I looked better). Counselors can participate in these exercises first by themselves and then with their coleaders to begin a discussion about body image and cognitive distortions. This should be the beginning of an ongoing discussion of how the group counselors' issues are sometimes mirrored in the group, when and how they are triggered, and how counselors react cognitively, behaviorally, and emotionally. Coleaders and their supervisor can facilitate exploration of these issues for each other and provide a reality check when the cognitive distortions of counselor and group member coincide.

Another exercise of potential value in helping group counselors understand what it is like to have an eating disorder is to use guided imagery to illustrate and experience a typical day in the life of a client with an eating disorder complete with a binge and purge, fears about gaining weight, resolutions about sticking to a diet that day, failing and then making resolutions for tomorrow, and the negative self-talk that occurs throughout the process. After the guided imagery is over, it is important for the group counselor to talk about what it was like to go through the guided imagery, what she identified with, what was hard for her to relate to, and what feelings she experienced as a result of the guided imagery. Again, it is recommended that both coleaders participate together in this exercise so they can share their experiences and acknowledge their similarities and differences.

The Appendix lists common themes that emerge in eating disorders groups and then suggests, as described earlier in this article, questions that may be helpful for group counselors to think about regarding these themes. In examining their similarities with clients with eating disorders, group counselors can begin by looking at the list of themes and asking themselves: Which of these themes influence my life? By what other themes do I live? Then, more specifically, group counselors can examine the list of manifestations of these themes and consider, In which of these thoughts do I believe and in which behaviors do I engage? For those beliefs and behaviors with which they do not identify, their task is to think about how they will dispute these beliefs and help clients look at how these beliefs can hurt them, and how they will challenge behaviors in group that interfere with group process or with a client making progress.

Each of the activities just described is designed to help group counselors examine their own beliefs and possible misperceptions about body size, weight, and food in an effort to facilitate similar examination in women with eating disorders.

Continued Examination Through Supervision

Weekly supervision is a vital component of the model. Counselors can begin to examine their beliefs about food, weight, and body image before beginning to lead an eating disorders group. However, they must continue to examine their beliefs and possible misperceptions throughout the life of the group. As with most issues, their beliefs must be examined repeatedly to achieve a level of comfort with them. A counselor may think that they are comfortable with their body size until a particular event in a group session or in their personal life resurrects that as an issue for them. It is then important for the functioning of the counselor and the group to examine this issue so that it does not influence her response to group members. This is not to suggest that supervision become therapy, but that personal issues should be examined to the extent that they potentially influence the group process.

Several ground rules must be established at the beginning of the group and the counselor supervision to promote safety and trust. First, coleaders will examine their beliefs about food, weight, and body image in the ways described earlier before commencing group leadership. Second, the foci of supervision will include individual members, group process, the relationship between coleaders, and personal issues of the coleaders as they affect group process. The third and fourth ground rules are correlates of the second. Third, coleaders and supervisors are expected to discuss personal reactions to members and group topics. Fourth, if a personal issue is the focus of supervision several times, then the coleader must seek other avenues to attempt to resolve this issue (e.g., enter individual counseling).

Structuring the supervision session is helpful to allow time for personal reactions. The content of a supervision session should include attention to the following: events of the previous session, behavior of individual members during the previous session, reactions to the previous session and individual members, and then goals and plans for the next session. As coleaders discuss events and behaviors of group members, it is important to assess and ask them to verbalize their reactions. The questions that follow are designed to clarify and illuminate reactions. What is it like to be in group while this happens? What is it like to hear a member talk about herself in that manner? What is it like to hear a member talk about her behavior in that way? Who do the members remind you of? Why? How do you deal with this person? Is it effective? If not, why not? How are you similar or different? How do your similarities or differences influence your behavior with that member? Do you treat her differently? Why? How does this group discussion help the members to decrease dysfunctional behaviors? Are the behaviors being described in group useful in decreasing dysfunctional behavior? Do you overtly or subtly reinforce dysfunctional behaviors or attitudes? Why? What would happen to you and the group members if you disagreed?

It is essential to begin the discussion of countertransference related to weight, body image, and food before coleaders begin to lead an eating disorders group and to continue throughout the life of the group in a trusting supervisory environment.

CONCLUSION

The sociocultural influences that govern how women in our society view and accept themselves, and the impact those influences have on clients with eating disorders specifically, also have implications for female counselors of eating disorders groups. If it is true that counselors share many similarities with their clients who have eating disorders, in part due to the fact they are influenced by the same societal factors, then it is also true that working with women who have eating disorders may trigger similar issues and concern for the counselors.

Beutler, Crago, and Arizmendi (1986) stated that the therapist's well-being and social influence consistently and robustly affect counseling outcome. This lends credence to the importance and necessity of thorough supervision for

group counselors. It is essential that counselor issues be addressed within the context of supervision, so that counselor issues do not impede the therapeutic process, but rather further the growth of group members. Group counselors' examination, exploration, and resolution of issues such as perfectionism, caretaking behavior, independence, and separation facilitate development of empathy and understanding for clients and also suggest potential intervention strategies. Essential to the group counselor's learning process about themselves and about eating disorders is the examination of the beliefs and behavior systems of women with eating disorders; sociocultural influences on women, their bodies, and self-esteem; and the role of women in relationships. Through readings, discussions with coleaders, and supervision, group counselors can then look at how they are similar to and different from members of their eating disorders group. These activities influence their ability to identify with, connect with, and confront their clients.

More research is needed on beliefs and behaviors with which group counselors can identify. Counselors must look at the origins and functions of their beliefs and behaviors and how they work in their life, then begin the process of planning how they will intervene with clients on these issues. Issues that a group counselor has in common with a group member are positive but challenging. The counselor can use her own issues to understand and empathize with members but must also challenge herself to confront dysfunctional behaviors and thoughts in clients, even when she is still working on them herself. This is the point at which the coleader's and supervisor's support, encouragement, reality testing, and confrontation can help the group counselor to effectively examine her issues and then, in turn, help a group member do the same.

The focus of this article is on the experience of female counselors in their leader role for an eating disorders group. Beyond the scope of this article, but also important, is how male counselors and supervisors may experience their roles as they relate to leading or supervising an eating disorders group, and how male counselors or supervisors may be affected by these issues in similar and different ways. Another area for further investigation regarding groups for women with eating disorders is the differences that may occur as a function of the type of group (i.e., support groups, counseling groups, psychoeducational groups, and self-help groups) and population (e.g., adolescents vs. adults, women with an active eating disorder vs. recovered women with eating disorders, and normal eaters vs. subclinical bulimic vs. clinical bulimic individuals) (Scarano & Kalodner-Martin, 1994).

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APPENDIX

Common Themes and Potential Questions for Group Counselors of an Eating Disorders Group

Perfectionism
- How do I expect myself to be perfect?
- How do I expect myself to be a perfect group counselor?
- If I do expect myself to be perfect, how am I going to react when I make a mistake (which I eventually will)?
- How do I expect my clients to be perfect?
- How quickly do I expect them to "get better?"
- How will I react to their mistakes, returns to old habits, and relapses?
- What is the perfect body size and type?
- How realistic is my image of perfect body size?
- How do I react to my clients based on their body size?

Dichotomous thinking
- How do I think in terms of good and bad?
- What areas do I think of in terms of good and bad?
- What behaviors do I perceive as good or bad?
- How do I respond to these behaviors based on my views of good and bad?
- Are there certain foods that I do not ever eat?

Diminished awareness of internal standards
- Are there certain behaviors I never engage in and have a hard time understanding why someone would. How do I know when to stop eating?
- Do I eat until I am too full?
- Do I stop eating when I am still hungry because I think I have eaten enough (or my diet says I have eaten enough)?
- How do I confront a client on paying attention to her body signals?
- Do I not pay attention to other body signals—when I get angry, sad, stressed?
- How do I know when I have done a good job?
- How important is it for me to have others tell me I look good?
- How do I reconcile differences between my perceptions of a situation and someone else's? Does it depend on the person? How?
- How will I talk with a client about our different perceptions?

Desire to please others and caretaking
- How comfortable am I disagreeing with someone?
- How comfortable am I expressing negative feelings, asking others to do something for me, or refusing a request I do not want to do?
- How do I tend to take care of others?
- How do I know that someone needs my help and how do I respond to their verbal and nonverbal requests for help?
- How will I confront a client when she is proud of her weight loss even though she did it in an unhealthy way? Or when another client compliments her on her weight loss?
- How will I confront a client when she is sharing unhealthy weight loss techniques in group?

Feeling of lack of control over life, helplessness
- How comfortable am I being in charge?
- Do I need to be in control?
- How do I react to being out of control?
- How comfortable am I with others when they are out of control?
- How do I respond when others take charge?
- Do I often engage in power struggles?
- How do I respond to clients who have a different style from me or want to go in a different direction?
- What will I do if I propose an intervention and the client says she doesn't think it will be helpful?

Avoidance of affect
- How do I deal with strong emotions?
- What emotions am I most comfortable with?
- Does my comfort level vary depending on clients' affect (sadness, anger, fear)?
- Do I avoid certain emotions?
- What emotions do I rarely express?
- Do I express my emotions directly to people?
- How do I handle clients' expression of emotions?
- Do I encourage expression of emotions, both positive and negative, in sessions?
- Do I express emotions toward my clients?

A "Primer" in Conceptual Metaphor for Counselors

Scott Allen Wickman, M. Harry Daniels, Lyle J. White, and Steven A. Fesmire

Conceptual metaphor provides a potentially powerful counseling framework, generalizable across theoretical orientations. According to the conceptual perspective, metaphor is not merely a matter of language, but is an indispensable dimension of human understanding and experience whereby more abstract ideas (like relationships) are understood in terms of more concrete experiences (like journeys). Consequently, when a couple in counseling says, "we're just spinning our wheels*," they are not only using a common colloquial expression, but also giving information about how they conceptualize their relationship. This article provides a theoretical foundation for use of conceptual metaphor and offers examples of its potential for counseling.*

Metaphoric language has been an important therapeutic tool since the first counselor attempted to understand fully a client's experience of the world. Traditionally, counselors have developed metaphors to demonstrate empathy and to suggest alternative interpretations of presenting problems. This use of metaphor, created by the counselor, does not change a client's problems; rather, it changes perception of the problem and allows for solutions as yet unconsidered. In this manner, metaphor has provided both a linguistic tool to facilitate empathy and an intervention technique with a history of therapeutic value (Bryant, Katz, Becvar, & Becvar, 1988; Cirillo & Crider, 1995; Haley, 1973; Hoskins & Leseho, 1996; S. B. Kopp, 1971; Leary, 1990; MacCormack, 1997; McMullen, 1996; Myers, 1998; Watzlawick, 1978; Watzlawick, Weakland, & Fisch, 1974).

Studies in cognitive linguistics have advanced a contemporary theory of metaphor that suggests metaphors represent more than rhetorical or linguistic techniques. These studies propose that humans use metaphor not only for communication purposes but also to experience and understand their lives (Johnson, 1987, 1993; Lakoff, 1987, 1993, 1996; Lakoff & Johnson, 1980, 1999; McNeill, 1992; Quinn, 1987; Simpson, 1996; Turner, 1987). To understand abstract ideas or events, even as such events are occurring, individuals access their knowledge of concrete experiences and apply them metaphorically. This continuous conceptual referencing of abstract ideas or events to concrete, bodily based experiences is termed *conceptual metaphor* (Lakoff & Johnson, 1980).

The purpose of this article is to discuss the use of conceptual metaphor and its special relevance to counseling. We contend that this contemporary theory of metaphor (i.e., cognitive linguistics) allows counselors a more complete and rapid access to a client's conceptual world than is provided by a more traditional understanding of metaphor (e.g., Cirillo & Crider, 1995; S. B. Kopp, 1971; Ricoeur, 1991). Because most conceptual metaphors are so common, pervasive, and mundane, they generally go unnoticed by both counselor and client. We contend that a more thorough understanding of conceptual metaphor provides counselors a framework for recognizing the underlying significance of metaphors and enables counselors to make better use of their occurrence.

METAPHOR IN COUNSELING

Certainly therapists know about and use metaphor in their work. Bryant et al. (1988) surveyed members of the American Association of Marriage and Family Therapists (AAMFT) and found that 95% (of those who responded) used metaphor, defined as "any verbal or concrete illustration, description, or reference designed to bring about perceptual and/or behavioral change" (p. 113). Recently, Myers (1998) discussed how bibliotherapy can be used as an effective strategy for cocreating therapeutic metaphors in counseling. Perhaps the best known use of therapeutic metaphor is the type popularized by Milton Erickson, who would create analogous stories and jokes that were structurally similar to clients' situations but that made no direct mention of the clients nor their descriptions of their problems

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(Bandler & Grinder, 1975; Bowman, 1992; Erickson & Rossi, 1979; Haley, 1973). Suffice it to say, metaphor is used frequently in counseling and typically is initiated by the counselor to effect client change.

We believe that viewing metaphor simply as an intervention technique is a narrow and incomplete perspective. Contemporary metaphor theory offers counselors a framework for becoming more attuned to the language and conceptual understandings of their clients. In addition, contemporary metaphor theory provides a structure for developing interventions that fit more naturally with client thinking and perception. In Piagetian theory, such a fit makes interventions more easily assimilated (Piaget, 1947/1973). In Batesonian theory, the interventions are "appropriately unusual" (Andersen, 1995, p. 15)—different, but not *too* different from client thinking (Andersen, 1992).

CONCEPTUAL METAPHOR: THE EMERGING VIEW

As just noted, the use of metaphor in counseling is far from a recent development. What is new, however, is the realization that metaphors are not merely linguistic expressions, but are integral to the very way we think (Johnson, 1981, 1987, 1993). As Lakoff (1993) stated, "the locus of metaphor is not in language at all, but in the way we conceptualize one mental domain in terms of another" (p. 203). According to this perspective, metaphor is an indispensable dimension of human understanding and experience and is essential to the way individuals think, reason, perceive, imagine, communicate, believe, and so forth (Johnson, 1987). There is evidence that even the most basic abstract concepts are understood through multiple and sometimes inconsistent conceptual metaphors (Gibbs, 1994; Lakoff, 1993; Quinn, 1987; Turner, 1987).

This means that metaphor is essential to "our having of a world" (Johnson, 1987, p. 205) and that all fundamental concepts are metaphoric. For example, conceptualizing "time as a valuable commodity," allows one to "spend" time, "save" time, "waste" time, and so forth. For this reason, people organize their lives around their own sets of personal and cultural metaphors: Who they are, how they understand situations, the way they relate to others, and what they see as possible courses of action all depend on which metaphors happen to constitute the fabric of their experience (Johnson, 1987). Although these mental processes are not directly observable, evidence for their metaphoric nature can be found in the verbal and nonverbal components of everyday communication (McNeill, 1992). Abundant examples of congruence between individuals' verbal and nonverbal metaphoric expressions can be found in the video documentary *Couples Arguing* (Gantz & Gantz, 1985), for example a wife shouting at her husband about his treatment of her children, "you come in here and you just *wipe them out*" as she concurrently makes a dramatic sweeping gesture with her hand. Similarly, the same conversation includes her bringing her hands together, raising her arms, and quickly pulling her hands apart as she says, "you just *explode* around them," using a conceptual mapping from the ANGER IS PRESSURE IN A CONTAINER set of metaphors to understand and describe her husband's behavior toward her children.

Traditional approaches to using metaphor in counseling seem to depend on a counselor's intuitive abilities. There are, however, at least two inherent flaws in this approach. First, an intuitive intervention, although it seems appropriate at the time, may depend heavily on guesswork. Thus, metaphors chosen by a counselor may or may not fit within a client's conceptual framework; after all, it is a guess. Second, intuitive ability probably exists on a continuum. For a master counselor (e.g., Albert Ellis, Virginia Satir, Milton Erickson, Carl Rogers), this dependence on intuition may not be limiting (Wickman, 1999). For others, a more systematic understanding of a client's metaphoric language and conceptual structuring should improve the goodness of fit of their therapeutic interventions.

We suggest that familiarity with the most common and pervasive metaphors and how they are referenced from one domain to another will provide counselors access to a qualitatively different understanding of a client's world. Although counselors cannot know precisely what a client is thinking or experiencing, they can know their client's thoughts and experiences are structured *this* way rather than *that*, with *these* possibilities rather than *those*. Thought processes that otherwise would have escaped notice now can be identified and brought into the therapeutic conversation. In addition, the ability to perceive clients' conceptual metaphors enhances counselors' abilities to access and reflect the frameworks through which clients understand and experience their worlds. As Lakoff and Johnson (1980) noted, "In therapy, much of self-understanding involves consciously recognizing previously unconscious metaphors and how we live by them" (p. 233). By understanding metaphor as a structure of a person's conceptual world, counselors are better able to facilitate recognition of personal metaphors and enhance self-understanding. Furthermore, counselors are better able to work within clients' existing metaphoric structure rather than impose metaphors (which may or may not fit) originating from the counselor's schema.

Adopting language that is more consistent with the client's way of thinking increases a practitioner's effectiveness (Bandler & Grinder, 1975; Latz, 1996; Rogers, 1957; Watzlawick, 1978; Watzlawick et al., 1974; Wickman, 1999). Familiarity with conceptual metaphor provides a method for developing and using such language; moreover, the counselor is able to hear previously unrecognized richness in client language and respond in kind. In this way, the effective use of metaphor is not left to the intuitive sensing of counseling "gurus" but can become an intelligently controlled and deliberate approach to therapeutic inquiry.

Conceptual Metaphor as Cross-Domain Mappings

The first step in using conceptual metaphor as an intentional counseling tool is to understand the nature of cross-

domain mappings. Traditionally, counselors have perceived metaphor as "a way of speaking in which one thing is expressed in terms of another, whereby this bringing together throws new light on the character of what is being described" (S. B. Kopp, 1971, p. 17). Other theorists (Johnson, 1987, 1993; Lakoff, 1987, 1993; Lakoff & Johnson, 1980, 1999; McNeill, 1992; Quinn, 1987; Turner, 1987) have operationalized metaphor specifically as cross-domain mappings in which the properties of one concept, from a concrete *source domain*, are transferred onto and structure the perception of an abstract concept, in a *target domain*. To illustrate, a couple seen in counseling by one of the authors reported, "we're *stuck*; we're just *spinning our wheels;* this *relationship isn't going anywhere"* (metaphoric language emphasized). As evidenced by their language, this couple described and perceived their relationship metaphorically. They were using their knowledge and experience of journeys (source domain) to understand and portray their relationship (target domain). One part, or possible entailment, of a journey is to travel in a vehicle. On a journey, a vehicle, like a relationship, can get stuck. Once it stops moving, its passengers (the relationship partners) become bewildered, frustrated, and uncertain of how to get it back in motion.

The language used in the preceding illustration suggests that the couple attributed to their relationship the same properties they attributed to a stuck vehicle. Another way to say this is that they were perceiving their relationship according to what they knew about stuck vehicles. Naturally, they wanted to act in a way that would move the relationship forward (i.e., to make progress). In this example, the couple saw their options for action delineated by the RELATIONSHIP IS A JOURNEY metaphor system. Their knowledge and bodily based experience from the concrete source domain (journey) carried over to organize their thinking and perception of the more abstract target domain (relationship).

The metaphoric understanding of a relationship, or any long-term endeavor, as a journey is hardly unique to the couple just mentioned. In fact, the journey metaphor is one of the more pervasive metaphors across domains, languages, and cultures. As Gibbs (as cited in Azar, 1995) explained

> Through bodily experiences, such as standing, walking, eating, and other interactions with the physical environment, people develop mental models—image schemas of concepts such as balance, containment, resistance, and verticality. . . . These same concepts crop up in language. For example, another image schema is "source-path-goal." Humans often move along a path to reach a goal—across the room to get a book, down the road to see a friend. People recognize abstract concepts, "life is a journey" and sayings such as "we're at the crossroads," and "we've gotten off the track" because they have an innate understanding of the source-path-goal theme. (p. 20)

Three Aspects of Conceptual Metaphor

Contemporary metaphor theorists suggest three aspects to conceptual metaphor: mnemonic, cross-domain mapping, and everyday language (see Figure 1). Cross-domain mapping, already discussed, is explored further in light of representing one of the three aspects.

PLEASE PLACE FIGURE 1 HERE

FIGURE 1

Three-Part Analysis of a Conceptual Metaphor: An Illustration

The mnemonic. The mnemonic is the name of a set of related metaphors. For example, the mnemonic RELATIONSHIP IS A JOURNEY includes the metaphors (i.e., cross-domain mappings) that relationship partners are travelers, the relationship is a vehicle, relationship problems are obstacles to motion, and so forth (see Figure 1). Other mnemonics are also likely to be present in discussions about relationships. In fact, Quinn (1987) found the following relationship mnemonics to prevail in Western culture: RELATIONSHIP IS A JOURNEY, RELATIONSHIP IS A BUSINESS PARTNERSHIP, RELATIONSHIP IS A MANUFACTURED PRODUCT, RELATIONSHIP IS A SAFE HAVEN, RELATIONSHIP IS AN ORGANISM, and RELATIONSHIP IS A DURABLE BOND. On the basis of her research, Quinn concluded that many difficulties in marriage occur when one spouse has a particular metaphor (e.g., RELATIONSHIP IS A BUSINESS PARTNERSHIP) that conflicts with the expectations generated by the other spouse's dominant metaphor system (e.g., RELATIONSHIP IS AN ORGANISM).

To illustrate, the person who perceives relationships as business partnerships may experience relationships as investing in contracts that stipulate rewards. Such rewards (e.g., respect) are contingent on contributions to the relationship (e.g., income earned) and are in contrast to the perception of relationships as organisms. For a person whose perception is structured by RELATIONSHIP IS AN ORGANISM, a relationship is nurtured and the partners grow together

without deference to just rewards for individual contributions. It takes little imagination to see how partners using different sets of metaphors could experience difficulty resolving conflict. It is almost as if they are speaking different languages or living in different conceptual universes. And in many ways they are.

Cross-domain mappings. Each mnemonic in fact represents a whole set of correspondences that are mapped from one domain onto another. Specifically, one domain provides a source or referent for understanding the other domain, called the "target." Again, the source domain, through which the target domain is experienced and understood, contains knowledge that people already have, based on their own bodily experiences and what they have learned from other people. Hence, knowledge from the bodily based source is "mapped" across domains onto the target in order to structure and organize how the target domain is perceived and understood. For example, as previously stated, RELATIONSHIP IS A JOURNEY includes cross-domain mappings such as the partners are travelers, the relationship is their vehicle, the course of the relationship is a path, problems in the relationship are obstacles to motion, and so forth. On the other hand, RELATIONSHIP IS A BUSINESS PARTNERSHIP includes cross-domain mappings like relationship partners are contractors, the relationship is a contractual agreement, the course of the relationship is a ledger, problems in the relationship are debits, and so forth. Yet a third perspective on relationships is found in RELATIONSHIP IS AN ORGANISM. In this case, relationship partners are caretakers of the organism, the relationship is a living organism, duration of the relationship is the life cycle of the organism, problems in the relationship inhibit growth, and so forth.

To reiterate, people's perception of an event or concept consists of knowledge and experience from a source domain being "mapped" or transferred onto a target domain. What a couple knows about journeys, business, organisms, and so forth structures their understanding and experience of relationships. For example, relationships, like vehicles, get stuck, break down, and run out of gas. As perceived through the RELATIONSHIP IS A JOURNEY metaphor, progress in a relationship can be impeded when something—or someone—gets in the way. If an obstacle is insurmountable, the journey or relationship stops. To summarize, "mapping knowledge about journeys onto knowledge about love permits us to reason about love using the knowledge we use to reason about journeys" (Lakoff, 1993, p. 207).

Everyday language. People's everyday language contains metaphoric expressions so pervasive, common, and seemingly mundane that they go largely unnoticed. Lakoff (1993) described this as the "surface realization" (p. 203) of conceptual metaphor: Everyday language is representative of the underlying, deeper cross-domain mappings that take place at the conceptual level. For example, couples describe their relationships as "at a dead end" or "making a lot of progress" because they are conceptualizing their relationship according to their knowledge and experience of journeys. If they were conceptualizing their relationship in terms of a business partnership, they might say, "I've invested a lot in this relationship," "I've given you the best years of my life," or "I don't get any credit for all the stuff I do." Similarly, people with a prevalent metaphor of RELATIONSHIP IS AN ORGANISM may be heard to say "we've grown a lot together," "this relationship is on its deathbed," "we're starting to branch out and do things with other people." As these examples demonstrate, everyday language reflects the cross-domain mappings that structure how people make meaning of the world. Taken together, mnemonics, cross-domain mappings, and everyday language offer a means of showing concretely how people reason about and experience the worlds in which they live.

Case Examples

Once a counselor becomes aware of the pervasiveness of conceptual metaphor, therapeutic interventions can be more appropriately structured around metaphors expressed and experienced by the client. Three of the following case examples are taken from our counseling experiences and illustrate the clinical utility of this knowledge. The final example is taken from the counseling session between Carl Rogers and Gloria (Rogers & Wood, 1974; Shostrom, 1965; Wickman, 1999) and illustrates the intuitive use of conceptual metaphor by a master clinician.

Case 1. A recently retired couple entered counseling saying "we're not getting along" and "we don't know where to go from here." After hearing more RELATIONSHIP IS A JOURNEY expressions (e.g., "I go out of my way for you," "we've been through this before," "I wish we could get over this hump"), the counselor began to respond and ask questions using parallel language. "It's been quite a journey for the two of you," he said. The couple enthusiastically agreed. Then he asked, "Imagine you were taking a journey in a car: Who would be the driver?" The wife pointed to her husband, who pointed to himself. The counselor looked at the wife and asked, "How safe do you feel as a passenger, with him as the driver?" She replied that she did not feel safe and that they were "headed straight for a wreck." The counselor continued by asking, "If this really were a vehicle, what would you do?" "I'd jump out!" she said. Hearing this comment, the husband's mouth visibly dropped and he gave other indications that he had heard his wife's concerns about their marriage in a way he never had before.

Case 2. Another way metaphor can be approached in counseling is to help counselors and clients use language that leads to clearer and more effective communication. To illustrate, a divorced mother in counseling was troubled by her apparently futile efforts to interact better with her 14-year-old son. When asked to pay attention to her son's language during their conversations, the mother reported that her son used expressions such as "don't you hate pay backs?" "you owe me one," "you're selling me short," and "I don't buy that." These expressions showed that the son consistently employed terminology from the RELATIONSHIP IS A BUSINESS PARTNERSHIP conceptual metaphor, one of many

metaphors found within the MORAL ACCOUNTING metaphor (Johnson, 1993).

As a part of the counseling process, the counselor discussed some details of this metaphor with the mother, including how the concept of a business transaction seemed to influence her son's perception of their relationship. In addition, she and the counselor practiced using business metaphors in session. Through this experience, the mother was sensitized to her son's conceptual viewpoint; that is, she began to use his conceptual metaphor for the relationship in her conversations with him. Subsequently, the mother reported that when she used business terminology, her son was more verbally responsive and their communication improved.

Case 3. Rogers (1957) noted that clients will sometimes disagree with statements reflected to them by the counselor, even when the statement is repeated verbatim. In this way, contemporary metaphor theory offers counselors another means by which to reflect client perceptions of presenting problems. By observing and using language consistent with the everyday metaphors clients use, counselors can more precisely reflect feelings and clarify underlying meanings. For example, a counselor noticed a husband using business transaction metaphors to discuss his marital relationship (e.g., "I've put a lot into this family that I don't get credit for." "I've held my end of the bargain." "I feel like I am indebted to her for the past and nothing I do is good enough."). The counselor then asked, "What investments are you willing to make in your wife?" The husband responded, "You know, I can't look at my wife as an 'investment;' she's a lot more than that to me." In this case, the husband consistently had used business language to describe his relationship. Nonetheless, the inadequacy of this metaphor became apparent to him once it was made overt, and he was able to explore alternative ways of looking at the relationship.

Case 4. Rogers (1957) posited that empathy was one of the core conditions for a helping relationship and that the most important aspect of empathy was that it be perceived by the client. Using metaphoric language from the client's conceptual domain can enhance the client's perception of being heard and can expedite rapport building. The Gloria session (Rogers & Wood, 1974; Shostrom, 1965; Wickman, 1999) provides some clear illustrations of Rogers's apparent intuitive appreciation of the conceptual nature of metaphor.

> Gloria: I want to approve of me, always. But my actions won't let me. I want to approve of me.
> Rogers: You sound as though your actions are kind of *outside* of you. You want to approve of you but what you do somehow won't let you approve of yourself.
> Gloria: Right! (Wickman, 1999, pp. 262–263)

Throughout the session Rogers seems to intuitively understand that Gloria is perceiving THE PSYCHOLOGICAL SELF IS A CONTAINER. The container holds psychological states and personality traits. In her idealized perception of herself, Gloria is not able to accept her container holding conflicting states and traits. Rogers recognizes this and uses the phrase "your actions are kind of *outside* of you" to convey his understanding of her metaphoric container of "self." At this point of the interview, her metaphoric container for her self as a "good and sweet" mother does not allow for actions that she deems "ornery." Her enthusiastic acceptance of Rogers's language suggests that this exchange has helped build rapport between them (Wickman, 1999).

CONCLUSION

Speaking a client's language has long been understood as a means to join with clients, gain their trust, and bring about the necessary and sufficient conditions for change (Rogers, 1957). Counselors who are familiar with conceptual metaphor advance their capacity for communicating with language from the same metaphor systems as their clients and for expressing a deeper awareness of clients' problems. By using language that is congruent with their clients' conceptual metaphors, we contend that counselors can communicate more empathically and respectfully while helping clients explore the logical conclusions of an issue more efficiently and elegantly. Knowing how entities and knowledge are referenced (mapped) from one domain onto another enables a counselor to use language congruent with a client's perceptual world. Consequently, the cross-domain mappings frame the therapeutic conversation, while allowing for any of the various theoretical counseling orientations to be practiced.

Conceptual metaphor offers a communicative tool to help counselors respect, understand, and reflect clients' conceptual systems. Furthermore, by attending to the metaphoric structure of clients' language, counselors are able to use that same metaphoric structure to frame their therapeutic language. Along these lines, Lakoff and Johnson (1980) have argued that "Metaphorical imagination is a crucial skill in creating rapport and in communicating the nature of unshared experience" (p. 231). Lakoff and Johnson, like Frankl (1963), also contended that much of clients' self-understanding is the product of the search for appropriate personal metaphors that give meaning to their lives. Consequently, counselors who recognize their clients' conceptual metaphors are better able to respond effectively to client concerns. Understanding conceptual metaphor allows counselors to join with clients through increased rapport and empathy and structure therapeutic interventions that are more consistent with clients' existing frameworks.

Counseling is a rich database for conducting research into conceptual metaphor. Although previous authors (e.g., R. R. Kopp, 1995; Kozak, 1992; Rosenblatt, 1994) have related conceptual metaphor theory to counseling, and others have studied the effectiveness of therapeutic metaphor as a counseling intervention (for an overview of this research, see Ingram, 1994, and McMullen, 1996), we are currently applying conceptual metaphor as a framework for investigating the language used in therapeutic conversations. Our initial findings suggest that clients use meta-

phors pervasively. Some metaphors occur intermittently, whereas others dominate perceptions about a problem. We are also finding that the interpretation of metaphors is context dependent. Each conversation participant brings with her or him a set of existing metaphors and experiences that structures their particular language and understanding (S. G. Kopp, 1998). Because these differences of meaning exist, counselors can increase common understanding with clients by consciously making metaphor mappings a part of the therapeutic conversation. In future investigations, we intend to address research questions such as how clients' metaphors change over time, how counselors' metaphors compare and interact with those of their clients, and how the use of differing metaphoric language by family members relates to their reasons for seeking counseling. The effects of training counselors to use conceptual metaphor in their sessions will also be examined.

Our enthusiasm for the potential of conceptual metaphor to nourish clinical research and training in the counseling profession is unabashed; however, the breadth of this line of research is greater than can be attended to by one research team. Therefore we hope this article will serve to inform and stimulate the interest of others who find these notions intriguing.

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Fifty Strategies for Counseling Defiant, Aggressive Adolescents: Reaching, Accepting, and Relating

Fred J. Hanna, Constance A. Hanna, and Susan G. Keys

Fifty strategies for establishing and maintaining a therapeutic relationship with defiant, aggressive adolescents are offered. Many of these are taken from the literature, whereas others are unique to this article. A variety of strategies, ranging from reframes to the use of paradox are provided, and take a transtheoretical approach using ideas from cognitive behavioral as well as existential, Gestalt, psychodynamic, and multicultural therapies. Strategies are arranged under 3 categories: reaching, accepting, and relating. The strong desire of defiant adolescents for freedom and autonomy is also discussed, with suggestions for using this in motivating defiant adolescents to work in counseling.

Many professionals in the field have noted how difficult adolescents are to engage in treatment and what a challenge they can be, even to the most skilled counselors (Gil, 1996; Liddle, 1995). Some have said that adolescents are the most difficult of clients to work with in a counseling context (Church, 1994). Trepper (1991) noted that most therapists view working with adolescents as "adversarial sport," and in some cases as "blood sport" (p. ix). This leads many professionals to avoid the prospect altogether, preferring to work only with adults and young children (Biever, McKenzie, Wales-North, & González, 1995). To the counselor who enjoys working with difficult adolescents, such an adversarial attitude is both unfortunate and unnecessary. It is not surprising that there is a marked lack of research on effectiveness with adolescents, especially with those who are violent (Tate, Reppucci, & Mulvey, 1995). There is also a lack of training in counseling approaches with adolescents (Rubenstein & Zager, 1995).

The purpose of this article is to suggest ways of building meaningful therapeutic relationships with defiant and aggressive adolescents. This is not always easy, even with adolescents in general. Many studies have indicated that adolescence is a time of great turmoil and stress. In a study of 3,998 adolescents in a nonclinical setting, Hibbard, Ingersoll, and Orr (1990) found that 20% reported some form of physical or sexual abuse. This already high percentage is probably much higher for those adolescents who are the focus of this article.

These young people typically display hostility, defiance, or other resistance to treatment. They present considerable challenges to counselors in many settings ranging from substance abuse treatment programs and locked-door institutions for adolescent criminal offenders and sex offenders, all the way to group homes and public and alternative schools. Specifically, this article pertains to those adolescents who fit the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (*DSM-IV;* American Psychiatric Association, 1994) profiles of oppositional defiant disorder or conduct disorder and commonly display many of the characteristics of attention deficit hyperactivity disorder as well. In addition, it is not unusual to find traits of narcissistic, antisocial, borderline, or histrionic personality disorders in the mix. Of course, alcohol and drug use is quite common and should always be assessed. From the family systems perspective, it is also important to bear in mind that when adolescents have been abused, it is frequently an indicator that their parents are under tremendous stress as well (Whipple, 1991). It is important to add that although these strategies are specifically directed toward defiant, aggressive adolescents, many of these strategies also apply to counseling any adolescents and to counseling in general.

THE IMPORTANCE OF THE RELATIONSHIP

Even limited experience with these young people quickly reveals how crucial the therapeutic relationship is to achiev-

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ing beneficial change in their lives. Little therapeutic benefit can be accomplished in its absence. Dozens of studies have provided evidence of the importance of an empathic therapeutic relationship in achieving positive outcomes in general (Garfield, 1994; Goldfried, Greenberg, & Marmar, 1990; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Orlinsky, Grawe, & Parks, 1994; Sexton & Whiston, 1994). The importance of an empathic relationship is also vitally important for defiant and difficult adolescents (Bernstein, 1996; Mordock, 1991) and is probably the pivotal point that determines eventual success or failure in counseling. Schorr (1997) identified strong relationships based on mutual trust and respect as one of the seven attributes of highly effective prevention programs. Yalom's (1980) observation, "It is the relationship that heals" (p. 401), is entirely applicable to defiant adolescents.

This article provides a wide range of strategies and suggestions that may be helpful in establishing a relationship that leads directly to positive, beneficial change. Therapeutic change in one form or another is, of course, a major goal of all counseling (Hanna, 1996a; Strupp, 1988). There is some evidence that a therapeutic relationship itself will produce some change in adolescents (Kazdin, 1994). Once the relationship is established, most counseling techniques that have been cataloged in the literature will be more effective. A counseling technique performed without a properly established empathic and trusting relationship seems to many defiant adolescents to be a threat to their integrity, and just another covert or overt adult attempt at manipulation.

On the other hand, if a technique is well executed by the counselor, a positive result can further enhance the relationship. The primary focus of this article, however, is on what will help bring about a positive working relationship in the critical early stages of counseling. We recognize that many of the strategies presented qualify as techniques in themselves. We emphasize that the following list of strategies will not work for all defiant adolescents, and it is up to the practitioner to determine which of these are most appropriate for a particular client, depending on his or her culture, class, context, and developmental level. We have arranged these strategies and approaches in a series of three general categories: reaching, accepting, and relating. There are various ways of categorizing these strategies; we chose these three because they serve as convenient, concrete organizing principles for working with this population. After this, we briefly discuss the topic of freedom and autonomy as related to motivating adolescents in counseling. We have found that most of the strategies and suggestions presented here are suitable for people of many cultures, in both individual and group counseling, and a few are applicable in family counseling settings. Many of the strategies are based on the research literature; we adapted others from lessons learned over more than 20 years of combined clinical experience. The strategies themselves are generally arranged in each of the three categories, beginning with those requiring the least skill or that are most fundamental and ending with the strategies that are the most advanced, demanding, or subtle.

STRATEGIES

Reaching Defiant Adolescents

One of the first things to recognize about defiant adolescents is that often they have been deprived of people who can serve as models of how to appropriately interact with and relate to others. Thus, the defiant adolescent is often heavily self-absorbed and feels that there is virtually no difference between adults and children (Sherwood, 1990). The idea of reaching them refers to attaining contact beyond the boundaries of egocentric self-absorption. It also refers to traversing the barriers common to adolescence. In a sense, adolescence itself can be viewed as a unique culture, and adopting a multicultural perspective in working with this type of client is essential. Here are some strategies for reaching difficult adolescents.

Offer a snack. This is a good icebreaker. Adolescents generally love to eat, and this helps them to be comfortable. Keep a jar of cookies, chocolates, chips, pretzels, or granola bars handy and in sight. Offering a snack can often influence "mouths to talk" and can even give an indirect suggestion of nurturance (Rubenstein, 1996).

Avoid desks. Sitting at a desk or even near a desk can maintain the stereotypical view of the counselor as a representative of a hostile, controlling adult establishment. Sitting face-to-face with no obstructions is more conducive to being seen as a genuine person, rather than as an "enforcer of rules" (Rubenstein, 1996).

Be familiar with music that adolescents like. Of course, this can vary from person to person, but we have many therapeutic conversations spring spontaneously from just being able to talk about certain groups or performers. One does not have to like the music to use discussion of it as a therapeutic tool, and this need not be limited to discussion. Invite the adolescent to bring a favorite piece of music to listen to together. Ask him or her to tell you what it is that they find appealing about their musical preferences. Whether the music is violent, sexist, artistic, or comforting can be topics to pursue in counseling by asking questions along these lines. Finally, be careful not to criticize the piece to illustrate "what's wrong" with it.

Allow the client to occupy their hands while talking. Do not insist on having the person's direct attention and eye contact. Many defiant adolescents have an amazing way of being able to both talk meaningfully and listen intently, even though their hands are busy and their eyes will not meet those of the counselor. It helps to provide pens and a pad, clay, or a Koosh® Ball so that the client's body can be occupied while the mind is focusing on issues. Many feel more comfortable being freed from having to establish eye contact, and for some, eye contact may not be culturally appropriate (Ivey, 1994).

Get out of the office whenever possible and appropriate (Gendlin, 1986). "Just talking" can seem painfully boring

to some adolescents. Many will spontaneously disclose in surroundings outside an office—during a walk around the agency, school, or waiting for a court hearing or a home visit. Conducting groups in a park or a campsite also has a way of encouraging disclosure. It is important to note that permission is needed from parents, schools, and agencies when conducting sessions with adolescents in nontraditional settings. Issues of confidentiality must be carefully attended to if this approach is taken.

Be genuine and unpretentious. Orlinsky et al.'s (1994) review of the literature provided evidence that genuineness as a counselor trait is effective in producing positive outcomes in general. This seems especially true for adolescents, who can detect phoniness, insincerity, or disingenuousness in a matter of minutes (Rubenstein, 1996), and with amazing accuracy and clarity (Ohlsen, 1970).

Show deep respect for the client. Courtesy and consideration should be given a client at every turn, even while he or she is profoundly angry, spiteful, or resentful. Some good work can be done during times of acting out. Adolescents are frequently surprised by this kind of courtesy and will often comment on it later. The defiant adolescent's need for respect should not be underestimated. If the counselor inadvertently shows disrespect to a client, an apology is in order. A genuine apology for a genuine mistake usually earns respect from angry adolescents who see adults as hopelessly insistent on being authoritatively right.

A sense of humor is invaluable for working with adolescents. The utility of laughter cannot be underestimated with this population. In many cases, just having a few laughs can help shift focus surprisingly easily from defiance to a therapeutic conversation. Adolescents appreciate a lighthearted atmosphere (Bernstein, 1996) and will often trust a person who can make them laugh. Adler (1956) also noted this many years ago.

Be able to laugh at yourself. Adolescents tend to look differently at adults who can laugh at their own faults or foibles. This helps them to be seen as real people rather than the rigid, pompous adults that most defiant adolescents are so dedicated to resisting and confounding. The key, of course, is not to take oneself too seriously.

Educate the client about counseling. Explain that counseling can help a person be more happy, more popular, and get along in life more easily. Satisfy the "what's-in-it-for-me?" attitude. Be concrete. Have the client identify how they would like things to be. Illustrate how your work together can help achieve this outcome. It can also be important to educate the client on what it takes to change and feel better (Garfield, 1994; Hanna, 1996a; Liddle, 1995). Many defiant adolescents do not possess the requisite knowledge or skills to change, and they are often pleasantly surprised to discover that counseling provides them with this ability.

Avoid being a symbol of authority. As long as you are seen as a symbol and not as a real person, the therapeutic relationship will not deepen and develop. Do not hesitate to point out the "madness" of society, in terms of how people are harmed by things such as racism, sexism, materialistic attitudes, illegal drugs, and discrimination against gays and lesbians. When the counselor can disagree with society, the defiant adolescent is more likely to think that he or she has something in common with the counselor. The opportunity presented here, once the symbol is dropped, is how to model responsible disagreement.

Avoid taking an expert stance, until the relationship is fairly stable. Question the client from the standpoint of not knowing (Biever et al., 1995), allowing the client to inform you. If one comes across as a "know-it-all" to adolescents, the counselor will be viewed as just another authority figure to deceive, manipulate, pacify, or appease. The proper way to state what you are fairly certain about is to pose your knowledge as a question, not as a statement of fact. A counselor might say, for example, "I have found that deep down, many gang members really don't like to fight and wish they didn't have to. Is that true for you?" Assuming an expert role with adolescents typically elicits animosity from clients and is generally a result of countertransference or lack of skill.

Avoid asserting your credentials to a defiant, aggressive adolescent or group. Similar to taking the expert stance, flaunting the possession of a doctoral or master's degree or years of experience can actually create distance and tension between the client and the counselor. This is usually done as an act of frustration, desperation, or a poor attempt to take control of a session that has gone awry. We have found that rather than gaining respect, the counselor actually loses it and sometimes becomes an object of ridicule or mockery. Of course, if the client asks, discussing one's training in detail would be appropriate and consistent with various ethical codes.

Avoid thinking in clinical labels. When it comes to establishing relationships, it is far better to drop the clinical labels and templates and focus on the "person." Gendlin (1992) called the person, the "I who looks at you from behind the eyes" (p. 453). This "I"—the real person—can be accepted unconditionally even though negative behaviors and thoughts are seen as something in need of change. Many adolescents are sensitive to this and will respond well.

Emphasize commonalities by noting similar experiences you have undergone. Hostile adolescents will often assert to the counselor, "I am tired of you saying you understand. You could never understand what I have been through!" If the counselor has been through a similar experience, this may be a good time to appropriately self-disclose. If the counselor does not have similar experience, a realistic and effective response is to say, "I may not be able to fully understand what you have been through, but I have had my share of personal pain, and I see plenty of pain in you. Maybe the only difference between yours and mine is how it got there."

Convey a "brief" attitude. Rubenstein (1996) noted that adolescents want results quickly. "We don't have much time because they don't have much patience" (p. 358). If one can, it is better to schedule a segment of six or seven sessions at a time. Do not imply long-term counseling but deal with issues of importance in the here and now, as sessions unfold.

Use a variety of media to allow the client to express what is inside without having to rely solely on verbal skills. Many adolescents respond well to using art in the form of drawing, painting, cartooning, sculpture, and collage. We have found the use of collage to be particularly effective with adolescent girls. This is done by providing a collection of magazines and asking the person to select pictures and words to create a collage that says something about who they are. We are often quite surprised at what the adolescent reveals, and both client and counselor often discover strengths or talents through this strategy that might have otherwise gone unrecognized. (See Hammond and Gantt, 1998, for a discussion of ethical issues related to the use of art therapy by counselors who are not trained art therapists.)

Use the technique of concentric circles. When in doubt about how much a client has "let one in," use the technique of concentric circles (Lazarus, 1989). This technique is designed to delineate the degree of client disclosure. It is done by drawing five concentric circles and labeling them from Circle 1 at the core to Circle 5 at the perimeter. The client is then asked to conceive the real self as being in the innermost, center circle where his or her most private and personal thoughts and feelings are held. The most superficial and insignificant information is at the surface in Circle 5. A client is then asked to point to the circle into which he or she is allowing the counselor. Clients will often be surprisingly honest with this technique, and it gives a good idea how much further the counselor has to go in establishing a close therapeutic relationship.

Avoid aiming only for insight with clients who are not cognitively inclined in that direction. Arkowitz (1989) noted that for many people, insight comes after behavior change rather than before. This seems especially true for some adolescents. In these cases, aim for behavior change, then ask what they can learn from it.

Admiration can often cut right through defiance and hostility. Assume that negative behaviors are an existential choice. If a defiant adolescent is "brilliantly" eluding your questions, compliment him or her on it. If he or she is angry, admire its intensity. If they are obnoxious or annoying, admire their effectiveness in producing frustration in others. If the person is intimidating, say so. Ask how or when he or she got to be so good at it, or how long it took, or what it accomplishes for them. A particularly defiant adolescent once told the first author, "If you even try to talk to me, I'll make your head spin." The honest reply was "My head is already spinning. You are even better than you think." A relationship with that client developed at that point.

Reframe drug and alcohol use as an attempt to avoid pain and hurt. Many defiant, aggressive adolescents often freely respond and admit to this view once presented. It helps them to understand their fascination with drugs and alcohol. Counseling can be reframed as a different road to the same goal of being able to deal with and reduce the hurt and pain that these adolescents have experienced.

Focus on the hurt, then address the anger. Many physically big, rough, intimidating boys, and flammable, defiant, angry girls will calm down when the counselor focuses on the hurt. Simply asking, "Have you felt a lot of hurt in your life?" can change the entire tone of a previously angry adolescent. The counselor can then ask, "How much of your anger is because of that hurt?" A typical answer is "Nearly all of it." The counselor can also ask, "How often do you think about the times you have been hurt." A common response is "A lot." Many clients can also easily answer the question, "How much of your life is driven by the hurt and anger inside you?" Get a percentage estimate. Defiant adolescents are often quite capable of providing such an estimate. If the percentage of anger and hurt is higher than 50%, point out that this may be evidence that the person's life is out of control and that counseling can help to deal with the hurt and return a sense of control. Many defiant adolescents wear their anger like battle scars or war medals and "love" to talk about it without intending any change. This strategy is a way to bypass this form of acting out.

Encourage resistance. An example of this paradoxical approach would be to say to an uncooperative client, "If talking about your feelings is going to make you feel too uncomfortable, then I don't want to hear it," or "If it's really important for you to not talk, then hold on to it as tight as you can and see how that feels." Of course, it is better if the counselor really believes what he or she is saying. Nevertheless, research has shown the use of paradox to be highly effective (Orlinsky et al., 1994). This approach is no exception, and treats resistance as a decision that can be changed rather than as a reactive defense.

Address positive personality aspects. When confronted by a particularly resistant adolescent who is not at all interested in counseling, there is a helpful alternative to talking about how uninterested he or she is in counseling. One can ask, "Is there a small part of you that is worried about what is happening with you?" A variation of this would be, "Is there a small part of you, maybe a tiny voice, that wants to talk about the tough times you have been through?" If the answer is affirmative, and it often is, the counselor can then ask, "What percentage of your whole attitude is made up of that part that is worried about you?" Once this is established, the counselor can then address that part directly and begin to work with it. This fruitful approach is based on classic ideas found in works by Jung (1934/1969), Assagioli (1965), and James (1890/1981); and more recently in works by Rowan (1990), Puhakka and Hanna (1988), and Schwartz (1995). This approach can do much to communicate empathy to the client.

Accepting Defiant Adolescents

It is important for the counselor to communicate the acceptance of the client. Even though behaviors, thoughts, and attitudes are seen as needing change, the person—the "I" behind the eyes, as Gendlin (1992) put it—can be unconditionally accepted. This can be communicated to the client with statements such as "I like you even when you screw up," or "I can sense the goodness in you regardless of

your attitude and behaviors." Adolescents who have heard only how "bad" they are will be amazed and touched by this approach.

One of the primary difficulties in working with defiant and aggressive adolescents is a peculiar situation in which the counselor actually begins to *resist the resistant client*, even to the point of being resentful toward the client for not improving (Hanna, 1996b). Various feelings can be evoked in counselors by defiant, aggressive adolescents. In addition to resentment, these feelings can range from pity and sympathy regarding the child's family situations, all the way to hostility, disgust, and abhorrence regarding their past and current behaviors and attitudes. These feelings are generally referred to as *countertransference,* or treating the adolescent as one would a significant other. Strean (1993), however, used the more descriptive term of "counterresistance." Other feelings of countertransference cited by Church (1994) are irritation, anger, wanting to control, frustration, helplessness, and feeling defeated. Counselors have also reported the feeling of wanting to parent or nurture certain adolescents who evoke maternal or paternal instincts. These are also countertransference phenomena and can adversely affect the therapeutic relationship by tempting the counselor to treat these clients as they would their own children. The feelings are fine, but giving in to these feelings is unprofessional and confuses roles. Finally, Ginter and Bonney (1993) discussed countertransference issues in terms of projective identification and the *Möbius relationship,* that is, how counselors can "hold" emotional aspects projected "onto" and "into" themselves.

Regardless of what the phenomenon is called or how it is conceptualized, these feelings can lead to a variety of struggles for the counselor, both internally and externally toward the client. All of these feelings are potentially counterproductive to establishing or maintaining a therapeutic relationship. The notable exception is if one uses these feelings to relate to the client instead of acting them out (see Cashdan, 1988). The ability to recognize and manage these feelings makes up much of the difference between an effective and an ineffective counselor (Ginter & Bonney, 1993; Van Wagoner, Gelso, Hayes, & Diemer, 1991). The net result is the vitally important act of accepting a client for who he or she is. This latter act presupposes empathy on the part of the counselor and leads to the client experiencing that crucial sense of"feeling understood" that is so much a part of empathic relationships, as Van Kaam (1966) discovered. Here are some techniques to assist with accepting and avoiding countertransference situations.

Be clear about boundaries of acceptable behavior in a counseling session. Part of the general skill of effective counseling is finding the right balance between acceptance of the client and communication of one's sense of respect for the work being done together. Limits regarding such things as physical contact, smoking in a session, and coming to sessions high or inebriated need to be clarified from the beginning.

Draw the line: Violence or threats of violence are not allowed under any circumstances. This is very rare, but such things do happen on occasion. It is one thing to be accepting, but the physical safety of the counselor must be made a priority. Clients should be informed from the beginning that legal action can be or will be taken in response to violations of this policy. When veiled threats are made, these should be explored immediately and the intent of the comment clarified.

Avoid power struggles. These are almost never therapeutic. A counselor often loses therapeutic effectiveness to the degree he or she attempts to be a disciplinarian or to display authority or control. Empathy is the key here. If a client is playing games of power and control, acknowledge the game. If the counselor can call the game faster than the defiant adolescent can create it, then productive conversation can ensue. Patience is required in such cases. In groups, it is often helpful to acknowledge the defiant adolescent's influence on the group. The counselor can then delegate some helping responsibilities of the group to that person. In many cases, such a client will be eager to help the counselor as a "coleader." This can be an effective and helpful strategy for all members of the group.

Avoid any unnecessary insistence on being verbally respected. Much of what a defiant adolescent says should be accepted and acknowledged, no matter how filthy, vulgar, or disrespectful to the counselor's so-called authority. Respect must be earned by the counselor. If the counselor does his or her job effectively, respect will come naturally. If a counselor is trying to help a client avoid reacting negatively to disrespect from others but reacts that same way, this amounts to hypocrisy. If the client is openly disrespectful to the counselor, explore the disrespect, saying "You really are [angry/hurting] aren't you?" Another approach is to say, "I have not done anything harmful to you at all, so I wonder, who are you really mad at?" This will often bring a response of, for example, "my father" or "my mother," and in some cases an apology will follow.

Accept flaming anger and hostility as a real aspect of the client's life. If the counselor is resistant to, disgusted by, or shrinks back from anger or talk of violence, the adolescent will sense this and the counseling relationship may be compromised. We have found that, in a fundamental way, defiant adolescents are themselves mystified and confused by their own angry, violent reactions no matter how these may be otherwise flaunted or glorified. If the counselor can accept his or her own reactions, it is much easier for the client to do so. On the other hand, if a client is successful at upsetting or angering the counselor, the counselor should temporarily avoid any more contact if he or she is still harboring any anger or resentment. Seeking supervision or consultation would be appropriate in such cases.

Validate the client's perception. Miller (1986) noted that people who are denied power tend to be remarkably perceptive. Adolescents are certainly denied power in this society, not having the final say over their own fates. Their perceptions and observations of the adults in their lives can be remarkably clear, whether of teachers, parents, clergy, or counselors. It is important to accept and explore these

perceptions. Although not always perfect, and often filtered through resentment and hurt, there is enough accuracy of perception to refine and hone as a valuable life skill. Of course, this does not apply to adolescents attempting to conceal, lie, or manipulate.

Recognize and use transference phenomena. This was briefly alluded to earlier. One of the most disappointing aspects of working with defiant, aggressive adolescents sometimes follows an apparently successful session in which some real progress was made. Just when the counselor thinks that things are going well, in the next session the client becomes especially hostile and verbally criticizes and attacks the counselor both personally and professionally. This is little more than the phenomenon of transference taking place. In such a case, the client may be unknowingly testing to see if the counselor will "hang in there" or abandon him or her as parental figures may have done. Transference is defined as a client regarding and treating the counselor as a significant other, such as a mother, father, or other family member. It takes place most often with authority figures, especially when those figures are considered superior (Fischer, 1991). It is not a sign of lost ground at all. Rather, it is a sign that the relationship is deepening. It helps if the counselor expects that this may happen. Thus, instead of being personally offended, as might be one's first impulse, a good strategy is to ask questions such as "Is this the way you sometimes talk to your [mother/father/grandparent]?" The answer is often a clear and simple yes.

Treat shocking statements with equanimity and instant reframes. Many defiant adolescents like to talk in ways that are intended to be shocking to adults. This kind of behavior is often effective in manipulating or controlling adults. It may also be useful as a coping skill in surviving in dysfunctional family situations. There are many ways of dealing with these comments, but perhaps the best method of handling such statements is to calmly do what might be called an "instant reframe." For example, a client may say to a counselor, "Oh, you have a cat? I like to throw gas on them and set them on fire." Rather than get upset and respond inappropriately, a counselor can accept the statement by saying, "Oh, I see. Do you do that to try to understand the pain that *you* feel inside?" Another example is this client statement, "I hate everybody and everything," to which a counselor can reply, "Sometimes hating is a way of trying to feel better. Is that true for you?" The instant reframe requires skill and practice but can be highly effective. Clients will often remind the counselor of what was said as much as several weeks later.

Relating to Defiant Adolescents

How the counselor relates to or interacts with defiant, aggressive adolescents can have a critical influence on therapeutic outcomes. Part of the problem is recognizing that adolescents will sometimes defiantly reject help and at other times humbly seek it (Church, 1994). There are a number of general strategies that will enhance the counselor's ability to relate to defiant, aggressive adolescents.

Admit when you are confused or uninformed. When working with adolescents, it is important to stay abreast of the evolving youth culture. Much of the counselor's education can be achieved by interacting and consulting with adolescent clients. For example, if there is something that one does not understand or wants more information about, ask the client to explain what it means when . . . or why someone would . . . or what would happen if . . .

Expect a crisis to occur and be ready for it when it does (Liddle, 1995). Crisis situations, such as being suspended from school, being arrested, or running away from home, routinely occur with defiant, aggressive adolescents and seem to have a way of doing so just when the client seems to be making progress. Often, the client is frightened by the prospect of positive change. Deal with the crisis as part of the therapeutic process and go into a crisis counseling mode (Roberts, 1996) if necessary.

Tell stories of other adolescents in similar situations who made changes in their lives. Narrative approaches have become quite popular (Howard, 1991; Zimmerman & Dickerson, 1996). Stories can also help to build that sense of hope so important to therapeutic change (Hanna, 1991, 1996a). A story of another adolescent who went through similar painful experiences can provide a parallel framework through which a client can relate to and step outside of his or her own situation. It also helps to bring in speakers who have experienced change and growth in similar circumstances.

Let clients know how much you have learned from their sessions. Be as specific as possible. After all, the counseling process should include the counselor's willingness to learn and change along with the client, emerging as enriched and fulfilled (Howard, 1989). We have observed that this routinely happens when working with this population. Adolescents have much to teach adults about a difficult transitional stage in life, but most adults mistakenly assume they have already worked through all that. It can be a wonderful validation and a turning point to realize that one has learned something from an adolescent.

Stay in touch with your own adolescence. Winnicot (as cited in Church, 1994) noted that adults' difficulty with adolescents stems from their own unresolved adolescent issues. Thus, it is very helpful to recall the adolescent's love of independence, along with their zest for life, joy of discovery, and love of laughter. We have found that adolescents seem to be drawn to adults who have not become rigid, sterile, or robotic. Even adolescents with depression appreciate a counselor's ability to stay in touch with his or her own adolescence.

If another counselor has a better rapport with your client, consider switching. No counselor can be all things to all clients. Sometimes certain clients will have difficulty relating to one counselor but will get along with another counselor easily and effortlessly—and vice versa. This can be due to differing worldviews (Lyddon, 1989) and many other factors. The client's needs are the priority and concern and justify appropriately initiated referrals.

Sound bytes are preferable to paragraphs when communicating a point. It is unfortunate, but most defiant adolescents seem to lack patience for long-winded explanations of ideas or education. Thus, the more one can pack into a single sentence the more powerful the impact of the message. For example, rather than going into a long treatise on the importance of being in touch with your feelings, you can sum it up in one sentence by suggesting that "If one doesn't have feelings, then one isn't really alive. What do you think?" This is, of course, an oversimplification but usually leads to fruitful discussions on the pros and cons of exploring various aspects of issues.

Recognize the limits of counselor self-disclosure. Self-disclosure can be powerful and helpful and seems to be related to the modeling process (Bandura, 1977). The rule here is to avoid self-disclosure regarding an issue or incident that the counselor has not resolved internally. Otherwise, the client feels odd or sometimes used, as if the counselor is really working on personal issues and is not at all empathic to the client's concerns. Another obvious rule is to avoid self-disclosure of anything that you do not want repeated (Bernstein, 1996).

Do not allow the depth of caring to interfere with your empathy. Empathy and caring are not the same. A father may care deeply for his 16-year-old daughter, but he probably does not empathize so much that she would talk to him about her first sexual experiences. Similarly, a counselor who is deeply affected emotionally by adolescents' stories of abuse and tragedy can get caught up in feelings of protest, sympathy, protectiveness, and righteous anger. This can interfere with the ability to empathically see the world from the client's perspective. The therapeutic process can be blocked at this point if the counselor is not aware.

Develop a therapeutic peer culture at every opportunity. Teaching kids to empathize with and help each other is a tremendously powerful tool that carries over and transitions into group therapy and everyday interactions. It also provides a sense of self-worth through Yalom's (1995) therapeutic factors of altruism and developing social skills. A therapeutic peer culture can be far more beneficial than any individual counselor can.

With gang members, acknowledge the gang's therapeutic benefits. Close inspection will reveal that many of Yalom's (1995) therapeutic factors of group therapy can be found in a street gang, regardless of its ethnic or racial makeup. Such therapeutic factors as universality, group cohesiveness, and catharsis can occasionally be found in gang membership, even though these are twisted remnants of what is fully therapeutic. For example, a Latino gang member with a devastatingly sad family history once told the first author how much he admired his gang leader, whom he had been "drunk with" the week before. The gang leader was telling the client that he would always be there if he needed him, while fellow gang members agreed in the background. The leader then, in an emotional outburst, threw an empty beer bottle, hitting the client in the head and leaving a bruise, yelling that he loved him like his own little brother and that they would always be friends. As strange as it may seem, this distorted act of caring held great therapeutic meaning for that client, giving him a valuable sense of belonging.

Do not back off from existential issues such as death, isolation, meaninglessness, and freedom (see Yalom, 1980). Many defiant, aggressive adolescents are actively grappling with such issues. Examples are the gang member who has witnessed the senseless, meaningless violence that has caused the premature death of family and friends; or the defiant adolescent who has experienced isolation through being seen as "weird," or "odd," or a "misfit." Adolescents often respond with great affective intensity to these issues.

Identify victimization regardless of its source. When a wife complains about a cruel husband or if an employee complains about a heartless boss, counselors are quick to acknowledge the clients' feelings of being victimized. Adolescents deserve no less yet are often deprived due to the hesitation of some counselors to question or criticize authority figures. Sometimes, these authority figures can be fellow counselors in an agency, parents, or teachers in a school. Surprise the client by not siding with the authority figure. It is important to call unfair or harmful actions exactly what they are. Acknowledge the client's perception and reflect his or her feelings without agreeing. The art of counseling often manifests in communicating the understanding of the inequity of a situation without alienating persons from whom one (the client) may someday be seeking cooperation. Thus, to create a situation in which the client perceives that you, too, believe that the authority figure is a "jerk" (see Sommers-Flanagan & Sommers-Flanagan, 1995) may further the client–counselor relationship in the short run, but it will be detrimental for the client who simply sees the counselor's remarks as validation "to get even" with someone.

Identify racism and gender discrimination. A situation similar to the previous one may occur when working with minority adolescents such as a Latino male or female, or a gay, lesbian, or bisexual adolescent. This is especially the case if he or she is subjected to the harmful influence of a racist, sexist, or homophobic teacher, principal, probation officer, stepparent, or some member of the society in general. Such situations should be acknowledged and processed honestly and accordingly. An empathic relationship with a minority client can hardly take place without this fundamental understanding.

Do not underestimate the sexual intensity of many defiant adolescents. Sexuality rages in many adolescent boys. Female counselors should be aware that hugs and touching can be highly erotic for many boys, despite the counselor's best intentions for nurturing (Bernstein, 1996). Likewise, male counselors may be targeted for acceptance by adolescent girls dressing provocatively, seeking approval and validation of their own sexual identities. It is a mistake to ignore this behavior (Bernstein, 1996). Deal with such issues directly by pointing out the behavior simply, honestly, and dispassionately. For example, we have found that a helpful approach to dealing with seductive dress is to ask the client

to observe how people react to him or her when wearing different outfits—in terms of how much respect one gets, or how people may treat them.

If the person is seeking attention, give it. We have often heard professionals regard certain acting out behaviors as "only seeking attention" and then recommend that the behavior be ignored. We disagree. Receiving attention is a basic human need; why deny it to someone whose problems are due in part to not getting enough? Let the person know by saying, "Okay, you have my full attention. What do you want to do with it?" Also, in groups, some time can be reserved so that needy clients can take turns sitting in the middle of the group and receiving attention. It is remarkable to watch clients smile as the attention flows. After this, the client can learn to seek attention only at appropriate times.

Develop a naturally confrontative demeanor. Confrontation is a natural and important aspect of working with defiant and aggressive adolescents (Bernstein, 1996; Church, 1994). Make it friendly and empathic, mix it with humor and caring, and reframe it under the category of being honest and real. This demeanor seems to pay dividends when major confrontations become necessary. If confrontation is a natural part of the counselor's nature, the client will hardly ever question it when it happens, treating it as though it was a part of routine conversation.

Be alert to apathy, the defiant adolescent's central defense. Rather than feel the burden of responsibility, or the pain of abuse, defiant adolescents will resort to apathy as a defense. Many are so sensitive to pain that apathy seems a way to avoid it. This manifests itself in statements such as "Whatever," or "I don't care," or "It don't mean sh—," or "F— it." Reframe apathy as an attempt to avoid hurt or hassle or difficulty. Another approach is to reframe "not caring about anything" toward a goal of "caring about everything but worrying about nothing." Many defiant adolescents respond to this, although it may be a delayed response.

THE ADOLESCENT NEED FOR AUTONOMY AND FREEDOM

An amazingly consistent issue in defiant and aggressive adolescents is the desire and need for freedom and autonomy (Church, 1994). Defiant, aggressive adolescents are remarkably and vehemently insistent on their own freedom and autonomy. In her study of adolescent autonomy, Church found that successful counselors acknowledge and respect this need for freedom and that when adolescents are treated in this way, they are more likely to ask for direction and guidance. Working with this human developmental need can provide a means of motivating clients by reframing counseling as a way of attaining freedom—that which they already want.

Freedom, from an existential perspective, comes in four modalities (Weiss, 1958)—*freedom-to*, *freedom-from*, *freedom-with*, and *freedom-for*—all of which are applicable to counseling. However, the first two are especially relevant to establishing relationships with adolescents. Freedom-to applies to a range of options and choices in life. Freedom-from relates to being released from difficulties and constraints. Much of what defiant adolescents are attempting in life is along these lines. Counseling can be presented as an aid. For example, counseling can provide freedom-from in that it can help to release a person from emotional hurt and pain, disturbing memories, and poor self-esteem. Counseling can provide freedom-to when presented as a means to develop the awareness to learn ways of coping with difficult people and situations and with danger as well. Acting out, one of the most troubling characteristics of adolescence, can be reframed as a loss of freedom. This can be done by suggesting that the issue or person that one is defiantly reacting to or blaming has control of one's life at that moment. Freedom, therefore, is not only a need and desire but can be promoted as a goal of self-control.

The freedom approach can be highly effective when combined with developing awareness. Awareness and freedom are closely related (Heidegger, 1927/1962; Sartre, 1953). Awareness is also a major aspect of the therapeutic change process (Drozd & Goldfried, 1996; Hanna, 1994). For adolescents, awareness can be attractively framed by using the adolescent "language of the day." In the 1990s, one would point out that the "cool" people seem to have a way of being aware of what is going on around them. Counseling can be promoted as a way of learning how to be more aware and, in the process, becoming more popular and even admired by peers. The best means to achieving the adolescent goal of being happy and carefree is through counseling.

Actually, many defiant adolescents are, in fact, in desperate need of freedom. Many are "stuck" in families characterized by interpersonal pain and chaos, in which loved ones have been hurt and extreme stress is present almost every day. To a large degree, they cannot choose their schools or their life circumstances (Rubenstein, 1996). From their perspective, freedom and autonomy are not so much a defiant rebellion as much as an ideal that represents an escape from a form of imprisonment and helplessness. To suggest that a defiant, aggressive adolescent has no freedom when they act out typically elicits protest, but when issued as a challenge, the adolescent will often work hard to attain the feeling of freedom sought by so many adolescents.

CONCLUSION

Working with defiant, aggressive adolescents can be a source of joy and hope rather than frustration, but it is important that one genuinely likes adolescents and wants to focus on this age group. We have found it best to take a theoretically integrative approach (e.g., Norcross & Goldfried, 1992), making use of behavioral, cognitive, Adlerian, existential, Gestalt, feminist, multicultural, and family systems approaches as appropriate. We have also found it helpful to make use of a wide range of counseling modalities. Some defiant adolescents respond best to individual counseling, others to group, and still others seem to do best in family settings. In many cases, a defiant adolescent can benefit from all three modalities.

Do not limit yourself to one modality. For example, some professionals claim that individual counseling is no longer appropriate for schools or agencies because of a lack of time and resources. But this does not change the fact that many adolescents are in desperate need of, and ask for, individual attention from an empathic adult. Work with whatever resources you can muster, and when connecting adolescents with community resources, connect them with a specific person at that particular agency. Adolescents will seldom contact a nameless, faceless organization or building, preferring the name of a real person whom they can ask for and who has been recommended by someone they trust (Rubenstein, 1996).

Finally, working with defiant, aggressive adolescents requires wisdom. Such wisdom includes deep insight into the human condition, self-awareness, dialectical thinking, problem-solving skills, advanced empathy, clinical intuition, proper timing, and recognition of culture and context (Hanna, Bemak, & Chung, 1999; Hanna & Ottens, 1995). It also requires perspicacity in the sense of being able to "see through" deceptions, lies, and manipulations (Sternberg, 1990). Although it is not an easy path for the counselor to tread, the lessons learned are remarkably valuable and rewarding for counselor and client alike.

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The Use of Humor in Counseling: The Laughing Cure

Eugene Goldin and Terry Bordan

The benefits of humor are briefly reviewed, and the ways in which humor can be effectively used in the client–counselor relationship are explored (i.e., using humor as a diagnostic tool and as a therapeutic tool). Finally, counseling vignettes are provided and admonitions regarding the improper application of humor in counseling are reviewed.

Counseling has been described as a dynamic interaction between a helper (the counselor) and "helpee" (the client; Doyle, 1992). Typically, the client asks the counselor for assistance in solving a problem that he or she has yet to resolve. The very act of seeking the help of another may be considered to be an embarrassing experience for the client (Haley, 1976). Needless to say, counseling is, principally, a serious endeavor. As such, one would be hard-pressed to find a discussion of the use of humor in most models of counseling (Herring & Meggert, 1994). The purpose of this article is to describe the application of humor within the counseling relationship.

Freud (1916/1938) described the psychoanalytic function of humor as "a means to gain pleasure despite the painful affects which disturb it; it acts as a substitute for this affective development, and takes its place" (p. 797). In his integration of psychoanalysis and existentialism, May (1953) considered the function of humor to be "the healthy way of feeling a 'distance' between one's self and the problem, a way of standing off and looking at one's problem with perspective" (pp. 53–54). Similarly, Adler (1933/1964) claimed to have "developed a method of saying to almost every patient that there are jocular situations that are almost completely similar in structure to his particular neurosis, and therefore that he can take his trouble more lightly than he is doing" (p. 296). Erikson (1963) spoke of humor as being a redeeming specialty in mankind whereby man could "play with and . . . reflect fearlessly on the strange customs and institutions by which man must find self-realization" (pp. 405–406). Maslow (1954) saw a sense of humor as an indication of a person's being self-actualized.

The report of the physiological benefits of humor was widely publicized in Norman Cousins's (1979) book *Anatomy of an Illness*. Since 1979, numerous reports have appeared that support the notion that humor has holistic benefits. For example, the positive contributions of laughter and play in the treatment of critically and terminally ill patients have been described (e.g., Maher & Smith, 1993; Simonton, 1980). Furthermore, exposure to humorous stimuli has been associated with elevated levels of salivary immunoglobulin A, an antibody that has been found to defend against infections that enter through the respiratory tract (i.e., Lefcourt, Davidson-Katz, & Kueneman, 1990; Stone, Cox, Neale, Valdimarsdottir, & Jandorf, 1987). In addition, the positive effect of mirthful laughter on both respiratory and cardiovascular system functioning has been observed (Dunn, 1993). The relationship between laughter, the stimulation of the immune system, and reduced stress levels has also been documented (i.e., Berk, 1989; Fry, 1992; Lefcourt & Martin, 1986). Finally, several reviews of the research pertaining to the physiological benefits of humor have found support for the aerobic benefits of laughter, the positive impact of humor on the functioning of the immune system, and the use of humor as a stress reduction technique (Clay, 1997; Prerost, 1988).

THE CONSIDERATION OF HUMOR IN CLIENT ASSESSMENT

Humor has long been recognized as a diagnostic aid in counseling in myriad clinical situations including measuring the level of a client's depression (Nussbaum & Michaux, 1963), predicting patient adjustment after hospital discharge (Starer, 1961), assessing schizophrenic group therapy client change over time (Harrelson & Stroud, 1967), and assessing schizophrenic patient difficulties in socialization (Senf, Huston, & Cohen, 1956). Humor has also been used for both assessment and intervention purposes in treating culturally diverse groups of psychiatric patients (Campinha-Bacote, 1997). Finally, several instruments have been developed for the specific purpose of measuring humor in personality assessment (i.e., Ruch, Kohler, & van Thriel, 1996; Svebak, 1996).

In general, a client who does not experience humor in life may be, among other things, grieving as a result of a loss, chronically depressed, unable to comprehend the humor,

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or generally unable to "let go" because of a need to monitor his or her emotions. Joylessness, gloominess, unhappiness, and lack of pleasure, criteria mentioned in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychological Association, 1994), are used to assess some mood disorders as well as depressive personality disorder. Furthermore, the absence of humor has been categorized according to different therapeutic modalities. According to Woititz (1983), some adult children of alcoholics (ACOAs) experience difficulty in letting go and having fun in social situations, fearing that the opening of the "floodgates" of irresponsible behavior that a parent was afflicted with will happen to them. Woititz recommended, among other things, that as part of their healing these clients revisit those activities that they wanted to but rarely, if ever, performed as a child, armed with therapeutic insight, guidance, and support. In addition, transactional analyst Harris (1973) interpreted a client's inability to find the humor in life as an indication of *ego state* dysfunction stemming from overly harsh parenting. As a consequence, individuals learned that the only way to be safe in life was to exclude their feeling-oriented *child ego state* from being activated. Although these people may never be able to develop an appreciation of humor, they can consciously resolve to act in loving, supportive ways to their loved ones.

It should also be noted that a client might not find what the counselor thinks is funny to be so. It is possible that a counselor's frame of reference may be too different from the client's or too esoteric, so that the client misses the point. After all, it has been commonly noted that "one man's meat is another man's poison." Needless to say, a counselor should use much more than a client's ability or lack of ability to appreciate his or her sense of humor in the assessment of a client.

THERAPEUTIC APPLICATIONS OF HUMOR IN COUNSELING

According to Gladding (1995), "humor is a natural occurrence in some counseling situations, and it is a resource that should be used" (p. 3). Furthermore, Ellis (1973) has used humor "to make therapeutic points with . . . [clients] in an intense, forceful, emotive manner" (p. 72). The use of humor in counseling has been applied in situations as varied as elementary school, career counseling, the counseling of Native American children, the group treatment of patients with depression, family therapy, and in analytic therapy and analysis.

The counseling of elementary school children has been found to be enhanced through the use of humor (Sluder, 1986). According to Sluder, an elementary school counselor can use humor to develop rapport, to model for children how they themselves can use humor as a coping mechanism, and as a self-disclosure technique in which the counselor can show that imperfection is an acceptable human condition by sharing his or her own human foibles. She concludes her discussion by declaring that "Laughter is a way of 'thumbing one's nose' at the inescapable and incomprehensible vagaries of existence . . ." (p. 126).

The uses of humor in career counseling have also been described (Nevo, 1986). Nevo contended that humor can be used in career counseling to challenge a client's irrational ideas about career choice issues. Nevo comically linked career selection to mate selection. Once the initial laughter decreases, a conversation leading to a more rational, deeper level of understanding about the career decision-making process is sought. Typical irrational ideas include (a) there is only one Mr. or Ms. Right (vocation); (b) there is love at first sight (regarding career); (c) one remains the picky bride and avowed bachelor until the perfect match (vocationally) is made; (d) with a spouse (or job), all problems will be solved; (e) once the right choice is made (vocation), they will live happily ever after (Nevo, 1986, pp. 192–194).

Humor has been effectively applied as a counseling strategy with Native American children (e.g., Herring, 1994; Herring & Meggert, 1994). Although noting that humor among Native Americans varies according to way of life and assimilation into the dominant culture, counselors have effectively used it to "confront cosmic questions about the world as a whole . . . [and] as a lens through which . . . [they] can glimpse social orders and daily life" (Herring & Meggert, 1994, p. 68). Storytelling, story reading, the use of imagery, puppets, limericks, tongue twisters, games, and the clown or contrary figure have been effectively used, often as a way of expressing emotionally laden messages that might be censored by the client if communicated overtly (e.g., using humor to express a painful event).

Berne (1977b), the creator of transactional analysis, discussed using humor, particularly laughter, in group therapy as a way of uncovering injunctions against having fun. According to Berne,

> The technique is simply to ask the group to laugh and to keep laughing whether anything is funny or not. The therapist laughs with the group, laughing in various ways such as a simpering Child and a jolly Santa Claus. It often becomes funny, always becomes revealing, and frequently gives new permissions. (p. 122)

Humor has been reported to have been used successfully in the group treatment of clients with depression (Roller & Lankester, 1987). In the context of group therapy, humor was never used to intentionally cheer up group members. Instead, it was produced spontaneously to accomplish an expansion of the definition of the problem to include others while increasing the sense of social interconnectedness and well-being, as well as the social skills of participants (p. 573). For example, members who expressed concerns of being banished from the group because they no longer felt depressed were "threatened" by others in the group with having their Kleenex boxes taken away.

Humor has been similarly used in family therapy. According to Bergman (1985), "Humor is a vital part of my therapeutic approach. With some patients, I may trade the latest jokes going around town, usually at the beginning or end of the session." (p. 184) In discussing the way that humor changes the affect of the social context in therapy, he

maintained that it "brings a different light to what may seem painfully depressing, despairing, or hopeless" (p. 185).

The use of humor in analytic therapy and analysis has also been addressed. According to Bloomfield (1980), "Humour is a direct expression of unconscious processes. It brings together opposites, highlights contradictions and shows up the absurdity of irreconcilable wishes. It is the paradox and the absurdity which makes us laugh" (p. 135). Thus, humor may be used by clients in analysis and analytic therapy as a vehicle for recognizing the absurdities in life, mastering anxiety and gaining a more reality based perspective, pinpointing therapeutic resistance, expressing ambivalence, making interpretations more acceptable, and humanizing the counselor.

ADMONITIONS REGARDING USING HUMOR IN COUNSELING

Although humor can be found across cultures, its manifestation can vary accordingly. Thus, although "It is, no doubt, possible to find jokes and other kinds of humour belonging to all the different levels of development in most societies . . . there are certain features which seem to be characteristic of particular societies" (Bloomfield, 1980, p. 136). The counselor is advised to pay particular attention to cultural differences in appreciating and expressing humor in treatment.

The counselor is cautioned that humor can be therapeutically counterproductive, even destructive, for some clients (Kubie, 1970). Counselors who use humor are encouraged to do so judiciously because it can hurt the therapeutic relationship if the client interprets it as derisive. Berne (1977a) also cautioned against a therapist's condoning humor that is denigrating to the client. This brand of humor, referred to as a "gallows" transaction, takes place when a client or counselor jokes about destructive behaviors. Berne held that such jokes were, in essence, messages to avoid taking the client seriously. The correct therapeutic response would be to challenge "gallows" transactions by asking "Why are you laughing? It's not funny" (Berne, 1977a, p. 68). Although possibly uncomfortable, the confrontation is necessary to let the client know that the counselor is not willing to go along with his or her self-destructive behavior patterns. A similar counterproductive use of humor in counseling occurs when it is used to "deny, distance, or avoid some aspect of reality that they need to confront" (Crabbs, Crabbs, & Goodman, 1986, p. 110). Furthermore, Gladding (1995) has contended that humor in counseling is improper (a) when the counselor uses it to avoid dealing with client anxieties, (b) when a client views it as irrelevant to his or her reasons for being in counseling, (c) when it is experienced as a put-down, (d) when it is used too frequently and becomes boring, and (e) when it is inappropriately timed.

COUNSELING VIGNETTE 1: USE OF HUMOR IN ASSESSMENT

Ms. X was a 45-year-old married, unemployed, mother of two well-adjusted high school-age children, who had sought counseling because of depression. During the initial interview, she informed the counselor that although she had friends, was a good wife and mother, and would be welcomed back to her former job in her family's travel business, something in her life felt missing. Although intellectually she appreciated her relationships, she felt somehow unconnected to them emotionally. Naturally, the counselor sought to develop rapport and attempted to communicate empathic understanding to her. At a particular point, the counselor used humor both to convey understanding and to help assess the level of her depression. The interaction was as follows:

> Ms. X: They [her husband, children and parent] say they love and care for me. I appreciate it in here [points to her head], but I feel empty in my heart.
> Counselor: Intellectually, you know they are there for you. Somehow, it's just not convincingly getting through to you in here [points to heart].
> Ms. X: And it makes me feel that maybe I'm really bad. Shouldn't I feel something?
> Counselor: Like something's defective or just not good.
> Ms. X: I know I'm not evil or something. I just want more and, honestly, they are all so needy, I sometimes think they are only there to get—I mean they're there, but they're really not there for me, or they're there as long as I keep giving, and that's not enough.
> Counselor: Let me see if I've got this straight. It seems as if they're present in your life, but not really there for you, and maybe even if they're there, it doesn't make it, it's not enough for you.
> Ms. X: Yes, they're really selfish in many ways.
> Counselor: You know, this reminds me of a counselor who saw someone who felt the way you do. She felt that no one who was in her life was really there for her. The counselor meant to make her feel better, but it came out wrong. He said, "Well, at least you always have yourself."
> Ms. X:(laughing) But that's what it's like. They're not really there to give, and I don't feel I'm getting enough in my life.
> Counselor: So, what do you think you need to get in order to feel that inside you were getting enough?

In the preceding example, the counselor used a humorous anecdote. In doing so, the counselor hoped to increase Ms. X's sense of feeling understood while getting a sense of the level of her depression. Had Ms. X not laughed, the counselor would have assessed her depression as possibly being more severe. Once the counselor determined that Ms. X was able to distance herself enough from her situation to see the humor in the counselor's remark, the counselor was able to pursue asking her what she would need in order to feel that she was getting enough in her life.

COUNSELING VIGNETTE 2: CHALLENGING GALLOWS HUMOR

Mr. and Ms. Y were married for 19 years. They had one 11-year-old son, who had several friends and was successful academically. She worked as a secretary, and he worked as an engineer. Their presenting problem concerned frequent arguing, particularly regarding Mr. Y's spotty work record. It seems that Mr. Y was typically hired as a well-paid computer consultant and fired after several weeks or months. Mr. Y attributed his work history to a combination of his refusal to play office politics and to the nature of his position as a special consultant. Once the problem was solved, his employers hired a lower paid worker to run the com-

puter program that he had developed. During his episodic periods of unemployment, Ms. Y complained of living in extreme fear of financial ruin as they ran up heavy credit card debts. Often, Mr. Y had to ask his own father to "bail him out" of his debts. Although Mr. Y's father would usually comply, he was forever critical of his son and daughter-in-law. During one session, Ms. Y bitterly complained about her father-in-law for never having appreciated her husband. In fact, even when Mr. Y was a child, his father would refer to Mr. Y as a "good for nothing." It seemed that her father and mother-in-law exerted a great deal of influence on her marriage because he was thought to be extremely wealthy and both Mr. and Ms. Y had always dreamed of inheriting a good portion of his money. However, no one was really certain if he had much money at all. The following dialogue occurred when Ms. Y humorously expressed the humiliating hold that her in-laws had on her marital relationship.

Ms. Y: I could never stand that he [her husband] never had the backbone to stand up to them [in-laws]. His father never felt that he would amount to anything, has never liked or accepted me, and they both expect to be treated like royalty when they come here to visit.
Counselor: Then, how do you explain the power that your in-laws have held over you and you husband for all these years?
Mr. Y: My father has a lot of money.
Ms. Y: Although no one really knows for sure. And also, he is cheap, so we never see it [evidence of his wealth] except when he has bailed us out.
Mr. Y: Who knows if he still has money?
Ms. Y: I've said to Mr. Y, sometimes I think we may be listening to the "sound of two-coins jingling" around in his father's pocket [she and Mr. Y smile].
Counselor: But, why are you both smiling at that thought? If that is true, it then isn't funny at all. It would be tragic that you have let the possible fantasy of his having money that you would inherit if you played your cards right sabotage your marriage for so many years. Especially if it turns out that he didn't have it.

In the preceding example, the counselor challenged the client's attempt to paint the destructive effect of their hoped-for inheritance humorously, when it had had, in fact, exerted a negative effect on their relationship for many years. The counselor's challenge to the humor in their situation was designed to jar the couple into becoming more autonomous. Parenthetically, in subsequent counseling cases, the author has humorously used the image of a client's possibly listening to the "sound of two coins jingling" when discussing the possibilities of inheritance coming a client's way if he or she "played their cards right." The goal in this second vignette is for the clients' to become aware of the choices that they are making and to discuss the reality basis behind their hoped for financial payoffs.

COUNSELING VIGNETTE 3: MAGNIFYING IRRATIONAL BELIEFS TO ABSURDITY

Ms. A was a 43-year-old divorced, unemployed mother of two preteens, who sought counseling because of depression and substance abuse issues. She was particularly inclined to blame herself for all of her family's and extended family's problems. She had grown up in an alcoholic environment and found it difficult to find any humor in life's foibles and events. At a specific time in the counseling session, the counselor used humor to aid her in appreciating that not all occurrences could be linked in a cause-and-effect way to her. The interaction was as follows.

Ms. A: My children are experiencing all kinds of school problems. The school is thinking of holding my younger son back. I don't know what to do. I am sure that it has to do with me. I have made it difficult for my son to do anything.
Counselor: You have made it difficult for your sons to do all things—personal and academic.
Ms. A: Yes, that's right. They are nervous because I am nervous and I have caused them to not even be able to do their homework.
Counselor: Let me try to understand this. *You* have caused them to be unable to do their homework. Have you broken their arms, not paid the electricity bills, or played loud music in order to distract them?
Ms. A: [Taking the question seriously and without any humor implicit in her response] No—I haven't done that.
Counselor: Well, could you help me to understand exactly what you did or do to prevent them from completing their assignments?
Ms. A: Well, it's nothing specific. They are probably just unhappy to have me as a mother, worried about my relationships. You know—whatever. They are not the only ones. My whole family probably blames me for everything. It's my fault that my brothers don't talk to each other and that my mother is sick right now.
Counselor: Have you been watching television lately? The president just went on TV to discuss the economy. I should think that he would have mentioned you directly.
Ms. A: What do you mean by that?
Counselor: Well, it seems to me that you blame yourself, hold yourself accountable for everything. Have you considered attributing any inflation worries or depressed economy or global warming or increased terrorist activities all to you? I am surprised that you left those out. [*Author's Note.* The counselor used this particular humorous intervention only after establishing a strong "working relationship" with this client.]
Ms. A: [For the first time appreciating the humor in the question—she began to laugh and her facial expression freed up] I guess you are right. I do tend to blame myself for everything. [She continued to laugh]

In the preceding example, the counselor successfully challenged the client's negative frame of reference, her unreasonable belief that she was to blame for everything. For the first time, the client was able to explore her tendency to go "on automatic pilot" and blame herself for everything. She would at several times in subsequent sessions refer to this "world economy joke."

COUNSELING VIGNETTE 4: PARADOXICALLY AIMED HUMOR

Mr. and Ms. B had been married for 5 years. They were thinking about having children, but were hesitant to change their lifestyle so dramatically. Both were professionals and had demanding careers and hours to juggle. Recently, Mr. B had become quite suspicious that Ms. B was being unfaithful to him. He presented alone at a session to explore these feelings. The interaction was as follows.

Mr. B: I don't know why I think my wife is having an affair. I just do.
Counselor: You have no indication, but yet you believe that she is having an affair.

Mr. B: That's true. She lost a lot of weight recently and has been dressing better for work.
Counselor: You believe that this is unusual for a person to lose a lot of weight and then begin to dress better.
Mr. B: Well, if you put it that way, no—but, there's something else, I just can't put my finger on it.
Counselor: I am getting a sense that there is something that you want to tell me, but haven't so far.
Mr. B: I followed her the other Saturday—I followed her for almost the whole day.
Counselor: You trailed her for almost a whole day. That must have been a very difficult maneuver.
Mr. B: It sure was and I am not proud of what I did. As a matter of fact, I feel pretty crummy. I feel like a cheat myself.
Counselor: Could you tell me about the experience?
Mr. B: [He then began to describe in detail how he had followed his wife on her Saturday errands. He had found it difficult and had been in "mortal" fear that he would be discovered. He also mentioned that he had followed her into a department store, watched her shop, and then go for a yogurt and to a public restroom facility.]
Counselor: So, you watched her for the entire time until she went into the bathroom. How do you know that she didn't meet someone in there? I wouldn't have stopped there—you never know.
Mr. B: That sounds pretty crazy to follow her into the bathroom. [He began to laugh. He seemed to find the paradoxical intervention humorous and was able to begin to examine some of his other, as he put it, "ridiculous assumptions" about his wife's dress and demeanor.]

Again, in the preceding example, the counselor used the paradoxical intervention to foster client exploration of his beliefs and behaviors. Whereas heretofore the client was not willing to be flexible in his assessment of the situation, the humor inherent in the moment and the physical release vis-à-vis the laughter, incited the client to be willing to challenge his beliefs.

CONCLUSION

Humor has been referred to as an example of the perceptual process of *bisociation* (Koestler, 1966). A bisociation occurs when a situation or idea is perceived in "two self-consistent but habitually incompatible frames of reference" (p. 35). Ziv (1984) has suggested that there are two categories of humor, creativity and appreciation. Humor creativity involves "the ability to perceive relationships between people, objects, or ideas in an incongruous way, as well as the ability to communicate this perception to others" (Ziv, 1984, p. 111); appreciation humor pertains to "the ability to understand and enjoy messages containing humor creativity, as well as situations that are incongruous but not menacing" (Ziv, 1984, p. 111). When humor is applied in counseling, the perception of a client's report of his or her life experience consists of one such frame of reference. The counselor offers an alternate frame, which is designed to create a bisociation that is intended to be of therapeutic value. This value includes strengthening the rapport between the client and counselor, a component of the counselor's assessment of the client's degree of pathology; offering to a client a less painful perspective of a painful experience; adding to a client's social repertoire; and providing a stress control method.

The counseling process centers on difficult situations that the client experiences. Perhaps, the most crucial element in the effective application of humor in counseling is timing. If humor is used too soon, the counselor can be viewed as incompetent or as someone who is insensitive to the client's particular concerns. If it is used too late, it can seem to be unrelated to the particular immediate focus of counseling. Humor must fit the situation just right for it to be most effective.

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Boundaries and the Use and Misuse of Power and Authority: Ethical Complexities for Clergy Psychotherapists

Ingeborg E. Haug

Acknowledging their power and authority and establishing and maintaining clear and safe professional boundaries tend to be complex issues for clergy psychotherapists. The legacy of dual training, insufficient attention to professional ethics, as well as differing role expectations and professional socializations as clergy and counselor make it imperative for clergy psychotherapists to be particularly thoughtful about boundary issues in counseling. This article discusses the vulnerabilities and complexities clergy psychotherapists encounter, particularly matters of multiple relationships, confidentiality, and practice policies. It also proposes preventive actions to raise awareness and safeguard ethical conduct.

In our society, clergy traditionally enjoy a particular trust and high regard (Gula, 1996), and many people with emotional difficulties tend to first consult their rabbi, priest, or minister for assistance (Steward, 1979; Weaver, Koenig, & Larson, 1997). Many clergy have, in fact, expanded their traditional role of providing spiritual care and acquired additional training to function as counselors, either as part of, alongside, or independent of ministry.

As society becomes more and more secular as well as litigious, complaints of boundary violations by clergy, including clergy psychotherapists, have increased significantly. For instance, a 1994 report by the Maryland state regulatory board indicated that 40% of the psychologists accused of sexually inappropriate behavior were also ordained ministers (as cited in Case, McMinn, & Rhoads Meek, 1997). In 1993, 4% of the American Association for Marriage and Family Therapy's (AAMFT) membership could be identified by their degree as having a theological background. These members accounted for a disproportionate 29.5% of those found in violation of Subprinciple 1.2 of the *AAMFT Code of Ethics* (AAMFT, 1991), which addresses dual relationships. Attention to the particular boundary dilemmas clergy psychotherapists face might be crucial to protecting the integrity of their professional relationships and to preventing client exploitation and harm.

Most violations of professional ethics are unintentional (Haug, 1993), perpetrated by generally well-meaning counselors lacking education, supervision, self-awareness, or self-control. Establishing behavioral rules and guidelines concerning boundary issues, however, is only partially helpful. It seems equally important to address the attitudes and practices that give rise to misuse of power and authority. This article endeavors to raise clergy psychotherapists' awareness of the factors that tend to predispose them to unique boundary dilemmas. It further provides suggestions to enhance ethical practice in the service of client welfare.

TERMINOLOGY

For the purposes of this discussion, the terms *counselor, psychotherapist*, and *therapist* are used interchangeably. *Clergy psychotherapists* are defined as mental health professionals who have received dual education and training as clergy and as psychotherapists (the term *clergy* encompasses Christian and non-Christian religions). Most commonly, theological training precedes mental health training. Clergy psychotherapists come from diverse religious traditions, and their mental health training may be in pastoral counseling, social work, marriage and family therapy, counseling, psychology, or psychiatry. In their professional capacity they may or may not use their theological degree and therefore are not necessarily identifiable as having a ministerial background. Psychotherapists with clergy training may work in secular settings as full-time counselors with minimal or no overt association with organized religion, in settings identified as providing pastoral counseling or religiously based therapy, or in settings in which they balance ministry and professional psychotherapy practice simultaneously. Although women in some Protestant denomina-

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tions constitute half of the student body in seminaries, clergy and clergy therapists still tend to be predominantly male.

Professional boundaries might be conceptualized as a frame (Gutheil & Gabbard, 1993; Peterson, 1992) which, like a picture frame, demarcates what is included in or excluded from the therapy relationship. This frame delineates the structure and content of the counseling relationship and establishes professional responsibilities and appropriate behaviors conducive to fulfilling the task of helping clients in distress. Among the issues included are place, space, timing and financial arrangements of counseling, psychotherapists' role and behaviors, and clients' rights and behaviors.

Power, for the purposes of this article, is defined as the ability to influence persons or events. It can be exercised in ways helpful or harmful to the parties involved. Unequal power, a situation in which one person is able to impose his or her will over others, is often due to such factors as one's role, sex, position, or knowledge (Richards, 1997). *Authority*, on the other hand, may be defined as legitimated power, publicly validated and usually institutionally conferred (Gula, 1996). *Ethics* and *ethical* refer to psychotherapists' attitudes and behavior that (a) give primacy to the welfare of clients, and (b) are mindful of the intended and unintended consequences of therapists' behavior not only to clients but also to clients' social context and to the public as well as the profession at large (Haug, 1998).

USE AND MISUSE OF POWER AND AUTHORITY

Psychotherapists have great power to influence those in their care. They hold this power and authority due to their training and professional affiliations and the trust and confidence these inspire in persons seeking their services. Counselors' fiduciary responsibility, documented in professional ethics codes, lies in exercising this power and authority in ways that will first serve clients' needs and protect clients' vulnerabilities. In fulfilling these obligations, counselors protect and advance their professional integrity.

Postmodern therapeutic approaches emphasize collaborative, egalitarian relationships between counselor and client and attempt to minimize or even deny counselors' power. However, although counselors and clients undoubtedly influence each other, this influence is not of equal proportions. Counselors' ability to influence counseling process, procedures, and content and clients' lives far outweighs, for better or for worse, the power clients have over counseling or counselors. The sheer fact that a client, but not the counselor, shares highly personal and often embarrassing matters in counseling makes him or her vulnerable and at risk should the counselor prove untrustworthy.

Clients' vulnerability might be heightened when they consult clergy psychotherapists. Due to the ministerial background of clergy therapists, clients may have exaggerated expectations of their ethical conduct and of the safety, if not "sacredness," of the counseling relationship. Clients may therefore grant them extraordinary trust, power, and authority over their lives (Lebacqz, 1985; Richards, 1997) and also desire special closeness and attention. Clergy psychotherapists, on the other hand, often have an ambivalent attitude toward issues of power and authority (Fortune, 1989; Richards, 1997). They tend to prefer to downgrade therapy to a friendship (Gula, 1996) and minimize both their influence over clients and their ethical responsibility for the relationship. The mix of these client and therapist dynamics makes wise handling of the therapy relationship very difficult because the risk of abuse of power seems greatest when professionals minimize or ignore the magnitude of the power they possess and become careless in monitoring power dynamics in therapy (Fortune, 1989; Gula, 1996; Peterson, 1992; Richards, 1997).

Power and authority, of course, present complex issues for every counselor, and misuse of power seems to be intimately and consistently connected to boundary violations of diverse kinds (Peterson, 1992; Rutter, 1989). Creating and maintaining safe, predictable, and reliable boundaries is therefore crucial to the integrity and success of any counseling dedicated to maximizing clients' welfare.

Unequivocally, the primary burden of responsibility to maintain clear boundaries and to protect the well-being of clients and the safety of the professional relationship lies mainly with the counselor (Bograd, 1992; Gula, 1996; Gutheil & Gabbard, 1993; Peterson, 1992; Pope & Vasquez, 1991), who should be more knowledgeable than clients about the role power dynamics play in therapeutic relationships. Due to a lack of understanding of the unintended potentially negative consequences, clients are rarely, if ever, in a position to give authentic consent to any crossing of professional boundaries. In addition, they are often not immediately aware of the harm they suffered from counselors' unprofessional behavior, and frequently lodge complaints after considerable time delay (Humphrey, 1994).

Setting safe boundaries is best accomplished proactively rather than reactively. Some clients, particularly those who have experienced prior violations of their boundaries or who find themselves unable to accept limits, can be expected to test those limits. They need to feel safe in discussing or even acting out their conflicts and to be assured that counselors remain committed to appropriate professional boundaries, regardless of clients' behaviors or counselors' ambivalence.

VULNERABILITIES DUE TO DUAL PROFESSIONAL TRAINING AND ROLE EXPECTATIONS

Clergy psychotherapists generally bring to counseling practice their previous socialization and experience as clergy. The expectations of what constitutes appropriate professional conduct in both of these helping professions are not identical. Some practices common to clergy and considered ethical by most, such as ad hoc home visits, might be viewed as ethically questionable or even unethical for counselors. These discrepancies can create confusion for the clergy therapist. Awareness of the differences in what is expected and deemed professional and ethical in the two professions, however, is the first step toward preventing a lapse in ethi-

cal conduct and client harm. The following dimensions need particular attention.

Professional Education

Clergy training generally does not include mandatory course work in professional ethics or emphasis on personal growth and development, sexuality, or clergy self-care (Haug & Alexander, 1994). As a rule, clergy also have no detailed, specific code of ethics to which they can turn for support and guidance (Fortune, 1989; Gula, 1996).

In their mental health training, clergy psychotherapists may or may not have received specific training in ethics and professional issues. Their initial clergy training, however, may predispose them to be less informed and less aware than is desirable about (a) the ethical dimension of professional behaviors and practices and (b) the ways their personal issues might contaminate counseling processes. They might therefore be vulnerable to impaired judgments due to ignorance, naïveté, or personal blind spots, to the potential detriment of their clients.

Gender Issues

Hierarchical, male-privileging gender relations are a legacy of our culture in general and of most religions in particular, embedded in theology and doctrine and enacted throughout history. Gender inequalities, for instance, are built into religions' anthropomorphically referencing the divine as male and by implication privileging men's experiences over those of women. This, in part, undoubtedly led to the historic devaluation of women's contributions to religious life through the ages. These entrenched gender dynamics and traditions may desensitize male clergy and clergy psychotherapists in power positions to the experiences of women. As a result, they may be at risk of neglecting to safeguard the rights and boundaries of women in their care.

Idealization

Public admiration and high expectations of moral conduct might make it difficult for clergy to acknowledge and remain mindful of their own humanity and "shadow side," including self-serving or sexual impulses. In addition, clergy who believe they have to uphold a public image that does not necessarily correspond to who they fully are, tend to be profoundly lonely and often disassociate their public from their private life. In a national survey, 12% of clergy reported feeling "always" or "often" depressed (Blackmon & Hart, 1990). There is a tendency for them to oscillate between a sense of self-importance when they identify with their public role and low self-regard when they reflect on their private self (Blackmon & Hart, 1990; Wiest & Smith, 1990). They may find it difficult to (a) view clients' idealized attachments as projections and transferential feelings and (b) to acknowledge and tend to their own emotional needs and impulses and keep them from contaminating the counseling relationship. This lack of integration provides a fertile breeding ground for unacknowledged impulses and needs to proliferate and possibly be acted out inappropriately.

Professional Socialization

Clergy are generally expected to be friendly and warm and to demonstrate their caring by initiating contacts with members (e.g., visiting parishioners in their homes, in the hospital, or over lunch; comforting them with hugs) and by placing minimal restrictions on their own physical or emotional availability. In addition, clergy often socialize with parishioners, attend family celebrations, or work side by side with them on community projects. It might be said that flexible, even ambiguous, boundaries and a tendency to become overly involved in people's lives come with the ministerial territory and tend to be positively connoted and actively encouraged as expressions of love, care, and unselfishness. In fact, it might be precisely these very attitudes and actions that enable clergy to be effective in their pastoral work. The cost of this "boundless dedication," however, tends to be clergy's neglect of their personal and family lives in the service of others, a temptation to meet personal needs through their work, and difficulty setting limits assertively and protecting professional and personal time and space. As a result, they may also feel secretly entitled to being rewarded for all their sacrifices with special favors from those they care for so much, whether or not such reward is appropriate.

Clergy psychotherapists who internalize these publicly and institutionally sanctioned socialization patterns may be prone to continue some of these behaviors in the different environment of ongoing and intensive counseling. They remain unaware of how the exclusivity and privacy of the counseling context changes the dynamics and meanings of behaviors and what confusion the lack of clear boundaries and of counselor self-care creates for clients. At best, this may be countertherapeutic and, at worst, may lead to harm and exploitation. Counseling becomes unsafe as the focus on clients' welfare and the parameters of the professional context are blurred.

Practice Structures

Clergy's job descriptions tend to be poorly defined (Craig, 1991) and lack explicit criteria for success. This undoubtedly further contributes to clergy's workaholism (Wiest & Smith, 1990) and lack of clear boundaries between the professional and personal realms of their lives.

In addition, clergy are paid by salary. Pastoral care or counseling is part of their job description and is not reimbursed on a fee-for-service basis. Clergy psychotherapists may therefore be ill at ease and unskilled in dealing matter-of-factly with such financial matters as fee setting and fee collection. Financial arrangements require clear policies and consistent boundary setting in their implementation. Lack of clarity or irregularities may lead to confusion and resentment when clients feel flattered and special for being undercharged and abused when therapists attempt to correct billing mistakes.

Clergy also often work in isolation, receive inadequate supervisory assistance in challenging circumstances, and lack peer review and accountability (Richards, 1997). This makes it more likely that they remain unaware of their biases and blindspots and retain unrealistic assessments of their abilities and competencies. Clergy psychotherapists may perpetuate similar behaviors and put themselves and their clients at risk when minor mistakes or improprieties may continue unnoticed and uncorrected until they escalate to major wrongdoing and come to the attention of authorities (e.g., church authorities, legal authorities).

The legacy of lack of (a) education in professional ethics, (b) theologically based self-care, (c) attention to personal growth, (d) support for clear professional boundaries in the face of traditionally unquestioned demands, and (e) controls and restraints, combined with the trust, power, and authority often blindly conferred on clergy place great burdens on them as far as wise handling of the helping relationship is concerned (Richards, 1997). Clergy psychotherapists, having generally been socialized into these pastoral attitudes and behaviors prior to becoming counselors, may find it difficult to reorient themselves to the different expectations and ethical guidelines of the mental health field—and they often resist those as cold, uncaring, and as "unpastoral." This revision may be easiest for those clergy who engage solely in full-time mental health practice and hold themselves primarily accountable to its professional values and codes of ethics. Clergy psychotherapists who work both as pastors, priests, rabbis, and so forth, and as therapists, face more complexities negotiating what constitutes appropriate behavior in which context. Setting, communicating, and maintaining distinct boundaries between both professional roles is of paramount importance for the integrity of both, ministry and mental health practice.

COMMON BOUNDARY DILEMMAS

Boundary violations are generally not a single event but a process (Peterson, 1992), a "slippery slope" where seemingly innocent and minor boundary crossings (Gutheil & Gabbard, 1993; Haug, 1993) precede more serious breaches in professional conduct. Relatively minor boundary violations can be early warning signals and need to be taken seriously, discussed openly in supervision, and rectified. Clear and consistent boundaries create and support safety, dependability, trust, and security and dispel anxieties and confusion (Haug, 1993). They also do not have to stifle therapists' ability to convey warmth and caring.

Boundary crossings or outright violations occur most frequently in several areas: nonsexual multiple relationships, sexual and sexualized multiple relationships, confidentiality, client autonomy, and practice policies.

Nonsexual Multiple Relationships

When counselor and client engage in relationships with each other beyond professional parameters, such as becoming friends, business associates, employers, or interacting neighbors, they are engaging in "dual" or multiple relationships. Multiple relationships of any kind invariably introduce complexities and multiple agendas (Peterson, 1992) into the encounter and can subtly or decisively detract from the concerns that brought clients to seek counseling in the first place. They open the door to misunderstandings, confusion, anxiety, and harm. Due to the vulnerability factors listed previously, clergy psychotherapists are particularly tempted to minimize the risk involved in multiple relationships. With the rationalization of showing kindness, they remain unaware of the potential misunderstandings and complications created by, for instance, taking clients out to lunch, putting an arm around them, offering financially needy clients employment or bartering arrangements, forgiving outstanding balances, sending depressed clients flowers, taking their car to a client's repair shop, and so forth. They are ill equipped to handle the conflicts when, for example, the client's car repair proves unsatisfactory.

Clients often naively or compulsively seek out these additional connections with their counselors. They may initially feel flattered and special when they occur, particularly when the counselor, like a clergy person, has high standing in the community. Over time, however, many clients experience confusion about the true nature of the counseling relationship and feel betrayed at having to subordinate their own needs to those of their counselor. Counseling becomes unsafe, no longer a "holding environment" where clients can securely express themselves without feeling compelled to please their counselor or being afraid that counselors exploit the information for their own gratification, be it social, emotional, or financial.

Although some professionals call for greater acceptance of nonsexual multiple relationships as introducing a humanizing and more "real" element in psychotherapy, multiple relationships are one of the most frequent reasons clients, students, or supervisees feel harmed by providers and lodge ethics complaints with the various mental health professions (Pope & Vasquez, 1991; J. Scalise, personal communication, April 22, 1998). The admonition to avoid multiple relationships is contained in the ethics codes of most mental health professions and proves most protective of clients (see American Counseling Association, 1995).

It is crucial for counselors, particularly clergy psychotherapists, to ask themselves these questions: Who will benefit from this boundary crossing? Who really needs this hug, this financial advice, this get-together outside the counseling room? What are the possible negative, unintended consequences for clients and those close to them, for the public, and for the profession at large? Am I satisfying personal needs, for instance for services, social contact, self-revelation, financial stability, and so on, that might and should be met otherwise? Could this multiple relationship be avoided? Am I rationalizing away my concerns? Am I comfortable having this course of action made public?

Clergy psychotherapists working at their site of worship (e.g., church) may have the greatest difficulty in setting

clear boundaries to prevent a conflict of interest. Issues such as office location and policies, when and under what circumstances they might accept a member for psychotherapy, financial arrangements, availability, or advisability or inadvisability of touch need to be established proactively to prevent confusion and misunderstandings.

Sexual and Sexualized Multiple Relationships

The codes of ethics of all major mental health professions explicitly prohibit sexual intimacies between counselor and client, often with a 2-year (or longer) posttermination clause (Herlihy & Corey, 1996). The definition of what constitutes sexual intimacies is somewhat vague. The prohibition is generally interpreted to mean client–therapist intercourse. However, sexual exploitation may also occur in what might be termed "sexualized behaviors" such as kissing, embracing, verbal suggestions of sexual content, and behaviors of a sexual nature short of intercourse.

The code of ethics of the American Association of Pastoral Counselors (1994) in Principle III G provides explicit and comprehensive directives concerning what constitutes unethical sexual behavior:

> All forms of sexual behavior or harassment with clients are unethical, even when a client invites or consents to such behavior or involvement. Sexual behavior is defined as, but not limited to, all forms of overt and covert seductive speech, gestures, and behavior, as well as physical contact of a sexual nature; harassment is defined as but not limited to, repeated comments, gestures, or physical contacts of a sexual nature. (p. 3)

All indications are that sexual boundary violations occur predominantly between men in power and the women in their care (Gula, 1996; Rutter, 1989). This is not surprising, given the nature of psychotherapy and the gender patterns deeply embedded in our culture. Clients reveal emotional and highly personal contents in counseling, and a closeness and intimacy often develops between counselor and client that may stimulate in both of them sexual desire and sexual fantasies (Rutter, 1989). Most counselors struggle at some time in their career with sexual attraction—their own attraction to a client, a client's attraction to the counselor, or both. At the same time, indications are that the less satisfied counselors are in their own sexual lives, the more they are in danger of wanting to have their needs met by clients (Balswick & Thoburn, 1991).

A 1984 study by Blackmon found that 38% of clergy of four major denominations admitted that they engaged in what they considered "inappropriate sexual behavior" (Blackmon & Hart, 1990). Complaints to ethics committees of various mental health professions seem to confirm similarly high numbers of clergy psychotherapists implicated in sexual misconduct (as noted in the introduction of this article). The legacy of the scant attention clergy tend to pay to their personal lives and the strong transferential feelings and desires directed at clergy psychotherapists makes dealing with sexual impulses difficult. In addition, wishing to be helpful, clergy therapists may nurture exaggerated and grandiose fantasies of the curative properties of therapists' "love" for needy, traumatized clients. They may not be educated, aware, or secure enough to differentiate caring from love and love from sexuality. Clergy psychotherapists may remain blind to their own or clients' behaviors, which might subtly or not-so-subtly encourage sexual fantasies, sexual focus of sessions, and sexual acting out, unaware of the romantic attachments fostered in both participants in such an encounter.

Research shows that sexual relationships between counselor and client can have long lasting, destructive consequences (Fortune, 1989; Peterson, 1992; Pope & Vasquez, 1991). Clients often suffer extreme shame, self-blame, loss of trust in close relationships, and symptoms of posttraumatic stress (Epstein & Simon, 1990). Counselors found in violation of sexual boundaries suffer as well, often with public humiliation, loss of respect, financial ruin, and deep shame.

The very common feelings of attraction become particularly dangerous when counselors keep them secret from peers or supervisors, thereby nursing them "in the dark" as shameful but alluring fantasies, often to the point where they escalate into inappropriate actions that override common sense and professional values. Research indicates that religious counselors find it particularly difficult to report sexual attraction and fantasy toward clients (Case et al., 1997). Safe supervisory relationships, however, in which counselors can reveal their own attractions or clients' longings or seductive behavior and can find ways to respond without acting out are imperative for the integrity of the counseling relationship.

Confidentiality Issues

Clergy are obliged and protected by law to keep confessions confidential. Many other matters, however, such as who they see during the course of their workday or who is experiencing a health or personal crisis or milestone are not necessarily considered confidential information for clergy. They do, however, constitute privileged communications for counselors. Clergy psychotherapists may have to be particularly mindful of these differing requirements when they are simultaneously employed as clergy and as therapist. It may prove difficult for them to uphold the requirements of each of their roles and to avoid accidentally and inappropriately revealing confidential information. It is prudent for counselors of all backgrounds to err on the side of respect for clients' confidentiality. Soundproofing counseling rooms; avoiding professional gossip; informing clients of supervision or consultation on their case, including the name of the supervisor; training administrative staff in confidentiality requirements; safeguarding records; and preventing unauthorized disclosures all help preserve clients' dignity and ethical right to confidentiality.

In many states, privileged communications laws govern the release of client information, including who is or is not a client at a given facility or private practice. Confidentiality is a client's right and client information can and must be

released only with the client's written permission. Exceptions stipulated by case law or statutes may be the duty to report suspected child abuse and neglect, the duty to commit clients dangerous to themselves or others, and the duty to warn the intended victim of a crime.

Client Autonomy

Clients of certain religious persuasions may seek out clergy psychotherapists who belong to their own faith group or who they assume will be respectful of their religious beliefs. Many clients, however, may not be aware of the clergy background of their counselor. Clergy psychotherapists who have a strong commitment to the values and behaviors their faith groups hold may find it difficult to respect clients' disinterest in exploring this area of their lives, or their strongly held divergent views. They may also be in danger of passing judgments and misusing their power and authority to proselytize or to inappropriately influence clients to adopt their view of the world. At particular risk may be counselors who share their religion's stand on issues such as reproductive rights; nonmarital sexuality, including adultery and gay/lesbian relationships; or divorce. These clergy psychotherapists may need to be vigilant so that they are not perceived as compromising clients' rights to determine their own beliefs and to act in accordance with these beliefs. If they feel they cannot be objective, they may need to refer clients who are dealing with these issues to other counselors, and to do so in a way that the client will not perceive as rejection or victimization (Haug, 1998).

Counselors do, of course, hold personal convictions and values. Clients, however, are entitled to informed consent concerning pertinent information of the counseling process and relationship, including counselors' religious persuasion and clinical orientation.

Practice Policies

Practice policies covering such topics as time, place and space, financial arrangements of counseling, acceptance of gifts, or counselor availability provide crucial boundaries that provide structure and containment to counseling sessions (Gutheil & Gabbard, 1993) and make them predictable. Practices such as extending the counseling hour, making oneself available on demand, meeting at places other than an office such as in cars or at lunch places, forgetting billings, or forgiving client debts introduce the great potential for these actions to be either misinterpreted by clients or become the fertile ground for further, more serious boundary crossings. Clergy psychotherapists, who in their clergy roles were often expected to behave in such fashion with parishioners, may have a difficult time understanding that counseling clients form a more intense connection and dependency with them and are apt to misinterpret these actions. Clients may easily mistake the professional relationship for a social friendship and feel entitled to further special treatment. Correcting these misconceptions and dealing with unmet expectations and feelings of rejection take time and deter from the primary focus of counseling.

Rigidity, of course, is seldom well advised. Stretching a boundary after thorough reflection may have a beneficial effect, for example conducting a session in the hospital, accompanying a client to court, or not charging when a child's illness prevents clients from attending sessions. It is, however, crucial to discuss with clients the intended and possible unintended consequences of such actions and to inform clients proactively about pertinent policies and procedures that govern the therapy relationship.

CONCLUDING RECOMMENDATIONS

Raising clergy psychotherapists' awareness that all actions, no matter how seemingly minor or unimportant, have ethical consequences that may harm or help clients is crucial to ethical practice. On the basis of my experience as both clergy psychotherapist and past member and chair of the ethics committee of one of the mental health professions, I propose several means, independent of therapists' conceptual frame, that might prevent the abuse of power and of resulting boundary violations:

1. Education in ethics and professional issues to expand and update clergy psychotherapists' knowledge base: Keeping abreast of contemporary developments in ethical thinking and professional codes is crucial for all mental health practitioners. Graduate-level or continuing education courses ought to address the use of power and authority, ethical principles and their application to ethical reasoning and decision making, and professional codes of ethics. Particular attention ought to be given to issues of gender sensitivity in counseling, multiple relationships, the recognition and handling of transference and countertransference, informed consent procedures, and legalities.
2. Education concerning all dimensions of sexuality, including sexual development through the life cycle, gender aspects, and ethical dimensions of sexuality: This ought to go hand-in-hand with creating avenues for clergy psychotherapists to openly and honestly discuss their own sexuality (Richards, 1997) and receive assistance with personal dilemmas.
3. Assistance in creating office policies and forming agreements with clients at the beginning of therapy: Proactive informed consent procedures are of great importance to prevent future boundary ambiguities. They ought to encompass counseling goals and expectations; counselors' training, orientation, and behaviors; confidentiality issues, including limits to confidentiality or how chance meetings (e.g., at the supermarket or at church) might be handled; administrative matters such as office policies governing professional availability; billing and fee collection, and so forth. Counselors should provide these disclosures in writing and request clients' signature.
4. Building supportive professional networks to reduce professional isolation and increase accountability, particularly for those clergy psychotherapists in private practice.

5. The acceptance and conscientious pursuit of ongoing supervision and peer consultation and review: Supervision is crucial for recognizing biases, blindspots, or misjudgments and for practicing ethically. Supervision should require a commitment not to withhold from supervisors any aspect of one's attitudes and behaviors with clients, including deviations from established policies and procedures, sexual attractions, or temptations to engage in multiple relationships. This supervisory assistance is particularly indispensable for clergy psychotherapists who simultaneously work as ministers or those who practice in small communities where multiple relationships may be unavoidable and therefore need proactive policy setting and careful handling and monitoring.

6. Encouragement and assistance in focusing on clergy psychotherapists' personal life and attending to personal needs in an ongoing manner: Satisfying personal relationships and rejuvenating, non-work-related experiences may be the best antidote to inappropriately meeting personal needs through work. A theological rethinking of the importance of setting appropriate limits and of necessary self-care may help prevent not only ethics lapses but counselor burnout as well.

7. Strong support for using personal therapy as a resource for resolving personal dilemmas: The special pressures and vulnerabilities clergy psychotherapists experience make it highly desirable for them to obtain individual, couple, or family counseling during times of crisis, transition, or conflict.

The role of clergy psychotherapists as mental health care providers is still emerging. It may gain more prominence in the coming years as a result of the current interest in our society and among mental health professions to include a spiritual orientation in mental health practice. When clergy psychotherapists' vulnerabilities receive the careful attention they require and deserve, their many contributions to clients' welfare may be augmented and become more visible.

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Responsive Therapy and Motivational Interviewing: Postmodernist Paradigms

Sterling Gerber and Alan Basham

Two counseling approaches of relatively recent origin, responsive therapy and motivational interviewing, are described and compared. Both operate through a series of stages and from a collaborative and postmodernist ethic. They involve prescriptive use of standard micro-skills at the beginning stage and progress to focused and active, intentional intervention strategies. Responsive Therapy claims to allow integration of active interventions from a variety of theory bases, whereas Motivational Interviewing has a strongly cognitive-behavioral flavor. Both serve as viable alternatives to a traditional diagnose and prescribe mindset while maintaining efficient and effective dynamics appropriate to contemporary brief therapy and managed care contexts.

Technique follows understanding. This principle captures the essence of a therapeutic conundrum of long standing. Is the counseling process better managed from a detached, clinical observation, diagnostic decision, and categorical intervention approach? Or does therapy work better when it involves clients as major participants in the process of defining their circumstances, delineating their preferences and talents, and collaborating in their intervention strategy? The categorical nature of the former modernist approach both places persons in predefined categories and implies certainty of the accuracy of therapist judgments about the client. The latter modality is postmodernist or constructivist in that it focuses on the unique phenomenological world of the client while engaging the client as an equal partner in the therapeutic process.

Modernist approaches to counseling are based on the premises of logical positivism, including the validity of the scientific method as a way of discovering reality and that reality or truth actually exist in some objective form (Sexton, 1997). In modernist approaches, the counselor applies his or her understanding of mental health or developmental maturity to the client's problem or situation, often within the confines of a particular counseling model. The objective truth or reality is known by the counselor, whose task it is to assist the client in conforming or adapting to that truth. In contrast, constructivists understand that reality is subjective and that persons create their own internal system of meaning and knowledge (Sexton, 1997). Constructivist counselors are focused on understanding how the client makes his or her own meaning, instead of whether or not that constructed meaning matches some objective reality. By joining with the client in an effort to understand the client's reality, the constructivist counselor acknowledges the client's reality and provides a supportive opportunity for the client to reconstruct that reality, as needed, and to restore balance to it (Hayes & Oppenheim, 1997).

Two models of counseling, *responsive therapy* (Gerber, 1986) and *motivational interviewing* (Miller & Rollnick, 1991) embrace collaborative, client empowerment dynamics and have demonstrated an efficacy in intervention (Allsop & Saunders, 1991; Baker & Dixon, 1991; Cox, Klinger, & Blount, 1991; Gerber, 1989, 1991; Gerber, Pederson, & Selby, 1996; Saunders, Wilkinson, Phillips, Allsop, & Ryder, 1991; van Bilsen & van Emst, 1986). These are not the only counseling models that operate on client awareness and involvement principles (Monk, Winslade, Crocket, & Epston, 1996; Purkey & Schmidt, 1996; Sexton & Griffin, 1997; White, & Epston, 1990). However, both are of relatively recent origin (Gerber, 1986; Miller & Rollnick, 1991) and both are expressed in direct and applied terminology. These models evolved independently of each other, although there are striking similarities and only a few significant contrasts. The following is an analysis of these two approaches, a comparison of each to the other, and an elucidation of both as exemplars of the maxim Technique follows understanding.

RESPONSIVE THERAPY

Responsive therapy begins with the assertion that a good counselor is one who matches interventions to the circumstance and style of each client. It may be helpful to separate the coun-

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seling process into three segments: (a) an analysis or clarification phase in which the client and counselor cooperatively construct an awareness of client circumstance and style (Stewart, 1983), (b) a decision phase in which the counselor and client consider alternate plausible intervention strategies and agree on the preferred one, and (c) application of learning-based procedures being careful to function within the parameters of the theoretical model that gives power to the techniques (i.e., techniques are true to their theoretical base). The first phase operates on the assumptions that the client is the primary source of information about self, circumstance, and style and that the counselor is proficient at managing communication and relationship dynamics to elicit progressively rich and complete descriptive information from the client. The counselor suspends theoretical judgment during this phase. Circumstance and style of the client drive the intervention strategy. Once circumstance and style are elucidated, it is possible to frame them into more than one theoretical context. It is critical for the counselor to differentiate among the possible interpretations and to choose, with involvement of the client, one approach to be followed precisely and with care not to contaminate the intervention by introducing dynamics alien to that approach.

Responsive therapy prescribes the careful use of select microskills for up to three sessions in order to build a trust-based working relationship between client and counselor and to identify the unique set of dynamics in which the client finds himself or herself (circumstance) and the preferred problem-solving approach inherent in the nature of the client (style). The select microskills used in this early part of counseling are those limited to invitations to the client for disclosure and the mirroring of client disclosure by the counselor. Invitations to disclose include broad, indirect leads and furthering responses of the "Tell me more," and "Give me an example" types, with studious avoidance of interrogative questions, probing, and interpretation. Mirroring techniques include paraphrase of message, reflection of feelings, and description of situation. It is believed that deviation from this careful pattern moves the focus away from the client's phenomenal world and into the counselor's (Gerber, 1986).

One way of verifying the counselor's understanding of client circumstance and style is the use of a drama or scripting metaphor in three acts. The counselor charts for the client the important dynamics and people leading up to the present (Act I); the actions being taken by the client in the present to cope with his or her circumstance, which usually are inadequate to remove the problem(s) (Act II); and two projections of the script for the future (Act III)—what will happen if the client does nothing different, and what would the client like to see happen in Act III? This is analogous to Wubbolding's (1991) presentation of the WDEP model of reality therapy, in which the counselor supportively helps the client to clarify *w*hat he or she wants, to examine what he or she is *d*oing and the *d*irection in which current behavior will lead, to self-*e*valuate these wants and behavior, and to make new *p*lans to more effectively fulfill personal needs.

An abbreviated example of counselor dialogue would be as follows.

> Let me share my awareness of where we are and where you would like to go. In the past (Act I), you have pretty much done what was expected. Your grades were acceptable, and your behavior was proper, even coming to this university was a result of your father's recommendation. Your course of study fits family tradition, and yet that tradition also prescribes becoming a wife and running a farm home in support of your husband's agricultural career.
>
> At present (Act II), you are approaching graduation with a teaching certificate and have the opportunity to take a job. You are not formally engaged but are expected to return to your small hometown community and marry a young farmer. You are not certain that you love him, nor are you sure that you want to accept the lifestyle that goes with a return home. You believe you must make a decision by graduation day.
>
> As we look to the future (Act III), what do you predict will be the outcome if you do nothing differently from your past ways? You will return home, marry the farmer, and either adapt to or resent being stuck in that lifestyle. What are some alternate scripts that would make the future more acceptable to you?

Counselor and client would explore options such as taking a job as a teacher in another community, clarifying thoughts and feelings about marriage and the farm so as to go intentionally and not as a matter of giving in to expectations, exploring alternative patterns of behavior in the home context such as living in town and being a teacher as well as a farmer's wife, continuing in school or doing some other activity that would postpone response to expectations until she has a chance to learn how to make and follow through on her own decision. Depending on the client's style and the preferred script for Act III, the counselor and client would agree on a strategy—such as restructuring some "should" statements, learning assertion skills, boundary management, development of decision-making skills, or creating alternative narratives.

In responsive therapy, once the counselor has an understanding of client circumstance and style, it is possible to select or create an intervention strategy that efficiently and effectively addresses the observed client dynamics (e.g., selection of a cognitive restructuring paradigm to a client showing reliance on erroneous self-statements or use of an operant procedure to alter some externally cued, self-defeating habit response). At that stage, counselor and client compare perceptions and enter into a contract, informal or formal, indicating the type of intervention believed to be the most appropriate to the client's circumstance and style. The contract indicates the role of client and of counselor, the type of active intervention to be pursued, and the approximate time required to resolve the problem.

It is noteworthy that the counselor engages the client, at that point, in an appropriate theory-based active intervention process (i.e., technique follows understanding and is not derived from a single theoretical approach). If the problem is the client's habit-bound self-defeating actions, the counselor becomes a behavior modifier. If the problem is cognitive deficit or cognitive distortion, the counselor becomes a teacher or engages in cognitive restructuring. If

the problem arises out of inexperience or from misleading perceptual frames, some active intervention of a Gestalt, experiential learning, or modeling nature would be the approach of choice. If the problem is affective in nature, a relational method for an affective deficit or a systematic desensitization process for an affective surplus might be called for.

To summarize, there are three stages to responsive therapy (Gerber, 1986): (a) approximately three sessions devoted to systematized active listening, being careful to avoid interrogation and to stay in the client's phenomenal space, in order to identify client circumstance and style; (b) a time of client and counselor comparison of perceptual awareness and contracting for a specific intervention process that is indicated by the client's circumstance and style; and (c) a period of active intervention wherein the counselor adheres carefully to the techniques that are grounded in an appropriate theory-sound strategy, a different one for each client.

MOTIVATIONAL INTERVIEWING

Responding to the premise that change happens most effectively when it is generated by the client, motivational interviewing is described as "a particular way to help people recognize and do something about their present or potential problems" (Miller & Rollnick, 1991, p. 52). Although the responsibility for change is assigned to and left with the client, the motivational interviewing practitioner works actively to create discomfort and discrepancy in the perceptual frame, the cognitive structure of the client, or both. This reflects the dynamics of cognitive dissonance (Festinger, 1957) wherein there is a natural tendency to seek resolution to dissonance, and the creation of such in the counseling interaction triggers this natural motivation for change.

Motivational interviewing is a multistage sequential model of counseling. It incorporates a structure from Prochaska and DiClemente (1982) who posited change as the result of a person going through six stages of change: precontemplation, contemplation, determination, action, maintenance, and often relapse and traveling through the stages several times. In the context of this model, motivational interviewing works most effectively in resolving the ambivalence commonly experienced in the contemplation stage and promoting readiness (determination) to change.

"[I]t was in working with problem drinkers that the concept of motivational interviewing was developed" (Miller & Rollnick, 1991, p. x). Historically, treatment of alcoholics required the client to admit, freely or as a result of overwhelming confrontation, that he or she was an alcoholic. This often happened only when the client reached some "mystical" level of malfunction, referred to as "hitting bottom." The proclamation of the label, "alcoholic," and the admission that it is a disease beyond control of the client were believed to be requisite to a reasonable prognosis. In contrast, motivational interviewing takes the approach that problem drinking is itself the self-defeating behavior, whether or not it can be externalized into a diagnostic label of alcoholism. The client can be brought to an awareness that the problem drinking is a barrier to his or her own desired goals, and the subsequent motivation to change comes as a product of the discrepancy identified by the client with the help of the counselor. The discrepancy between the effects of the drinking behavior and the client's broader goals for life is the source of motivation for change.

> Motivational interviewing is an approach designed to help clients build commitment and reach a decision to change. It draws on strategies from client-centered counseling, cognitive therapy, systems theory, and the social psychology of persuasion. The appearance of a motivational interviewing session is quite client-centered; yet the counselor maintains a strong sense of purpose and direction, and actively chooses the right moment to intervene in incisive ways. In this sense, it combines elements of directive and nondirective approaches. . . .
>
> The style . . . specifically avoids argumentative persuasion, and instead operationally assumes the validity of client's subjective experiences and perspectives. This aspect involves listening to, acknowledging, and practicing acceptance of (though not acquiescence to) a broad range of client concerns, opinions, preferences, beliefs, emotions, styles, and motivations. (Miller & Rollnick, 1991, pp. x–xi)

The following are five general principles, enacted somewhat sequentially, that underlie motivational interviewing (Miller & Rollnick, 1991).

1. The counselor expresses empathy. This is accomplished through skillful reflective listening—genuineness, warmth, and positive regard.
2. The counselor develops discrepancy. The focal frames are present behavior and broader goals. The experience of dissonance often occurs when the client is confronted, softly, with the incongruity between present responses and what would be required to accomplish the desired goals. It is a formalization of the often stated counselor observation, "What you're doing isn't working." "A goal of motivational interviewing is to *develop* discrepancy—to make use of it, increase it, amplify it until it overrides attachment to the present behavior. The strategies of motivational interviewing seek to do this *within* the client, rather than relying primarily on external motivators" (Miller & Rollnick, 1991, p. 57).
3. The counselor avoids argumentation. Confrontation is done "softly" with care to focus on behavior and not client character. It would include techniques such as qualifying and one-down positioning.
4. The counselor "rolls" with resistance. Through skillful reframing of client observations, new perspectives are invited but not imposed, and continued self-responsibility for selection of the approach toward solution is reinforced. Consistent with Teyber's (1997) salient model for honoring the client's resistance, the motivational interviewing counselor enlists the client's help in understanding the sources of resistance and the form of and the degree of flexibility in the client's rationale. Rather than confront resistance as a problem, the counselor communicates acceptance and understanding of the self-protective nature of such resistance and, in so doing, assists the client to value but move beyond the impeding defensiveness.

5. The counselor supports self-efficacy. The counselor expresses confidence in the client's ability to cope with the specific task or challenge. The position of motivational interviewing is nicely summarized in the statement, "If you wish, I will help you to change yourself" (Miller & Rollnick, 1991, p. 61).

SIMILARITIES BETWEEN RESPONSIVE THERAPY AND MOTIVATIONAL INTERVIEWING

By way of comparison and contrast of these two approaches, consider the following eight descriptions of similarities and six statements of differences (in the next section).

1. Both are rooted in person-centered therapy (Rogers, 1961) and, although subscribing to some of its basic principles and practices, deviate markedly in the direction of active intervention in a relatively short time.
2. Both start with a process of empathic listening to get an awareness of client dynamics.
3. Both encourage the counselor to avoid argumentation, to hear and honor resistance rather than confront or discount it.
4. Both respect the client's ownership of the problem and responsibility for its solution (client self-efficacy).
5. Both engage the client in a decision to pursue intervention.
6. Both commonly eschew formal diagnosis and any other kind of labeling of the client (such as calling him or her "alcoholic") as disrespectful of the client's role in formulating a vision of the problem and its solution. In this sense, both models are postmodernist because of their nonlabeling approach to clients.
7. There are segments or phases to both. Motivational Interviewing includes Phase I (building the relationship), Phase II (strengthening the commitment to change and transitioning to the action stage), and Phase III (action toward change). Responsive therapy focuses first on understanding client circumstance and style, moving through a comparison of summary perceptions between client and counselor with a resulting contract for intervention, and a change phase that is marked by active intervention in one of four theory-based models.
8. They share many technical procedures, including the following:

   a. A common emphasis on establishing the counseling process early in the first session, teaching the client how to be successful in counseling
   b. Avoidance of interrogative leads (e.g., "Are you disregarding good health practices?")
   c. A preference for starting with open-ended leads followed by paraphrases and reflections (e.g., "Describe for me your experience" "You thought you were being polite, yet she increasingly profaned you and started hitting you")
   d. Avoidance of confrontation-denial and "yes/but" dynamics (e.g., "So you intentionally egged her on"/"No, I didn't want her to go that far"; "Have you considered taking an anger management course?"/"Yes, but none are convenient to my time and location")
   e. Working from where the client is rather than from a counselor-determined diagnostic category or label
   f. A rejection of faultfinding, blaming, or undue focus on what caused the problem, moving instead to what the discrepancy is and what can be done about it
   g. Avoidance of question hooks, the ending of statements with upward voice inflections, while paraphrasing (e.g., "You are really sorry for your part in this conflict?"). These are avoided because interrogative leads and question hooks carry an implicit message of "Your job is to answer my questions." Clients often fall into the pattern of waiting for specific questions and giving answers that are acceptable to the counselor in contrast to explaining more freely and completely the cogent dynamics from their phenomenal perspective. It moves the focus away from the client's experiential space and into the counselor's assessment paradigm.

DIFFERENCES BETWEEN RESPONSIVE THERAPY AND MOTIVATIONAL INTERVIEWING

1. Motivational interviewing uses a single, unitary approach. Responsive therapy makes a conscious effort to draw from several possible theoretical bases.
2. Responsive therapy is careful to stay within the client's phenomenal frame until a formal verification and decision phase is conducted. Motivational interviewing moves to create or magnify discrepancies early on. In other words, motivational interviewing looks for a cognitive-behavioral discrepancy (works from a predetermined mind-set). Responsive therapy works from a broader perceptual frame, seeking to identify client dynamics and compare them with four frames: cognitive, perceptual, affective, and behavioral. Unlike motivational interviewing, responsive therapy purposefully delays focusing on a heuristic schema until one emerges perceptually through interaction with the client.
3. As a unitary strategy and although adaptable to many problems and clients, motivational interviewing claims it is not effective for everyone. Responsive therapy subscribes to an integrative approach that permits counselors to select from at least four approaches to fit a much broader sampling of client concerns and styles. Even though Miller and Rollnick (1991) claimed a difference between motivational interviewing and cognitive behavioral approaches, motivational interviewing would be considered one of several cognitive behavioral methods of use within the responsive therapy framework. In other words, responsive therapy and motivational interviewing would look very similar only in dealing with a client whose circumstance and style are cognitive. Motivational interviewing claims to be adaptable for use with a broad range of strategies or as preparation for other approaches such as behavioral training or medication mediated approaches.
4. Motivational interviewing accesses the client initially and principally through the cognitive channel, thereby be-

ing suitable mostly to relatively verbal and cognizant adolescents and adults. Responsive therapy works from a perceptual base and applies equally to primarily aware and verbal clients as well as to younger children and to people whose style is affective, perceptual, or behavioral.

5. Potentially, much more questioning is present in motivational interviewing than in responsive therapy, which heavily favors paraphrase of message and description of situation (inference statements from the contextual frame).

6. There is more of a sense of the counselor using techniques to guide client response ("Columbo" technique, paradox; see Miller & Rollnick, 1991; Watzlawick, 1978 for explanation of these techniques) in motivational interviewing than in responsive therapy, which emphasizes feedback and collaborative process. Paradox and other manipulative techniques are appropriate in the responsive therapy framework only as a manifestation of the specific process enhancers (theory-based models) that encompass such techniques.

SUMMARY AND CONCLUSION

Two independently formulated, yet strikingly similar, therapy delivery models are motivational interviewing and responsive therapy. Both rely heavily on reflective listening techniques and working within the client's phenomenal framework. Both claim superiority over traditional medical models of the diagnose and prescribe genre. Motivational interviewing is focused on one sequential process, grounded in cognitive change theory. Responsive therapy is an integrational model, allowing for intentional use of four families of theory: perceptual, cognitive, associational, and behavioral. The number of similarities in approach combined with some compelling differences in foundation and application commend a study of both models.

These approaches are logically and theoretically sound, but they lack rigorous empirical support, especially regarding comparison with other extant approaches. Available support in the literature tends toward clinical case studies and conclusions based on practice with a limited clientele (Allsop & Saunders, 1991; Baker & Dixon, 1991; Cox et al., 1991; Gerber, 1989, 1991; Gerber et al., 1996; Saunders et al., 1991; van Bilsen & van Emst, 1986).

As concerns application under managed care dynamics, we recognize at least two mind-sets: (a) rapid diagnosis to maximize time in treatment and (b) intense involvement of the client in the process, with efficiencies in treatment coming from interventions tailored to the client and from increased motivation and cooperation on the part of the client. These two models subscribe to the latter perceptual frame and recognize that many, but not all, client circumstances, styles, and motivational readiness states fit neatly into episodes of 10 or fewer sessions. It is believed by proponents of responsive therapy and motivational interviewing that recognizing and managing client motivational and style dynamics provide, in the long run, maximum economy of treatment investment.

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Multipotentiality, Giftedness, and Career Choice: A Review

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The giftedness and career-choice literatures have traditionally spoken in different terms about the same phenomenon, multipotentiality*. Multipotentialed individuals have numerous and diverse abilities and interests. Appropriate interventions are necessary to help them cope successfully with the abundance of career choices available to them. This review links the giftedness and career-choice literatures through a discussion of the concept of multipotentiality and explores ensuing practical implications and challenges to the overall idea.*

In the literature on giftedness, multipotentiality frequently refers to individuals who have numerous and diverse abilities and interests. The term itself has multiple definitions and is used somewhat inconsistently, yet inevitably it is found in reference to the career indecision it is reported to cause. Multipotentialed young people may anguish over an abundance of choices available to them during career planning unless appropriate interventions are available (Emmett & Minor, 1993; Kerr, 1991). Although multipotentiality *per se* is rarely addressed directly in the career-development literature, it is consistent with low differentiation in Holland's (1985) theory of vocational choice. Until now, the giftedness and career-choice literatures have spoken in different dialects about the same phenomenon. This review links these two literatures through the concept of multipotentiality and explores ensuing practical implications as well as emerging controversies regarding the soundness of the construct.

THE CONCEPT OF MULTIPOTENTIALITY

References to multipotentiality in the career-psychology literature date back to the first half of this century (for example, Fryer, 1931; Kitson, 1925). Yet it is in the field of giftedness that the concept of multipotentiality truly took hold. In fact, many of the numerous definitions of giftedness that exist contain within them references to multipotentiality. For example, the United States Office of Education's revised definition of giftedness includes children who give evidence of high performance capability in a variety of intellectual and creative areas (United States Commissioner of Education, 1972). The construct of giftedness has evolved further in theory but more slowly in school practice. In the 1980s and early 1990s, researchers began to examine cognitive processing as a correlate of high IQ and conventional academic achievement (cf. Shore & Kanevsky, 1993; Sternberg & Davidson, 1986). Conceptual links are also being strengthened between giftedness and the cognitive expert-novice literature and also with flexible and creative thinking (cf. Friedman & Shore, in press). Up to now, however, the idea of multipotentiality has been especially rooted in a psychometric conceptualization of the nature of human abilities. This meaning of giftedness, essentially high IQ and related academic achievement, is therefore appropriately assumed in the present discussion; however, this does not presuppose that it is the most suitable conceptualization of giftedness for other purposes, for example, the design of school curricula or the understanding of superior performance of other types, such as creative performance in any domain, including the arts or leadership.

Some researchers in the giftedness field have used the term *multipotentiality* in reference to multiple abilities (Davis & Rimm, 1989; Frederick, 1972; Fredrickson & Rothney, 1972; Herr, 1976; Isaacs, 1973; Jepsen, 1979; Marshall, 1981; Willings, 1986), and the term *multipotentialed* became equated with the traditionally defined term *gifted and talented* (Frederick, 1972; Fredrickson & Rothney, 1972). Ehrlich (1982), on the other hand, emphasized multiple interests as the key to multipotentiality. More recent publications, however, have referred increasingly to both multiple abilities and multiple interests (Berger, 1989; Colangelo, 1991; Delisle & Squires, 1989; Kerr, 1991; Roper & Berry, 1986; Sanborn, 1974; Silverman, 1993).

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The most widely used definition of multipotentiality comes from Fredrickson and Rothney (1972): the ability to "select and develop any number of competencies to a high level" (p. vii). This definition evolved out of their research with gifted students wherein they found that these students had consistently high scores across different aptitude and achievement tests, showed a pattern of high achievement in class work, and were regularly involved in a variety of social, athletic, community, and solitary activities (Sanborn, 1974). Although there are a select few individuals who are considered highly talented or "profoundly" gifted who do not demonstrate multipotentiality, the majority of the gifted population is widely regarded as multidimensional or multipotentialed (Herr, 1976; Milgram, 1989).

More recently, there has been renewed critical interest in the concept of multipotentiality. Rysiew, Shore, and Carson (1994) proposed a clarification of the term *multipotentiality* and its associated career-choice implications. On the basis of communication with several prominent researchers in the field, they recommended limiting the definition of multipotentiality to describing those individuals with multiple abilities. The associated career indecision that generally accompanies multipotentiality arises when four key variables—abilities, motivation, interests, and opportunity—are all abundant and is referred to by these authors as "overchoice syndrome" (Rysiew et al., 1994, p. 44). Achter, Lubinski, and Benbow (1996) and Achter, Benbow, and Lubinski (1997) have challenged the utility of the entire notion of multipotentiality based on their observation of widely varying patterns of specific abilities and interests in a large sample of gifted adolescents, thereby challenging the ubiquity of low differentiation or high-flat interest profiles. They also noted the small amount of empirical research supporting the notion of multipotentiality. On the other hand, the existence of persistent clinical and anecdotal reports of multipotentiality and indecision in highly able youth and adults points to a need for continuing consideration of multipotentiality and related links between career decision making and giftedness. In addition, it may not be possible to simply set aside the interest component of multipotentiality given Holland's (1985) proposed connections between well-developed interests and competencies. Before either abandoning or further endorsing an intriguing and potentially useful concept, it is important to examine the connections between multipotentiality and other important areas of scholarship and practice.

CAREER DECISION MAKING

Because jobs frequently require specialization (Durkheim, 1984), vocational choice is generally conceived as a narrowing-down process (Fredrickson, 1972). This does not fit well with multipotentiality because multipotentialed individuals are good at many things, highly motivated, and eager to explore new experiences (Berger, 1989; Ehrlich, 1982; Rysiew et al., 1994). Decision making becomes much more complex when choosing from several equally compelling career options. Unfortunately, there are few jobs that provide an outlet for an individual who possesses a multitude of talents, although some may indeed empower gifted employees to enjoy the flexibility to use their multipotentiality (Crites, 1969; Hollingworth, 1976; Kerr, 1981a; Kitson, 1925; Terman & Oden, 1947; Willings, 1986). As a result, the multipotentialed may vacillate among career options, and multipotentiality can be viewed as hindering successful decision making, thus causing the positive aspects of having multiple potentials to be overlooked. Although one would imagine that it is exciting to be faced with several opportunities, as Pask-McCartney and Salomone (1988) pointed out, it may also be confusing and anxiety-producing to be confronted with "overchoice" (Fredrickson, 1979; Hollinger, 1991; Kerr, 1985; Kerr & Colangelo, 1988; Perrone & Van Den Heuvel, 1981; Rysiew et al., 1994).

Kerr (1981b) classified career decision-making problems into three areas: (a) making a single career choice despite multipotentiality, (b) making long-range career plans before having the necessary emotional maturity, and (c) reconciling personal career goals and social expectations. Such problems may take the form of career indecision, which often becomes apparent in high school. Holland and Nichols (1964) studied two samples of National Merit (Scholarship) Finalists. They found that students who scored high in career indecision reported having more competencies, higher extracurricular achievement, more experiences, and resource-richer homes than those who were decided about their careers. It seems that the indecisive students had high levels of ability, interest, motivation, and opportunity (Rysiew et al.'s, 1994, four key variables of multipotentiality) and as a result were finding it difficult to decide on a career.

Indecision and avoidance of career choice can lead multipotentialed people into a pattern of falling behind their same-age peers in career progress and even sometimes in social development (e.g., marriage, family, community involvement; Kerr, 1991). Delisle and Squires (1989) earlier suggested a revised definition of multipotentiality that takes into account its potential attendant difficulties. In their definition, multipotentiality is "the interest and ability to succeed in so many vocational areas that choosing one career path becomes problematic" (p. 98). This parallels the "overchoice syndrome" mentioned earlier.

Empirical support for delay and unpredictability in career choice by the gifted has been provided by a number of researchers (Emmett & Minor, 1993; Fredrickson, 1972; Jepsen, 1981; Perrone & Van Den Heuvel, 1981). For example, in a 10-year follow-up study, Perrone, Karshner, and Male (1979) found that individuals who had maintained stable career choices since high school graduation were more satisfied and held higher status jobs. The individuals whose career choice had been unstable were characterized as less able to acknowledge any weaknesses or limitations. For the gifted, the "inability" to acknowledge weakness or limitation may result from the fact that they possess significantly fewer weaknesses or limitations compared with others.

For many high-ability individuals, vocational selection is an existential dilemma, which often goes hand-in-hand with an identity crisis (Herr, 1976; Perrone & Van Den Heuvel, 1981; Silverman, 1993). These individuals tend to view a career as more than merely one aspect of life and a way to make a living (Carroll, Paine, & Miner, 1973; Yankelovich, 1981). Consequently, they look for occupations that are more than simply interesting. The gifted place great emphasis on choosing an occupation that will be an avenue for self-expression, a venue in which they can implement a philosophy of life and tap into many of their skills and talents (Sanborn, 1974; Shore, Cornell, Robinson, & Ward, 1991; Yankelovich, 1981). The gifted strive toward merging values of self-actualization, self-expression, interdependence, capacity for joy, and full lives in their career choice (Bennis, 1970; Kerr & Claiborn, 1991). Career choice is highly value-driven, and occupational choice becomes a choice of life-style (Kerr & Claiborn, 1991; Rodenstein, Pfleger, & Colangelo, 1977). Thus, gifted and multipotentialed individuals place huge responsibility on themselves at the junctures where career decisions are made and their fate seems to hang on a single decision.

In addition, many multipotentialed gifted individuals suffer from perfectionism: They believe that the "perfect" career for them exists, and they must both find it and succeed at it (Perrone et al., 1979; Silverman, 1993). These individuals fear being less than their ideal or failing to live up to their potential (Silverman, 1993). It is very stressful and very difficult to "measure-up" in the real world, and some may choose to remain in the comfortable role of student in which external recognition is easily obtained and in which they are almost guaranteed success (Perrone et al., 1979; Sanborn, 1974).

Likewise, some multipotentialed students choose "safe" academic majors (Kerr, 1991). Some make decisions based on pragmatism, earning potential, or conformity with peers (Astin, Green, & Korn, 1987). Others give in to expectations of parents, teachers, or society in general: Pressure to achieve at high levels or sex role expectations restrict the range of available career options (Kerr, 1997; Sanborn, 1974). With such expectations, multitalented students may feel as if they are being pulled in different directions (Marshall, 1981) and career choice ceases to be a matter of commitment and becomes more a matter of default (Herr & Watanabe, 1979).

Internal and external high expectations can lead to problems for the multipotentialed individual. Early commitment, a long training period, and a heavy investment are needed for many careers (Sanborn, 1974), yet multipotentialed individuals are often hesitant to make the commitment. The result is often delay in career planning, agonizing indecision, and fluctuations in academic majors or occupations (Herr, 1976; Isaacs, 1973; Willings, 1986). Economic independence, as well as starting a family, may be delayed until formal education is completed (Colangelo, 1991). During the time it takes for entry into a given occupation, the person and the occupation may each have changed (Perrone et al., 1979); but once started along a career path, many have found it difficult to see the possibility for change into a different field (Sanborn, 1974). The individual is often able to find occupational success but little satisfaction in any one choice (Kerr, 1981a). Unfortunately, the multipotentialed lack appropriate norm comparisons and have few readily accessible models to help guide their career paths (Jepsen, 1979; Zorman, 1993).

CONTRIBUTIONS FROM HOLLAND'S THEORY OF VOCATIONAL CHOICE

Theories and research borrowed from the field of career development can add structure to and assist in understanding the phenomenon of multipotentiality. One theorist—John Holland—has written extensively about interests and career (Holland, 1985; Holland & Gottfredson, 1976; Holland & Holland, 1977; Holland, Johnston, Hughey, & Asama, 1991). Holland's theory of vocational choice is based on the matching of personal with environmental interests thus, combining the four key variables—abilities, motivation, interests, and opportunity—delineated by Rysiew et al. (1994). Holland also discussed the implications of having too many diverse interests, and hence he indirectly refers to multipotentiality and "overchoice syndrome."

In his theory, Holland (1985) suggested that there are six personality types with six corresponding favorable environments. People search for environments in which they can best express their personality. Vocational behavior, according to Holland, is largely determined by the interaction between personality type and environment. Holland also asserted that individuals can have clear or diffuse personality types. Those individuals with clear identities will be good decision makers: They know what vocation they would like and hence are able to find it. Individuals who are "undifferentiated" or who have poorly defined identities, on the other hand, are likely to move along diverse career paths because they have "incorporated diffuse personal characteristics, or because no clear patterning of characteristics has developed" (Holland & Gottfredson, 1976, p. 21). In fact, in one study it was found that the largest difference between vocationally decided and undecided high school and college students was in the degree of identity differentiation (Holland & Holland, 1977).

The implications of Holland's (1985) theory for multipotentiality are numerous. In his work Holland uses interest inventory profiles to determine the degree of differentiation of identity. Holland's description of an undifferentiated, inconsistent person who lacks identity is similar to the multipotentialed individual. When an undifferentiated profile is elevated on several subscales, indicating a variety of strong interests, a parallel exists with the gifted. Swanson and Hansen (1986) distinguished between two types of flat profiles: high-score undifferentiated (HSU) and low-score undifferentiated (LSU). Whereas the LSU group demonstrated weak interests, the HSU group had a variety of strong interests. The high-flat group was also found to

have a higher grade point average (GPA) and Academic Comfort score on the Strong Interest Inventory (Hansen & Campbell, 1985) than the low-flat group, indicating ability as well as broad interests. It seems that a good way to identify multipotentialed individuals is to look for those with HSU interest-inventory profiles. Thus, the same interest inventories that are used to implement Holland's theory could arguably be used to operationalize multipotentiality.

The concept of *diversity* seems to be very closely related to Holland's (1985) concept of differentiation. Diversity can refer to a large number of interests or to interests that, although not necessarily numerous, are unrelated (Gaeddert & Hansen, 1993). Thus, Holland's differentiated individual would be characterized by low diversity of interests, and the undifferentiated individual would be characterized by high diversity of interests. This provides an additional means of conceiving differentiation. Interests alone may be problematic regarding the definition of multipotentiality (Rysiew et al., 1994), but Holland's (1985) notion of a personality fit to favorable environments subsumes more than mere preferences. Some preferences develop into interests supported by increasing competencies. Gaeddert and Hansen (1993) developed a measure of diversity built around the General Occupational Theme (GOT) of the Strong Interest Inventory (Hansen & Campbell, 1985). Because Holland's theory links interests and abilities, the Gaeddert and Hansen measure of diversity may be worthy of exploration as an index of multipotentiality. This index was found to be the best predictor of diversity of interests (next to self-rating) when compared with six other measures of diversity (Gaeddert & Hansen, 1993). GOT scores rate interests as *very high*, *high*, *moderately high*, *average*, *moderately low*, *low*, and *very low*. By definition, high diversity individuals have four to six GOT scores in the moderately high to very high range, and lower diversity individuals have only one of six GOT scores in this range. This measure of diversity seems to be a valid measure of differentiation (or, more precisely, undifferentiation in this case) as well as of multipotentiality.

INTERVENTIONS TO AID THE MULTIPOTENIALED

The myth that the future of gifted students is assured or that they do not need any sort of career counseling has largely been put to rest (Berger, 1989; Shore et al., 1991). Yet, although many practitioners and theorists consider career education for the gifted to be a top priority, they also feel that this need is not being satisfactorily met. Consequently, too many multipotentialed students make misinformed, misguided, or just plain wrong career choices (Herr, 1976; Kerr, 1991; Milgram, 1991). Helping multipotentialed and gifted students to reconcile their diverse interests and abilities and exploit their talents could alleviate much existential struggling and would provide society with more well-functioning, contributing members of the highest caliber. Although further research in this area is needed to better understand the problem and its solution, many suggestions that exist can be used or modified to help multipotentialed individuals facing career-planning decisions.

GENERAL RECOMMENDATIONS AND CONSIDERATIONS

Career education and guidance should begin as early as elementary school for all students (for suggested age-related interventions, see Kerr, 1991, pp. 92–93). It can then continue as an ongoing process influenced by important elements in the young person's environment, for example, family, school, and community (Darden, Gazda, & Ginter, 1996; Delisle & Squires, 1989). For the multipotentialed, this guidance must be specially tailored, and multipotentiality must be recognized as the "mixed blessing" that it can sometimes be (Delisle, 1982). It has been found that the gifted rate career education as the most positive part of their school experience (Colson, 1980), and one study found a trend for the gifted to prefer structured rather than unstructured counseling (Kerr, 1991). Guidance should be used early in life to help these students recognize their capabilities and clarify their interests, as well as to expose them to the range of possibilities that exists for them (Silverman, 1993).

Rather than early career choice, the goal of career guidance should be identification of a general field of interest through career exploration and understanding the career decision-making process and anxieties that arise (Kerr, 1991; Marshall, 1981; Terman & Oden, 1954). Discussion of the potential for external and internal clashes when selecting one career from many possibilities is a useful preventative measure (Delisle, 1982). Career exploration has been found to increase congruence, therefore vocational satisfaction would be expected to increase as well (Grotevant, Cooper, & Kramer, 1986).

There are many sources of career information available that can easily be adapted for use with multipotentialed individuals. Career information can be acquired through direct, hands-on experiential learning, for example, interviews with successful multipotentialed adults; experiences "shadowing" an adult worker; participating in jobs, internships, or volunteer positions; and visiting university classes and speaking to professors (Herr & Watanabe, 1979; Kerr, 1981b, 1991; Kerr & Ghrist-Priebe, 1988; Milgram, 1991; Mitchell, Levin, & Krumboltz, 1999; Silverman, 1993). Kerr and Ghrist-Priebe (1988) set up a 1-day guidance laboratory for gifted high school seniors designed to provide them with some of the learning experiences described above. Students completed interest and value inventories, visited a university campus and attended the class of their choice, had an individual counseling session in which the tests were interpreted, goals were set, and continued decision making was emphasized. They also participated in a counselor-led group life-planning session in which future lifestyles, barriers, and ways to reach goals were discussed. This intervention was found to be extremely successful, and a full 100% of the students who participated reported that the day was helpful for them. It is important that exploration experiences be structured and time limited and that students be

encouraged to apply their knowledge gained from these experiences to making career decisions (Emmett & Minor, 1993; Marshall, 1981; Miller, 1981).

A counseling process that supports the notion of multipotentiality will help gifted students anticipate change in their careers (Fredrickson, 1979). Students need to be informed of the possibility of "late blooming" and to understand that career decisions are not irreversible (Mitchell et al., 1999; Silverman, 1993). Multipotentialed students "need assurance that their multipotentiality is an asset rather than a liability and reassurance that lack of early specialization does not mark them as washouts for life" (Silverman, 1993, p. 220).

Helping gifted youth to view career decision making as an ongoing process rather than a one-time choice is an important aspect of career counseling (Emmett & Minor, 1993; Herr, 1976; Mitchell et al., 1999). Summaries of interviews with successful multipotentialed individuals indicated that they kept their options open and combined their different interests into careers that provide opportunities for constant learning and satisfaction (Sosniak, 1985). Under these conditions, some of the struggle concerning career choices can be lessened, and individuals will be able to control their own career plans and direction.

Career decisions are based on knowledge of oneself and knowledge of careers. In the career-guidance field, the traditionally used sources of self-knowledge are interests and abilities. However, attention to interests and abilities alone is often insufficient ground on which the multipotentialed individual can base career choice. Unfortunately, for the multipotentialed, interests and abilities are numerous, and most interest and aptitude tests lack the sensitivity required to provide useful career profiles (Freeman, 1991; Kerr, 1981b). This lack of sensitivity gives rise to the high-flat vocational interest inventory profile found by Holland (1985). Anecdotal evidence supports such a profile. For example, one multipotentialed girl described her test results as follows, "I got a computer printout, which was supposed to select the ideal job. It said 'Cut off after 80, 127 remaining.' I was supposed to select four. But there wasn't much point when I was suitable in attitude and qualifications for all of them" (Freeman, 1991, p. 146). In a comprehensive literature search, we could only locate two published empirical studies, Fox (1978) and French (1958), in which the interest inventory profiles of gifted and nongifted students were compared. As predicted, both studies found gifted students' profiles to be relatively high and flat. Frederickson's (1979) caution—that although this profile is widely acknowledged in career counseling, research on it has been lacking—is still an accurate claim.

SPECIFIC RECOMMENDATIONS AND CONSIDERATIONS

A number of specific interventions seem to be especially relevant for working with these multipotentialed individuals. Examples discussed next are serial or concurrent career paths, relating leisure activities to career choice, value-based interventions, peer-support groups, and adult role models.

Self-exploration beyond one's interests and abilities is required for multipotentialed individuals. Because career choice is also a lifestyle choice for these individuals, personal and humanitarian relevancy are often driving forces behind their selection (Perrone & Van Den Heuvel, 1981; Phelps, 1991). Results from interviews and self-image questionnaires given to gifted Grade-12 students revealed that these students sought lifelong careers that allowed for creativity and self-expression (Leroux, 1986). There is evidence to suggest that the multipotentialed must consider vocations that are sufficiently open-ended to allow for extensive growth, and they must feel that they are able to move beyond the confines of the channel or channels marked for them by societal expectations (Davis & Rimm, 1989; Simpson & Kaufmann, 1981). Silverman (1993) presented the notion of serial or concurrent careers for the multipotentialed individual because, as Fredrickson (1979) has suggested, the multipotentialed have a greater capacity for adaptability; therefore, changing careers is both conceivable and permissible. Multipotentialed students can also be helped to think about the concept of "career" in broader terms than a single, lifelong occupation that fully meets all their personal needs. It should be emphasized that career strategy and one's strategy for creative growth need not be identical. A job may complement a lifestyle path. Furthermore, one's "calling" or vocation need not be one's livelihood (Silverman, 1993; Willings, 1983), while true pleasure is derived from interests pursued outside the workplace (Ehrlich, 1982).

Leisure activities very often play a large role in the life of a multipotentialed individual, and such activities should be considered. Because the multipotentialed are unlikely to find occupations that use all of their talents (Fredrickson, 1986; Kerr, 1991; Tyler, 1958), leisure activities can help to supplement careers and provide for expression of a variety of interests (Herr & Watanabe, 1979; Pask-McCartney & Salomone, 1988; Roper & Berry, 1986). These activities can be a forum in which interests are explored and prioritized (Milgram, 1991): Leisure activities pursued by adolescents have been found to be valid predictors of adult occupational choice (Milgram & Hong, 1993). Therefore, links between particularly fulfilling leisure activities and possible careers should be sought (Davis & Rimm, 1989; Simpson & Kaufmann, 1981), and it should be suggested that career choice be personalized "based on a composite of [the individual's] talents" (Roper & Berry, 1986, p. 52).

Values-based intervention also seems to be effective with multipotentialed students. Kerr and Erb (1991) studied the effects of a values-based intervention on the identity and development of purpose in 41 university honors students who had requested career counseling. The participants were told that the focus of such counseling was to help the multipotentialed make career decisions based on values. Social influence techniques were used to emphasize the importance of values, and several values-based interventions were administered and interpreted. Significant differences in pre- and posttest scores on the Identity-Confidence

and Development of Purpose-Vocational subscales of the Student Development Inventory (Hood, 1986) were found in the expected direction. Half of the students changed their majors, and although there was no change in the measured certainty of major, there was an increase in the measured certainty of occupation.

Support and guidance from peers helps multipotentialed individuals realize that they are not alone with their uncertainty and worries (Perrone & Male, 1981; Perrone & Van Den Heuvel, 1981). Simpson and Kaufmann (1981) suggested that the nonjudgmental, open-ended environment provided by peer-support groups can help the multipotentialed to explore various career options and provide a forum in which ways of overcoming career indecision can be shared. Kerr (1986) has found that same-sex groups are preferred by both sexes.

In some cases, the multipotentialed lack adult role models who can help them to envision future possibilities (Gowan, 1960; Marshall, 1981). In a review of the literature on mentorship, Edlind and Haensly (1985) found multiple benefits, and many successful gifted adults cite mentors as highly valuable to their development (e.g., see Bloom, 1985; Casey & Shore, in press). As well as providing exposure to various career fields, mentors can help younger students see how career and lifestyle can be combined and satisfaction achieved.

It is important to remember that decision making can always be delayed until more evidence swings the balance in favor of a particular career.

> When gifted students find it difficult to determine which path to follow, it is wise to allow them extra time in which to make their career choices and to give them a broad enough educational base so that later they can move in several different directions. (Silverman, 1993, p. 223)

Of course a balance must be maintained between premature decision making and chronic career indecision.

It should also be noted that additional recommendations for the multipotentialed client are found in the *User's Guide for the Strong Interest Inventory* (Hansen, 1992). For example, it is recommended that they maintain a variety of leisure activities, make friends who have a variety of interests, seek employment with those who have diverse interests, or change occupations periodically. Those who have opposing fields of interest are also advised to select one group of interests to be satisfied in an occupation and another group of interests to be satisfied avocationally, perform one type of activity in the opposing environment, or mold one's job to combine the various interests.

Recommended interventions therefore range from early career education in school but not imposing pressure for early career choice, facilitating contacts with other multipotentialed youth and adults as peers, role models, and mentors, and validating the prospects of late blooming and career decision making as an on-going rather than once-only process. Students or clients can consider parallel or sequential multiple careers and channeling some of their abilities and interests into hobby activities.

CHALLENGES TO THE CONCEPT OF MULTIPOTENTIALITY

There is a shortage of independent empirical research in support of the concept of multipotentiality, partly because multipotentiality is strongly rooted in but one conceptualization of giftedness, namely the equation of giftedness with high intellectual ability and potential or realized school performance. Conceptually, the roles of ability and interests are difficult to separate, partly because the realization of the potential inherent in any ability depends heavily on motivation, of which interest is in turn a part. In addition, one of the most highly developed conceptualizations of interests (Holland's) depends in part on elements of ability, motivation, and opportunity. On the positive side, the anecdotal and clinical reports of counselors and psychologists who work closely with highly able adolescents and young adults continues to support the existence of a characteristic such as multipotentiality with both ability and interest dimensions. The ability component is mostly explored in the literature on giftedness and gifted education, especially that part of the literature based on a definition of giftedness tied to IQ and achievement. The interest component is more thoroughly explored in the literature on vocational decision making. There are contrasting views of the contributions of ability and interest and the shape of their profiles, but one always seems to be at least partly defined in terms of the other.

It would be interesting to receive reports of future research that, for example, use stepwise regression techniques to investigate the relative contributions of independent measures of ability and interest to outcomes believed to be tied to multipotentiality, and to have more systematic, detailed clinical case reports. Other needed research includes studying the idea of multipotentiality under other conceptualizations of giftedness. In both cases there is a need for longitudinal rather than cross-sectional studies. Multipotentiality is an attractive idea under challenge. Before its future fate is decided, it deserves the best possible defense, both conceptually and empirically. We hope this article has set out some of the key issues on which its future importance may depend.

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The Role of Perceived Barriers in Career Development: A Social Cognitive Perspective

Katrice A. Albert and Darrell Anthony Luzzo

Recent research has verified the claim that high school and college students perceive a variety of career-related barriers. Lent, Brown, and Hackett's (1994, 1996) social cognitive career theory and Weiner's (1979, 1985, 1986) attribution theory are useful approaches to increase understanding of the role that perceived barriers play in career development. This article presents a brief overview of the primary components of each theory as they relate to career-related barriers, discusses counseling implications associated with each approach, and provides ideas for future research to explore the utility of these theories in explaining career-related barriers.

Over the past several years, many career development researchers have systematically examined the role that perceived barriers play in the career decision-making process. Results of recent studies have consistently revealed that high school and college students perceive a substantial number of barriers to career goal attainment (Luzzo, 1993, 1995; McWhirter, 1997; McWhirter & Luzzo, 1996; Swanson & Daniels, 1994; Swanson, Daniels, & Tokar, 1996; Swanson & Tokar, 1991a, 1991b). Much of the recent focus on the role of barriers in career decision making has been on perceived barriers. The use of the word *perceived* to refer to such barriers implies that the career-related barriers an individual believes currently exist or may be encountered in the future are not necessarily grounded in reality or based on factual information. Yet even those barriers with no basis in reality can, and often do, have a direct impact on the career decision-making process of an individual.

Lent, Brown, and Hackett's (1994, 1996) social cognitive career theory (SCCT) and Weiner's (1979, 1985, 1986) attribution theory seem to provide especially useful theoretical frameworks for increasing our understanding of the role that perceived barriers play in career development. Although both theories have been suggested as potentially useful frameworks for examining career-related attitudes and behaviors (Brown & Lent, 1996; Luzzo, Funk, & Strang, 1996; Luzzo, James, & Luna, 1996; McWhirter, 1997; McWhirter & Luzzo, 1996; Swanson et al., 1996), there have been relatively few evaluations of each theory's contributions to describing the particular role that barriers play in career development (e.g., Brown & Lent, 1996; Hackett & Byars, 1996; McWhirter & Luzzo, 1996; Swanson, 1996). The purpose of this article is to examine these two theoretical approaches and identify theoretically based strategies for integrating perceived barriers into the career counseling process.

SOCIAL COGNITIVE CAREER THEORY

Theoretical Overview

Lent et al.'s (1994, 1996) social cognitive career theory (SCCT), which is grounded in Bandura's (1986, 1997) general social cognitive theory, emphasizes the importance of personal agency in the career decision-making process and attempts to explain the manner in which both internal and external factors serve to enhance or constrain that agency. Consistent with Bandura's theory, SCCT recognizes the mutual interacting influences between people, their behavior, and their environment. Bandura termed this interaction *triadic reciprocality,* in which personal attributes, such as internal cognitive and affective states, physical attributes, external environmental factors, and overt behaviors or actions, all operate as interlocking mechanisms that affect one another bidirectionally (i.e., a causative agent also is affected in the process).

SCCT takes on a similar objective in that it attempts to explain the development of career and academic interests, the career choice process, and performance outcomes (Chartrand, 1996). Moreover, Lent et al. (1994, 1996) claimed that career interests directly influence career choice goals (e.g., career aspirations), which increase the likelihood of certain career choice actions (e.g., declaring an academic major). With this triadic causal system, SCCT functions in a framework that emphasizes three social cognitive mechanisms that seem particularly relevant to career deci-

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sion making and career development: *self-efficacy*, *outcome expectations*, and *goal setting*.

Self-efficacy is defined as "people's judgement about their capabilities to organize and execute courses of action required to attain designated types of performances" (Bandura, 1986, p. 391). Self-efficacy, which seems to be the most central defining element of personal agency, derives from four principle sources of information: performance accomplishments, vicarious learning, verbal persuasion, and physiological arousal. These sources of information help to create a dynamic set of self-beliefs that are specific to particular performance domains and that interact with other people, behavior, environment, and contextual factors.

Outcome expectations represent another important component of SCCT. Outcome expectations are personal beliefs about the probable outcome of a behavior. They involve the imagined consequences of performing a certain behavior. Thus, outcome expectations play a major role in motivating certain behaviors. These expectations can be viewed on many levels including physical, social, and self-evaluative, and they include several types of beliefs about those outcomes, such as beliefs about extrinsic reinforcement, self-directed consequences, and outcomes derived from the process of performing a given behavior. In essence, outcome expectations involve a person's imagined consequences of performing a certain behavior.

A third central component to SCCT is that of goals and the roles that they play in the self-regulation of behavior (Lent et al., 1994, 1996). Goals may be defined as the determination to engage in a particular behavior or activity or to effect a particular future outcome. By setting goals, individuals help to organize and guide their behavior. Moreover, when these individuals are able to exercise forethought (i.e., set goals), they are able to self-regulate themselves—even in the absences of external reinforcements—and simultaneously increase the likelihood that their desired outcome will be attained. Goals seem to be a critical aspect through which individuals are able to exercise their personal agency (Bandura, 1997).

SCCT suggests that there is a complex interplay among self-efficacy, outcome expectations, and goal setting. These aspects work together to help individuals exercise personal agency and become self-directed, especially with their career decision making and career development (Lent et al., 1994, 1996).

The Role of Perceived Barriers

The interplay among the three major components of SCCT (self-efficacy, outcome expectations, and goal setting) do not occur inside a vacuum, nor do they function alone in shaping interests and various vocational outcomes. Social cognitive and contextual factors are hypothesized to directly influence the development of career interests, plans, and actions. Lent et al. (1994, 1996) argued that the particular effect that contextual factors have on individuals' career choices often depends on their personal appraisal of and response to such factors.

Lent et al. (1994, 1996) conceptualized contextual factors as responsible for shaping the experiences that lead to the development of career interests and choices. Basic tenets of SCCT suggest that these contextual factors (e.g., perceived barriers) constitute the perceived opportunity structure within which career plans are developed and implemented. Even if individuals possess high levels of career self-efficacy, high outcome expectations, and interests that are congruent with those expectations, they may still avoid selecting a particular career if they perceive insurmountable barriers to career entry or career goal attainment (Brown & Lent, 1996). In their recent discussion of SCCT, Brown and Lent posited that perceived career-related barriers primarily inhibit the translation of interests into choice goals and goals into actions: "[E]ven persons with well-developed and differentiated interests in a particular career path will be unlikely to pursue that path if they perceive (accurately or inaccurately) substantial barriers to entering or advancing in that career" (Brown & Lent, 1996, pp. 355–356).

In addition, some people are not granted the opportunity to make career choices under optimal conditions. Economic needs, educational limitations, lack of familial support, or various other considerations (e.g., gender and ethnic discrimination) may inhibit the pursuit of primary interests or preferred career goals. For example, someone from an ethnic minority group may realize that there are few representatives in a certain career field from their ethnic group. Perceived barriers or impediments may arise in this individual due to their conceptual processes of differential opportunities for skill development, self-beliefs, standards, and outcome expectations that may become internalized. Thus, this individual may prematurely foreclose on this potentially rewarding career because their environment has offered a limited amount of efficacy building opportunities or because a lack of ethnic minority representation in that career has led to an inaccurate set of self-efficacy beliefs or occupational outcome expectations. The result of these beliefs and expectations can make any given career option seem out of reach or unattainable.

Another way that SCCT may be particularly relevant to the perception of career-related barriers is in its explanation of the importance of coping efficacy. Coping efficacy refers to the degree to which individuals possess confidence in their ability to cope with or manage complex and difficult situations (Bandura, 1997). As Bandura noted, perceived barriers or obstacles that might otherwise prevent certain successes or accomplishments related to a specific task may not be as detrimental to those who exhibit high levels of coping efficacy. In other words, people who possess relatively high levels of coping efficacy are more likely than those with low coping efficacy to engage in efforts to overcome perceived barriers associated with a particular goal or objective. As Hackett and Byars (1996) recently explained, "strong efficacy for coping with obstacles and barriers can result in successful performance despite expectations of barriers and impediments such as racism and discrimination" (p. 329).

WEINER'S ATTRIBUTION THEORY

Theoretical Overview

The general attributional approach to motivation developed by Weiner (1979, 1985, 1986) asserts that the causal beliefs people hold about their successes and failures have important consequences for their feelings, expectancies, and behavior. Weiner's theory incorporates the antecedents of attributions, causal dimensions, and affective and cognitive consequences of different types of attributions. Weiner's model has been referred to as "more complete than other attributional conceptions, and . . . the framework of choice for most educational psychology researchers" (Graham, 1991, p. 6).

According to Weiner's (1979, 1985, 1986) attribution theory, people are likely to explain outcomes and events in their lives that are perceived as novel or important. The causal attributions (i.e., explanations) that result from the causal search process are hypothesized to directly influence subsequent cognitions and emotions, and the precise properties of an attribution are hypothesized to have an impact on individuals' motivation and behavior associated with future events (Perry, Hechter, Menec, & Weinberg, 1993).

Weiner (1986) has proposed a three-dimension taxonomy for classifying all attributions.

> The locus of causality dimension defines the location of a cause as internal or external to the individual. Among the dominant causes, ability (aptitude) and effort are internal because they reflect characteristics of the person. Task difficulty and luck, on the other hand, are external or environmental determinants of outcomes. The stability dimension designates causes as constant or varying over time. Ability is stable in that one's aptitude for a task is relatively fixed, whereas effort and mood are unstable because individuals may vary from one situation to the next in how hard they try and in how they feel. Finally, controllability refers to personal responsibility or whether a cause is subject to one's own volitional influence. Effort is controllable because individuals are believed to be responsible for how hard they try. In contrast, aptitude and luck are generally perceived to be beyond personal control. (Graham, 1991, p. 7)

According to Weiner (1986), all attributions are classifiable within one of the eight cells of a Locus × Stability × Controllability dimensional matrix.

Despite the utility of SCCT and other social cognitive and cognitive information processing theories applied to career development (e.g., Krumboltz, 1996; Mitchell & Krumboltz, 1996; Peterson, Sampson, Reardon, & Lenz, 1996), previously forwarded models have not fully integrated the role of career-related attributions and general attributional style into their explanation of the career exploration and planning process. Furthermore, although research has revealed support for the application of Weiner's (1979, 1985, 1986) attribution theory to the field of career development (Healy, 1991; Luzzo, Funk, et al., 1996; Luzzo, James, et al., 1996), we are aware of no discussion to date regarding the application of Weiner's (1979, 1985, 1986) theory to an understanding of the role that perceived barriers play in career decision making.

Role of Perceived Barriers

According to Weiner's (1979, 1985, 1986) theoretical propositions, an individual who believes that career-related barriers are caused by external, uncontrollable, and stable factors is likely to attribute career-related barriers to such factors as fate or misfortune. As a result, such people are unlikely to expend time and energy addressing career-related barriers. Instead, they are more apt to consider perceived barriers as permanent obstacles to career success and satisfaction rather than engage in activities targeted at overcoming the barriers. On the other hand, people who attribute career-related barriers to internal, controllable, and unstable causes (an effort attribution) are likely to consider strategies aimed at coping with and overcoming perceived barriers as useful ways to increase opportunities for career success and satisfaction. On the basis of these assumptions, it can be argued that attributing career-related barriers to uncontrollable, external, and stable factors (i.e., exhibiting a pessimistic attributional style associated with perceived barriers in career decision making) may serve as an obstacle to effective career development (Luzzo & Jenkins-Smith, 1998; Luzzo & Tompkins-Bjorkman, 1999; Nauta & Epperson, 1995).

Research has consistently revealed, over time, significant career decision-making benefits associated with a belief that career decisions are internally caused and controllable (Bernardelli, De Stefano, & Dumont, 1983; Blustein, 1987; Fuqua, Blum, & Hartman, 1988; Luzzo & Ward, 1995; Taylor, 1982; Trice, Haire, & Elliott, 1989; Wu, 1991). Results of investigations with college students have shown that students who exhibit an internal career locus of control (contrasted with students with an external career locus of control) are more likely to be employed in occupations that are congruent with career aspirations (Luzzo & Ward, 1995), to exhibit high levels of career maturity (Bernardelli et al., 1983; Wu, 1991), to engage in career exploration activities (Trice et al., 1989), and to be career decided (Fuqua et al., 1988). As Taylor (1982) summarized, individuals who believe that career decisions are internally caused and under their own control "may take both an active role in the direction of their educational/vocational futures and personal responsibility for decision making and for gathering the kinds of information necessary to such decisions" (p. 319). It stands to reason, then, that by helping students develop attributions for making career decisions that reflect a strong sense of control over and responsibility for making career decisions, positive changes in career beliefs, attitudes, and behaviors may result.

IMPLICATIONS FOR COUNSELING PRACTICE

According to the theoretical arguments provided by Lent et al.'s (1994, 1996) SCCT and Weiner's (1979, 1985, 1986) attribution theory, it may seem as if increasing clients' self-efficacy for overcoming perceived barriers (i.e., coping efficacy) and helping clients to adopt more of an optimistic attributional style toward career-related barriers are *always* appropriate activities in which to engage. It is important to note, however, that not all barriers a person perceives can, in

fact, be overcome. Counselors need to help clients distinguish between barriers for which personal control and responsibility are appropriate and barriers that the individual may not have the capacity to overcome. In essence, counselors need to gather as much information as they can relevant to a client's particular ability to overcome perceived barriers, rather than to assume that barriers that can be overcome by some clients can necessarily be overcome by others. Using self-efficacy enhancing procedures with clients who lack the skills and abilities necessary to successfully cope with certain barriers to career development could be problematic and even unethical (Luzzo, Funk, et al., 1996). Such clients should first engage in activities designed to enhance skills and abilities related to particular barriers. Once the requisite skills are mastered, self-efficacy-enhancing strategies could then be used.

Furthermore, even if an individual possesses the skills necessary for successfully overcoming a perceived barrier and has a relatively high level of coping efficacy, beliefs about the negative consequences associated with implementing a career choice or vocational decision must be considered. For example, suppose a gay man interested in pursuing a teaching career cited poor study habits as a barrier to completing a teacher training program. After successfully completing a study skills course, it is possible that the individual may correct his previous weaknesses regarding study habits and begin to realize an increase in self-efficacy toward a career in teaching. Nevertheless, the individual might avoid entering a teacher training program because of his expectations that the consequences of such a choice would result in discrimination on the job due to his sexual orientation. In situations such as this, the cultural and sociopolitical climate may be the primary source inhibiting the client's further exploration of a particular career choice. Career self-efficacy or attributional style may have very little to do with the career decision. Political activism and systematic efforts on the part of counselors to alter such cultural and structural barriers might prove more efficacious in some ways than specific counseling interventions designed for use with individual clients.

Counselors cannot assume that all barriers are the same for everyone and that high levels of career self-efficacy and positive attributions for career decision making are sufficient for addressing all perceived barriers. Self-efficacy enhancing interventions and attributional retraining strategies are most appropriate when a client possesses the skills and abilities to overcome certain barriers but is kept from doing so mainly because of low self-efficacy or a pessimistic attributional style for career decision making. It is essential that counselors consider the structural, cultural, and sociopolitical barriers that also play a role in the career decision-making process.

When working with clients to increase their coping efficacy and to assist them in adopting a more optimistic attributional style toward career decisions, counselors should invite clients to consider all potential barriers to career pursuits. Such a process might begin with a counselor encouraging the client to identify all of the barriers that the client perceives as obstacles to successfully pursuing a particular career goal or exploring a general career direction. It is important to note in this regard that the use of perceived barriers measures that require clients to respond to a predetermined list of potential obstacles to career success (Swanson & Tokar, 1991a, 1991b; McWhirter, 1997) tends to produce more comprehensive lists of barriers than free thought-listing techniques. Such observations suggest that providing clients with a list of commonly cited barriers and asking them to determine which barriers they perceive as relevant to their personal career development would be a useful strategy. Allowing clients to cite any additional barriers relevant to their personal situation could then follow.

After perceived barriers have been identified, a counselor might ascertain—either by clinical interview or by administering an appropriate measure—the degree to which the client believes that each barrier is caused by internal or external factors (locus of causality), is controllable or uncontrollable (controllability), and is likely to persist over time (stability). Determining the client's attributions for the perceived barriers provides the counselor with useful information. If a client views certain perceived barriers as caused by external factors, as uncontrollable, or as stable, then further examination of those barriers would be warranted.

Suppose, for example, that a client believes that one of the most likely barriers to her pursuit of a career as an electrical engineer is poor mathematics skills. An attributional analysis of this perceived barrier might reveal that the client believes that her poor mathematics skills are the result of internal, uncontrollable, and stable factors. She might claim something like the following:

> No matter how hard I have tried over the years, I just can't ever perform at an acceptable level in math. I know it must be something inside of me . . . maybe something wrong with the way my brain is wired or something. No matter what I try to do, I just can't seem to get over my "math problem." I guess I'm just always going to have problems with math. There's really nothing I can do to change that.

A client who presents this type of attributional analysis might benefit from additional discussion and clarification of the barrier from an attributional perspective. With her presenting perspective, attributional theory suggests that the client will be unlikely to exhibit effort in the future to overcome the perceived barrier. Her attributions toward poor mathematics performance are more likely to develop into a type of learned helplessness toward mathematics rather than encourage behavior aimed at overcoming the barrier. In addition, the client's perception may not even be accurate. It is possible, for instance, that the client's mathematics skills are actually above average, yet (for any number of reasons) the client may perceive that her mathematics skills are well below the standard for electrical engineering students. A discussion of barriers in the context of career counseling can provide clarification between real and perceived barriers and provide clients with valuable information about their vocational self-concept.

Individuals who perceive substantial barriers and maintain a pessimistic attributional style regarding such barriers might benefit directly from attributional retraining proce-

dures. In other words, clients who believe that they lack any significant control over their barriers, that most occupational or career-related barriers are caused by external factors, and that "it will always be that way" (a stable attribution) might benefit from a deeper analysis of this perspective. Attributional retraining might be used with such clients in the hope of assisting their development of a more optimistic attributional style for perceived barriers. Attempts to alter maladaptive attributions for career decision making might include using videotaped interventions, peer group counseling, and counselor analysis of diaries or journals in which clients write down their attributions for important career-related events. These attributional retraining techniques could be used to help clients gain an increased sense of control over and responsibility for career-related barriers that they could successfully manage or overcome with increased effort or training.

Additional ways that counselors can work with clients from a social cognitive perspective to address perceived career-related barriers include using strategies specifically designed to increase coping efficacy (i.e., clients' confidence in their ability to overcome perceived career-related barriers). Self-efficacy theory posits four primary mechanisms by which coping efficacy could be increased: performance accomplishments, vicarious learning, verbal persuasion, and physiological arousal. In the area of performance accomplishments, for example, counselors might review a client's list of previously encountered career-related barriers. Reviews of such lists could focus on celebrating clients' successful experiences in overcoming previously encountered barriers. Counselors could also encourage clients to keep a journal of barriers they might encounter in the future and help clients recognize the variety of resources available to them for successfully managing and overcoming such barriers.

Vicarious learning and verbal persuasion can also be implemented into career counseling interventions. For instance, counselors could recommend that clients establish mentoring relationships with successful professionals in specific work environments as a means of learning about and accessing successful strategies for managing barriers. When possible, counselors might even consider creating a database of mentors in a various career fields who could serve as potential models for clients who perceive substantial barriers to their success in particular vocational domains. Such models would serve not only as vicarious examples for clients regarding ways that barriers can be successfully addressed but also as sources of verbal persuasion and encouragement toward the elimination or successful management of perceived career-related barriers.

According to Bandura's (1986, 1997) self-efficacy theory, clients' coping efficacy related to the perception of career-related barriers can also be bolstered when counselors help clients to decrease their anxiety related to the career decision-making process. Anxiety reduction and management strategies (e.g., systematic desensitization) borrowed from other cognitive models of therapy can be especially useful in this regard. Helping clients demystify the process of career decision making through structured workshops and individual counseling may be equally useful in decreasing the anxiety often associated with making vocational choices.

FUTURE RESEARCH NEEDS

Fully realizing the utility of Lent et al.'s (1994, 1996) SCCT and Weiner's (1979, 1986) attribution theory in increasing the professional counselor's understanding of the role of perceived barriers in career development requires additional research. To begin with, most previous studies in this area have focused almost exclusively on differences in perceived barriers among high school and college students on the basis of such demographic characteristics as sex and ethnicity. Future research might extend the application of SCCT and attribution theory to an understanding of other personal characteristics that may potentially distinguish the number and types of career-related barriers perceived by persons. Evaluating differences in perceived barriers on the basis of age, social class, level of education completed, cultural worldview, sexual orientation, and disability status would help to clarify the role that perceptions play in career exploration and planning. Research designed to evaluate the interactions between gender, ethnic, and cultural identity development and the perception of career-related barriers would be especially useful.

An examination of perceived barriers among younger and older populations is sorely needed. Research investigations to date have focused almost exclusively on perceived barrier differences among high school and college students, thereby limiting our understanding of the role that perceived barriers play in the career development of younger and older populations. Longitudinal research would be especially enlightening in this area. Examining perceived career-related barriers across the life span might reveal changes in perceptions that occur throughout the developmental process of career decision making or, on the other hand, might reveal that perceptions of barriers remain relatively stable over time.

In reference to SCCT, there is a clear need for continued evaluation of coping efficacy and its relationship with affective, cognitive, and behavioral components of career development. It is likely that individuals' confidence in their ability to overcome perceived barriers may have a direct influence on whether barriers are perceived as insurmountable obstacles or motivating challenges. Research is needed in particular to determine the mediating role of coping efficacy in the translation of vocational interests into career goals and actions. Results of such investigations could be instrumental in developing effective strategies for integrating perceived barriers into the career exploration and planning process.

Regarding attribution theory, investigations to date have been limited to evaluating the effectiveness of attributional retraining techniques as methods for increasing college students' career decision-making self-efficacy and sense of control over and responsibility for career decisions (Luzzo, Funk, et al., 1996; Luzzo, James, et al., 1996). Studies evaluating the efficacy of attributional retraining for younger and older populations are warranted. Researchers interested in furthering the application of attribution theory to an un-

derstanding of perceived barriers in career development also might consider examining the relationships between the three components of attributional style (controllability, locus of causality, and stability) and the numbers and types of barriers clients perceive. Furthermore, it will be important to determine the degree to which changes in clients' attributional styles for career decision making are accompanied by subsequent changes in perceived barriers. It is plausible, for instance, that as clients increase their sense of control over and responsibility for career decisions, barriers once considered insurmountable may begin to be viewed as minor challenges or perhaps may no longer be considered as barriers at all.

Finally, with the recent development and validation of psychometrically sound measures of perceived barriers in career development (McWhirter, 1997; Swanson et al., 1996; Swanson & Tokar, 1991b), researchers can embark on a comprehensive analysis of the influence of perceived barriers in career exploration and planning. Similarly, counselors can consider using these measures in combination with clinical interviews as they work with clients to evaluate the role that perceived barriers play in the broader context of career decision making.

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Caregiving in Attachment Relationships: A Perspective for Counselors

M. Carole Pistole

This article examines how caregiving, an aspect of attachment theory, can be applied in counseling. Discussion begins with an overview of attachment theory, then focuses on the counselor's position as caregiver, adult relationship issues, and termination of counseling.

Attachment theory (Bowlby, 1988) addresses the bonding and strong emotional reactions associated with connecting and disconnecting with others throughout the life span as well as the purposes of connection, both people's positions and behavior in the relationship, and the consequences of disruptions in the bonding. To date, the theory has been applied to a variety of core relationships, including the child–parent (see Hazan & Shaver, 1994a, 1994b), adult–adult love (Pistole, 1994, 1995a), adult child–older parent (Krause & Haverkamp, 1996), professor–student (Lopez, 1997), and counselor–client (Pistole & Watkins, 1995). Attachment theory has demonstrated the power to cut across various types of relationships in theoretically consistent ways, contribute to practical understanding about how relationships work, and generate a strong tradition of research.

Attachment theory seems particularly relevant to counselors' work because of the central position that interpersonal relating occupies in counseling. Emotionally important human relationships embody the meaning of people's lives (Marris, 1982), and research indicates that addressing core interpersonal relations in counseling can be beneficial for clients (Orlinsky, Grawe, & Parks, 1994; Rogers, 1951; Strupp & Binder, 1984). Counseling itself "is anchored in, and fundamentally inseparable from, a *human relationship*" (Strupp, 1997, p. 92). More important, clinical and databased studies (Goldfried & Padawer, 1982; M. Horowitz et al., 1984; Strupp, 1996) suggest that the "human relationship is the primary component interwoven explicitly or implicitly through all counseling" (Kelly, 1997, p. 342).

In recent years, attachment theory has been applied to clients' relationship issues and to the counseling relationship (Bowlby, 1988; Pistole, 1997; Pistole & Watkins, 1995). In particular, conceptualization has centered on changing clients' attachment organization so that current relationships proceed with less distortion and enhanced competence. In addition, these writers have suggested that the counseling relationship can be characterized as a caregiving-attachment bond. There has been, however, little discussion of how caregiving can be used in counselors' conceptualizing, and the notion that clients' personal relationships will be improved by their having more effective caregiving skills has been relatively ignored, as has a caregiving view of termination. This article contributes to the literature by examining these last three issues. Because the reader may not be familiar with the major constructs, adult attachment theory is briefly reviewed to provide background that will facilitate breadth and depth of theoretical understanding.

ATTACHMENT THEORY

In developing attachment theory, Bowlby (1988) proposed that attachment and caregiving are interrelated, complementary systems. The attachment system serves the evolutionary function of protection, with attachment reflecting a motivation to maintain proximity to a specific, preferred figure (in childhood, a parent, and in adulthood, often, a romantic partner) who provides a sense of security through the safe haven and secure base aspects of caregiving. When proximity is not maintained within a tolerable range, the attachment system is activated: The attached person experiences separation anxiety and acts to reestablish physical or psychological proximity, which in turn deactivates the attachment system. When proximity cannot be reestablished, grief ensues.

Caregiving, like attachment, is an innate, biological component of being human (Bowlby, 1988; Kunce & Shaver, 1994). The caregiving system is concerned with providing emotional care and protection. Its functions are to meet the attached person's needs for proximity and security through

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some form of closeness or soothing (safe haven) and to provide an anchor and guidance for the attached person's exploratory behavior (secure base). Caregiving is aroused when the attached person signals a need for proximity, is in distress, or is perceived to be in some form of physical or psychological danger. Caregiving behavior ends when the attached person has established proximity and felt security or when the danger is perceived to have ceased. Environmental or contextual factors, such as the quality of a marriage, can support or detract from the caregiver's sensitivity and availability to the attached person (Belsky & Isabella, 1988; Bowlby, 1988).

Individual Differences in Attachment and Caregiving

Individual differences in the quality of both attachment and caregiving organization are accounted for by the concept of the working model (Bowlby, 1988). Through attachment–caregiving interactions, people organize both sides of the complementary attachment-caregiving systems within an internal cognitive-affective schema called a "working model." In terms of attachment, the working model consists of beliefs about the self's worthiness of care, beliefs about the attachment figure being the kind of person who will be accessible and responsive when needed, and rules or strategies directing attention to and processing of attachment-related cues (Bretherton, 1985; Main, Kaplan, & Cassidy, 1985). Because of different rules directing attention, there are also systematic differences in sensitivity to attachment-related information and affect regulation (Fuendeling, 1998). The components of the caregiving side of the model have received less specific attention, but the model seems to include rules for noticing the attached person's needs for physical or psychological protection, for attending to bids for proximity, for processing and interpreting those cues, and for determining whether and how to respond.

Synthesizing across research and theory, four prototypical styles of adults' attachment–caregiving organization can be distinguished. The *secure* style is characterized by positive beliefs about the self and the other (Bartholomew & Horowitz, 1991), positive relationship characteristics such as trust and intimacy (e.g., Hazan & Shaver, 1987; Levy & Davis, 1988), problem-solving coping strategies (Mikulincer, Florian, & Tolmacz, 1990; Mikulincer, Florian, & Weller, 1993), and support seeking that results in mutual affect regulation (Fuendeling, 1998). Caregiving is associated with openness to attachment-related information, support in anxiety situations (Simpson, Rholes, & Nelligan, 1992), and the provision of proximity and sensitivity with little compulsive caregiving (Kunce & Shaver, 1994). *Preoccupied* attachment comprises a negative view of the self and a positive, usually idealized (Feeney & Noller, 1990) view of the other person. Strategies for regulating proximity include hypervigilance and hypersensitivity to attachment-related information and close monitoring of the partner (Bretherton, 1985). Affect regulation is characterized by high attentiveness to emotion, especially negative emotion; relatively high appraisals of threat; self-criticism (Fuendeling, 1998), and emotionally focused coping strategies in response to distress. Caregiving is usually characterized by low sensitivity, high proximity, compulsive caregiving, and inconsistent responsiveness to attachment cues (Ainsworth, Blehar, Waters, & Wall, 1978), probably because of being obsessed with and motivated by the self's attachment issues. The unwillingness to recognize the other's distress may also be related to fears of being overwhelmed with negative emotion (Fuendeling, 1998). *Dismissing-avoidant* attachment comprises defensively positive beliefs about the self and negative expectations of the partner. Such people are distant in relationships, desire low intensity (Feeney & Noller, 1990), dismiss the importance of attachment, value independence, and seem emotionally detached. In *fearful-avoidance*, the person has a negative view of both the self and the other person and uses distance to militate against fears of intimacy and rejection. With avoidance, people use distancing coping strategies and may have a very restricted emotional life with relatively high levels of anxiety being managed through inattention to affect, which is kept fairly isolated and minimized by a sense of control. Reliance on others is quite low and is impeded by communications that produce low mutuality or emotional exchange. Caregiving is characterized by low support in anxiety situations and low proximity, with fearful-avoidance demonstrating high compulsive caregiving and dismissing-avoidance demonstrating low compulsive caregiving (Kunce & Shaver, 1994). Because of restricting attention to attachment-related information, people with an avoidant organization may fail to recognize and support an attached person's bids for proximity, or they may reject or devalue such cues.

Having been developed from real-life transactions rather than fantasies or drives (cf. Diamond & Blatt, 1994), the working model is a reasonably accurate representation of reality (Bowlby, 1988). Research (Ainsworth et al., 1978; Main et al., 1985) indicates a fit between a pattern of inconsistency in caregiving and preoccupied attachment as well as between a pattern of rejection in caregiving and avoidant attachment. Similarly, the intergenerational transmission of caregiving behavior seems to be relatively normative (Main et al., 1985; Ricks, 1985). It is as if early attachment relationships form a template that influences later relationships and becomes more resistant to change across time because (a) environmental, child-rearing conditions may remain fairly constant across time; (b) processing is directed in such a way that there is selective attention to attachment-related information; (c) caregiving or proximity seeking behaviors may be misinterpreted or distorted in schema-consistent ways by internal expectations and strategies; (d) behavior may induce others to act in ways that meet and maintain expectations; and (e) the model usually operates in an automatic, routine fashion outside of awareness. Although the model can be updated to match current experience (Bowlby, 1988), it may also act as a lens that

distorts current attachment-related information so that the organization remains continuous across time, that is, consistent with previous nonsecure attachment experience that compromises development (Klohnen & Bera, 1998).

Individual Differences in Security and Competence

Although caregiving provides the attached person with a sense of felt security, the adequacy or optimality of that security differs systematically among the attachment-caregiving organizations. A caregiving pattern of inconsistent responsiveness or rejection inhibits the security and the exploratory behavior that accrue from the secure base function, that is, from the anchorage provided by proximity that can be returned to for security and guidance when needed. People who are preoccupied with attachment agendas, because of monitoring a partner who is inconsistently responsive, cannot devote the same attention to exploratory behavior as those who do not have such concerns, and they may, therefore, have diminished mastery or coping skills (Fuendeling, 1998). Likewise, research (Dozier & Kobak, 1992) indicates that those who avoid attachment-related information do so at a cost in physiological arousal, so they too have competing concerns during exploratory behavior. Thus, it is not surprising that research indicates systematic differences in exploratory behavior such as work (Hazan & Shaver, 1990), curiosity and information processing (Mikulincer, 1997), constructive thinking (Lopez, 1996), career maturity (Blustein, Prezioso, & Schultheiss, 1995), and adolescent development and adjustment to college (Kenny & Rice, 1995). Taken together, the research indicates that secure attachment promotes effective problem solving and adjustment, including effective, satisfying, and lasting romantic relationships (Hazan & Shaver, 1994a, 1994b).

CAREGIVING IN COUNSELING

Based on this attachment theory foundation, the following sections discuss three areas in which a caregiving perspective might be useful to counselors. First, although Bowlby (1988) and others (e.g., Dozier, Cue, & Barnett, 1994; Osofsky, 1988; Pistole & Watkins, 1995) have suggested that the counseling relationship is a nonreciprocal attachment relationship, there has been little discussion about the elements that contribute to conceptualizing the caregiving position (i.e., the counselor's contribution to the relationship). Second, because it is important in forming and maintaining emotionally close relationships, caregiving is an important component of clients' central relationship issues. Finally, a caregiving perspective also pertains to the termination of counseling.

The Counselor's Functions as a Caregiver

Construing the counselor and client as engaged in a nonreciprocal attachment relationship means that the client experiences an attachment bond and a care-seeking position with the counselor, and the counselor experiences a caregiving bond and position in relation to the client. However, this proposition requires that attachment does occur. Therefore, it is important for the counselor to consider if or when attachment theory is relevant to a particular client.

The conditions for establishing an attachment–caregiving bond are implicit in most counseling situations. Clients usually enter counseling when they are feeling vulnerable and distressed, and the initial session that involves getting to know the counselor and the tasks of counseling can engender discomfort and stress. Anxiety and distress activate the attachment system so that the person seeks proximity to and care from someone stronger and wiser. The counselor seems stronger and wiser because of the unilateral focus on the client's concerns, the counselor's congruence in the relationship (Rogers, 1951), and the counselor's socially sanctioned expertise in counseling. In turn, by presenting for sessions, the client is explicitly seeking care. The counselor notes physical features, vocal tone, or verbal reports that indicate distress and signal the need for care, that is, proximity, safety, and guidance. As the counselor responds to these signals with interventions that comfort and guide, the ensuing accessibility and responsiveness provide proximity and felt security, and attachment is secured. The client's attachment system is deactivated, and the attachment–caregiving connection emerges as the foundation cementing the counseling relationship. (It is worth noting that this process is consistent with theory indicating that clients' distress subsides with the establishment of the therapeutic alliance, M. Horowitz et al., 1984.)

Actively promoting such initial bonding may, however, require thoughtfulness. More specifically, because attachment-caregiving relationships are coconstructed (Bowlby, 1988), the client's attachment organization may be an important element to consider in initially engaging the client, as well as in maintaining the relationship and delivering services. Research indicates that attachment organization influences clients' approach to the counselor and to counseling (Dozier, 1990; Dozier & Tyrrell, 1998). Therefore, it may be useful for the counselor to tailor his or her interpersonal stance to dovetail with the client's attachment organization (Dolan, Arnkoff, & Glass, 1993). As does a parent, the counselor attunes to the client's signals, monitors the effects of caregiving, and modifies responses in order to be perceived as accessible, thereby promoting the client's idiosyncratically defined sense of felt security (Osofsky, 1988). Thoughtfulness is essential because, unlike a parent, the counselor may need to compensate for and challenge the results of previous experience with caregivers (Dozier & Tyrrell, 1998).

To mesh with the client's attachment style, the counselor will need to perceive and accurately decipher attachment-related material to formulate hypotheses to direct interventions. Information about the client's attachment organization may be obtained with brief research questionnaires (e.g., Bartholomew & Horowitz, 1991; Collins &

Read, 1990), with more clinically focused inventories (e.g., Mallinckrodt, Gantt, & Coble, 1995; West & Sheldon-Keller, 1994), and through discussion that answers questions such as (a) can the client recognize the counselor as trustworthy and willing to provide care and (b) can the client collaborate with the counselor in establishing and maintaining a relationship (Bowlby, 1979). By asking about the client's perception of caregiving behaviors in counseling, the counselor gains information to support or revise attachment-related conceptualization and also demonstrates concern for and sensitivity to the client's experience, as if saying "I am interested in your welfare and want to provide care in a trustworthy fashion." The interaction promotes proximity, attachment, and a reality-based connection.

Asking the client to collaborate with feedback may also facilitate conceptualization by distinguishing the real and transference aspects of the therapeutic relationship (Gelso & Carter, 1985). From an attachment perspective, there is a real attachment–caregiving bond: The client does obtain security, and the counselor does wish to provide care. There is also a transference attachment to the counselor, which is related to perceptions derived from past attachment relationships. In a sense, accommodating the client's style may be meeting the client's transference that is based on an outdated working model; that is, the counselor may intentionally behave somewhat like previous caregivers (for instance, by maintaining a distance level that suits the client). However, once attachment is solidified and felt security is experienced, the counselor, unlike previous caregivers, can alternate between care that meets the client's transference expectations and care that is more appropriate to promoting secure attachment in the real relationship. Contrasting the two caregiving stances can help to clarify the client's interpersonal reality and promote change in the working model so that at termination a less distorted view of the counseling relationship can exist, with the client responding to caregiving conditions that are associated with secure attachment.

Caregiving—safe haven and secure base functions. In providing counseling from a caregiving perspective, the counselor needs to anticipate and attend to the ongoing fluctuation, like an ebb-and-flow rhythm, in the relationship. As the client distances from the counselor to explore and then returns for proximity and security when feeling threatened or anxious, the counselor will, correspondingly, move between the secure base and safe haven functions, keeping in mind that these two functions can be separated conceptually even though they are intertwined and actually work together rather than distinctly. In providing a safe haven, that is, being comforting and soothing when the person feels threatened, emotionally vulnerable, and insecure, the counselor simultaneously supports the secure base function, that is, serving as an anchor that the client can return to "knowing for sure that he will be welcomed when he gets there, nourished . . . emotionally, comforted if distressed, reassured if frightened" (Bowlby, 1988, p. 11). The humane, compassionate context and space anchors exploratory behavior, but as a secure base, the caregiver is also ready to assist with guidance when, and only when, needed. Proximity and guidance, then, are both beneficial only at particular times and are contingent on the client's signals.

To explicitly consider how to enact the soothing and comforting, the safe haven function, the counselor can think in terms of basic counselor response skills because providing a safe haven "involves being empathic, appropriately responsive and psychologically available" (Belsky & Isabella, 1988, p. 50). For example, making personal contact and "touching" the client emotionally (Meier, 1989) demonstrate emotional availability and provide proximity. Psychological presence and interest in the client's welfare denote being the kind of person who is accessible and willing to respond when needed. Nonverbal behaviors such as culturally appropriate eye contact and body language, forward lean or appropriate spatial distance between the counselor and client, vocal tone communicating warmth and interest, and mirroring the client's movement (Ivey, Ivey, & Simek-Morgan, 1993) also reflect accessibility and a willingness for proximity. In addition, the counselor's containing the client's overwhelming affect as a means to help the client learn to tolerate and modulate strong emotion (Delvey, 1985) can be construed as a safe haven function providing comfort.

Relatedly, in providing a secure base (i.e., an anchor and guidance when needed), the goal is to facilitate the client's mastery behavior by supporting culturally appropriate autonomy that is developmentally apropos. Letting the client lead in initial sessions can be construed as developing a context for observing and attending to the client's signals so that the counselor can intervene when and how needed. It also demonstrates that the counselor is mindful of the client's autonomy and position as an adult who is cooperating in the therapeutic enterprise (Greenson, 1967; Safran, 1993; Strupp, 1996), and who, from a caregiving perspective, needs guidance only some of the time. The counselor's "determination to persist in trying to help no matter how desperate the patient's condition or how outrageous his behavior" (Jones, 1983, p. 239) anchors exploration as does the counselor's belief that increased mastery is beneficial and contributes to well-being, even if there is no cure for life. The counselor's office may "literally become a 'secure base' . . . to which the patient can return" (Jones, 1983, p. 240).

Guidance occurs through therapeutic interventions (e.g., clarifying, identifying contradictions or discrepancies, confronting, interpreting, and reframing) that facilitate exploration of the self and the life context and result in increased mastery. However, because guidance is offered when needed, the secure base function may include letting the client tolerate some frustration. For example, the counselor is consistently accessible and willing to help, but this availability is usually structured by sessions. Clients with preoccupied attachment who monitor availability and express distress to gain proximity may request consultations between sessions. Rather than being more physically available, the counselor's guidance may be directed at increas-

ing awareness that care is consistently (if not constantly) available, in conjunction with developing other strategies for attaining care (e.g., through a brief phone call or through an imaginary dialogue with the counselor).

C*aregiving—protection function*. It is noteworthy that caregiving is to provide protection (Bowlby, 1988), and correspondingly there are mandates in counseling that are related to protection. First, informing clients about professional/legal standards related to confidentiality and reporting of harm places the client in a position to make informed and reasonable decisions and bolsters the counselor's position as a trustworthy person who is accessible and willing to provide help, rather than being someone who may cause injury by assuming some authority to make capricious decisions about the client's life or by withholding information that is vital to the client's decisions. Second, when clients enter counseling, they often feel threatened and in danger; they need protection from dangers to existence including threats to the self-concept and integrity, loss or threatened loss of a central attachment figure (West & Sheldon-Keller, 1994), or jeopardy related to being in a vulnerable position with others. Counseling interventions protect by providing a safe haven and secure base and by dealing with issues related to self-concept and loss. Third, both caregiving and counseling are a commitment to promoting the welfare and development of a specified other without taking advantage of the other's vulnerability as a way to gratify the caregiver's issues. Because the caregiving-attachment relationship is nonreciprocal, with the client's position being more vulnerable, protection is the counselor's responsibility and is achievable only if the counselor does not violate the boundaries of the caregiving position. For example, the counselor provides psychological protection by serving as a "container," that is, remaining calm and reasonable, when confronted with intense emotions (Delvey, 1985) such as those that accompany loss or threats to integrity. In remaining calm, the counselor provides protection by guiding the client toward learning to manage emotions and by not retaliating with more intense emotion that could cause injury through contributing additional threat to an already disruptive emotional state.

Attachment theory also defines the caregiving and attachment systems as distinct from the sexual system (Bowlby, 1979). Although adult romantic relationships involve the sexual system as well as reciprocity in caregiving and attachment, in nonreciprocal relationships (e.g., counselor–client or parent–child), sexual behavior is a violation of the caregiving position:

> As a society, we do not see the adulthood of the child as opening the door to sexual relationships with the parent. We acknowledge that there remains within the equal relationship between parents and their adult children some remnant of the enormous power imbalance that is the hallmark of early parent–child relationships. (Brown, 1988, p. 252)

The attachment–caregiving and sexual systems have different purposes. The sexual system is concerned with reproduction or pleasure, not protection and felt security (Bowlby, 1969). Theoretically, physical contact interventions that contribute to a safe haven, a secure base, protection, or proximity fit within the boundaries of caregiving; contact that fosters physical or sensuous pleasure fits within the boundaries of the sexual system and, therefore, violates care and protective functions. However, the sexual and caregiving systems can be easily confused in adult relationships (Bowlby, 1988). Therefore, even with a solid rationale for physically touching a client, the counselor may need to process the client's responses to touch or to interventions that deal with sexually related material. The counselor may intend to facilitate attachment, provide care, or explore sexual values, but the client may not clearly distinguish the three systems and may not understand or accurately receive the intervention. The client's confusion may be exacerbated by or connected to an attachment history in which caregivers have not been comfortable with close body contact, as with preoccupied and avoidant attachment (Ainsworth et al., 1978).

Caregiving-Related Counseling Goals

Previous literature (e.g., Pistole & Watkins, 1995) has examined attachment issues in adults' love relationships without specifically addressing caregiving as an aspect of effective relationships. However, there is reason to believe that such a focus would be worthwhile (cf. Mackey, 1996). Romantic relationships are reciprocal attachment–caregiving relationships in which the adults are sometimes the attachment figure and sometimes the caregiver for each other (Bowlby, 1988). In such relationships, a partner's emotional support is important for alleviating mental and physical distress and is a central element contributing to psychological well-being (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996). "For the receiving spouse, this support creates the sense of being cared about, loved, esteemed, and valued as a person and of having someone who cares about his or her problems" (p. 625). This description captures the safe haven function and its influence on beliefs about the self's lovability and the partner's willingness to be accessible. On the other hand, relationship success also requires competency skills such as "effective problem-solving . . . and accurate perceptions of a partner's intentions" (Basic Behavioral, 1996, p. 626). These skills relate to the secure base function of caregiving. Indeed, with consistent and effective mutual caregiving, the partners may establish a relationship safe haven and a relationship secure base (cf. Byng-Hall, 1995; Donley, 1993; Wynne, 1984) that can facilitate exploratory behavior (e.g., communication and problem-solving) and minimize threat, which means that felt security and proximity remain within tolerable ranges.

C*aregiving issues*. In thinking about clients' change related to caregiving, it is interesting that research (Main et al., 1985) found that parents' caregiving patterns with their children seemed to change when the parents had gained a

more coherent understanding of their own childhood attachment histories. Clients may, therefore, benefit from reevaluating both the attachment and caregiving positions in their past and current core relationships. Contrasting experience across various attachment relationships (i.e., therapeutic, partner, parental) provides an opportunity to apprehend the meaning, purpose, and normality of caregiving functions so that meaning is revised and change occurs (cf. Lyddon, 1993). Moreover, because the context influences caregiving, perspective on previous experiences will be enhanced by directing attention toward culture; child-rearing norms; parental supports or stressors; and the social, historical, and economic times (Bowlby, 1988). For example, parents who were overwhelmed with stressors may not have been sufficiently attentive to a child's signals for proximity and so may have devalued or responded inconsistently to attachment-related cues. Because children do not have perspective on their parents' struggles, the client may have learned that (a) the self is not loveable enough to merit care, (b) the parent is not the kind of person who will respond when needed, (c) proximity is best managed through a secondary strategy such as avoidance or preoccupation with its inhibited or exaggerated signals for care (Main, 1990), (d) caring is not contingent on the more vulnerable person's felt need or signals, (e) being relied on for care is not acceptable, or (f) attention to the self's attachment-related issues supersedes attention to cues related to the need for care. Moreover, the client may not have learned what behaviors do constitute effective attention to and provision of care.

While attending to each of these points, the counselor guides exploration into whether the client recognizes attachment-related signals and behaviors, monitors the partner's (e.g., client's dating partner) responses to caregiving, and modifies the safe haven and secure base function in attunement to the partner. A related objective is for the client to understand how desires for proximity and use of caregiving are normative and acceptable in adults. Also, it may be useful to examine how caregiving and attachment are interrelated so that the client can notice interlocking patterns and identify how attachment-related management strategies contribute to relationship distress associated with caregiving lapses. The goal is for increased appropriateness in both providing care and relying on care.

For example, John is a client with an avoidant attachment who complains that his dating partner, Jane, is too needy and should be more independent like he is. Because the goal is for John to experience greater comfort with relying on and providing care, the counselor Ann S. might reference the counseling relationship and verify that help-seeking is normative, potentially useful, and reasonable behavior, while acknowledging that help-seeking seems to be relatively unusual and possibly anxiety provoking for John. Remembering that people with avoidant attachments typically have vague understandings of others' experience (L. M. Horowitz, Rosenberg, & Bartholomew, 1993) that contribute to misinterpreting others' accessibility and willingness to be of help, Ann S. may verbalize a desire to be of help and provide feedback about therapeutic intentions so that John can contemplate and better understand others' behavior and differentiate the meaning of others' behavior from his self-relevant distortions of their behavior (Biringen, 1994; M. Horowitz et al., 1984). Especially if there is a breach in the therapeutic alliance (Safran, 1993; Safran, Crocker, McMain, & Murray, 1990), a focus on the counselor–client relationship (perhaps in contrast to other sources of caregiving) might help John develop some faith in Ann S. as a person who intends to be an accessible, trustworthy, and nonintrusive source of reliable, if imperfect, caregiving. This focus guides John into more appropriate reliance on caregiving, while simultaneously modeling effective care (i.e., being accessible, monitoring and attuning to the other's experience and signals).

Ann S. will also guide exploration of care in John's romantic relationship. First, because of expecting and fearing rejection from Jane, John may try to protect proximity by being under-assertive (Bartholomew & Horowitz, 1991); however, being under-assertive may elicit perceived rejection from Jane who is unaware of his needs for care. More specifically, if John says "I don't care what we do tonight" when what he wants is closeness and he really does care, he may feel rejected when Jane wants to do something that seems contradictory to his unstated and, therefore, unknown desires for proximity. When he is especially stressed and desiring caregiving functions, this interaction will reinforce John's negative beliefs about Jane's willingness to be accessible, will maintain strategies of distancing from attachment-related information because of being rejected, and will support his belief about not being lovable enough to deserve care. If Ann S. directs attention to the management of the attachment-related information (fearing rejection, asking for proximity in a disguised form that is not likely to elicit a desired response, and then misinterpreting the meaning of the interaction in terms of the caregiving), change may gradually occur in both the attachment and caregiving systems. John may learn that "Jane is not accessible because she is especially busy right now"; "Jane does not really provide very effective caregiving" (compared with Ann S.); or "Jane does not realize that I am asking for closeness." He may also recognize that "Jane's being inaccessible is not a statement that I am not lovable enough" and "I need to tell Jane when I want closeness rather than expect her to figure it out."

Second, with distancing from attachment-related information intact, John also will not note Jane's attachment-related cues and so will reject her cues and be inaccessible or intrusive as a caregiver. Ann S. may direct interventions so that John can better interpret and respond to Jane's signals for caregiving. If John complains that Jane is calling him every night and so he is going to screen his calls and not speak to her so often, Ann S. might clarify that Jane seems somewhat anxious about her new job, is seeking comfort and security, is interpreting John's inaccessibility as withdrawing from the relationship, and is, therefore, be-

coming more anxious due to the seeming separation. John can also be coached to realize that reliance on relationship partners is normative and to think about how to provide a safe haven and secure base. For instance, John might call Jane and say, "I have noticed that you seem upset, and I am concerned about that. At the moment, I have an important project. Can we get together later for an hour, or maybe we can meet tomorrow?" This call responds to Jane's attachment-related cues and also sets limits that protect his own attachment-related distance. Throughout such exploration and guidance, Ann S. needs to monitor John's discomfort and provide safe haven functions as needed by pointing out when and how John seems uncomfortable with appropriate reliance on care. By termination, John's distortion of and distancing from attachment-related information may be reduced so that he is more able to rely on caregiving and provide caregiving, with the result that there is less separation-related distress in his relationship.

Termination of Counseling

The distress related to separation from the attachment figure may also occur in response to the termination of counseling. Termination of the counseling relationship is "the end point of interpersonal closeness or attachment" (Bloom-Feshbach & Bloom-Feshbach, 1988, p. 551), although the discomfort of termination is influenced by factors such as the closeness of the client–counselor relationship, the length of therapy, and whether loss has been an issue (Marx & Gelso, 1987; Pinkerton & Rockwell, 1990). Because separation experience can generate very strong feelings of distress that pose a threat to self-integrity, as sessions end, clients may experience a loss and fear or be unwilling to "face life alone without the underlying support of the therapeutic hour" (Rogers, 1951, p. 87). Emotionally, the experience of separation and loss may be like "reviving within oneself the world of the child whose survival—both in a biological and psychological sense—literally depends on the reliable and trustworthy presence of a nurturant caretaker" (Strupp & Binder, 1984, p. 260). As important is that when an attachment figure seems (or is) lost, the source of security, soothing, and anchorage is also lost, and with the attachment system activated, exploration is compromised (Bowlby, 1975, 1988).

The counselor has, then, several agendas to address in managing termination. To continue providing a safe haven, the counselor needs to be prepared for and able to tolerate strong and intense emotions and respond to the pain by symbolically cradling and soothing while providing guidance. Typical termination behaviors such as increased anxiety, anger, the return of symptoms, or missed appointments may be construed as a protest designed to maintain proximity (Bowlby, 1975, 1988) and can be related to the client's current or previous attachment organization and affect management strategy (e.g., coping with distress with preoccupation or with avoidance). It may also help to distinguish the specific sorrows or losses: (a) the attachment relationship with its sense of felt security; (b) the counselor as a specific attachment figure with a style of caregiving; (c) the guidance, safe haven, secure base, and protection implicit in counseling; and (d) any resonance with previous losses (Biringen, 1994; Strupp & Binder, 1984). Previous loss may be especially relevant for clients with insecure attachment histories because early parental limitations in caregiving may have been experienced as short-term separations that resulted in accumulated loss (West & Sheldon-Keller, 1994). The counselor can also confront the illusion that one is responsible for or can control the losses within a life (Sollinger et al., 1986) by maintaining strong independence or by being hypervigilant to separation cues.

Providing a secure base also means supporting the client's exploratory behavior and appropriate self-reliance. In this regard, it is important to point out clients' contribution to the therapeutic work (Quintana, 1993), including their recognizing when another is available and willing to serve as a secure base, their being willing and able to rely on and use an attachment figure, and their increased competence accruing from appropriate reliance on caregiving. Another relevant agenda is anticipating life without the counselor (Pistole, 1991), for example by reiterating the lessons learned about productive responses to separation and grief (Ward, 1984) and by reinforcing the client's continued reliance on and ongoing development of attachment-related resources within his or her social network. In this regard, the counselor can lead the client toward exploring how to maintain the safe haven and secure base functions of the therapeutic relationship in memory, without the counselor's physical presence (Geller, 1988). With an imaginary dyadic internal dialogue, the client can retain the counselor as a caregiver, that is, as a sympathetic audience providing relief from turmoil as well as a means to attain clarity about issues. For example, after therapy, when encountering an experience the client would have brought to Ann S., the client might say "Dr. S. would say . . ." This thinking may provide the secure base or safe haven function of caregiving. Likewise, accessing a memory of Ann S. may provide security; for instance, the client may remember the counselor standing by his or her rocking chair at the end of each session and feel comforted or more secure. Although the face-to-face interaction has ended, the relationship and its meaning for the client are intact and available for use when needed.

At termination, when many attachment–caregiving transference aspects of the client–counselor relationship have been clarified (e.g., Pistole, 1989), the client can hold a more realistic, de-idealized version of the counselor and recognize "that the main thing lost [from the idealization] is a fantasy, not a condition of one's actual survival" (McWilliams, 1987, p. 104). The relationship, then, reinforces the client's recognition that "I no longer need a parent in order to survive; I can get needed care from both my self and my personal relationships."

Throughout the termination phase, the counselor needs to attune both to the client's attachment organization and

its possible influences on grieving (Pistole, 1995b, 1996) and coping (Dozier & Kobak, 1992; Kobak & Sceery, 1988) and to the injunction that caregiving is a response to the client's agendas and needs. By thinking about how to provide a safe haven and secure base, the counselor may more effectively reduce any tendencies to neglect the negative aspects of ending (Quintana & Holahan, 1992) and provide more fully for the client's expression of all feelings (e.g., regrets, reproaches, or yearnings, Marx & Gelso, 1987) and plans related to ending counseling (Bowlby, 1979). If the counselor has initiated a premature termination (e.g., because of a move to a new location), the client may experience an unwilling separation and feel more abandonment, rejection, or anger. On the other hand, with a timely termination, the client may feel sorrow, but as a result of the security of knowing "that someone is 'there to be left'" (Osofsky, 1988, p. 165), separation may be experienced as a natural and appropriate developmental step that is an inevitable part of living and growth (Bowlby, 1975; Jones, 1983; Lewis, 1988).

CONCLUDING COMMENTS

Attachment theory and its emphasis on caregiving can provide a useful perspective for understanding the counseling relationship, clients' relationship issues, and termination agendas. The caregiving perspective of counseling neatly dovetails with theoretical conceptualizations that view the counselor as performing "good enough" parenting (Whitaker, 1989; Winnicott, 1965) and, perhaps, with conceptualizations of the working alliance (Bordin, 1979; Greenson, 1967). Attachment theory illuminates the bonding and anchoring elements that underlie the therapeutic collaboration on tasks and goals (Jones, 1983). The counselor's attention and attunement to clients' attachment style during the early sessions may enhance security and the client's positive evaluation of the alliance, especially for those clients who are not accustomed to experiencing secure attachment relationships (cf. Bachelor, 1995; Dolan et al., 1993; Jones, 1983; Satterfield & Lyddon, 1995).

Other complexities are worth a brief consideration. First, attachment theory is proposed as a universal process that is influenced by environmental features (Bowlby, 1988). Research suggests that (a) expectations for appropriate parenting and child behavior differ among cultures (e.g., Julian, McKenry, & McKelvey, 1994; Zayas & Solari, 1994) and (b) there may be cultural differences that affect the attachment organization (Harwood, 1992; Main, 1990; Sprecher et al., 1994). Therefore, in attuning to their clients, counselors need to be alert to cultural norms and incorporate these elements into their caregiving. Second, given that early working models are believed to reflect reality in a reasonable way, clients with insecure attachment histories may not have a strong network capable of supporting the conditions for secure attachment. To maintain therapeutic progress and psychological well-being, clients may need to improve relationships within the family of origin, find a secure romantic attachment, or develop a network of core relationships that together constitute a voluntary family that serves as a secure base. On the other hand, clarifying transference elements may allow current relationships to become more satisfying and effective. Third, Bowlby (1988) has suggested that there are multiple attachment relationships in infancy, for instance, to mother and to father. These relationships can be qualitatively different and may be hierarchically arranged with the primary caregiving relationship representing the template for important romantic partner relationships (cf. Main et al., 1985). Research (Lamb, 1981) indicates that attachments with fathers are associated with "playful—often vigorously stimulating—social interaction, whereas mothers are associated with caretaking" (p. 478). It seems possible that if one relationship is primarily exploratory and the other primarily soothing the counseling relationship may be complicated by the client's alternating between attachment organizations that are based on transference related to the counselor's agenda being one of safety or of exploration.

In conclusion, the hypotheses and rationale for arguments in this article were derived from synthesis across a broad base of research and theory. The propositions are, therefore, proposed as somewhat speculative, awaiting further research to provide support and revision. Although preliminary research indicates that attachment theory is relevant to counseling (Dozier & Tyrrell, 1998), specific research related to caregiving is warranted. In addition, the arguments presume that the attachment and caregiving organization are relatively stable across time (Baldwin & Fehr, 1995; Klohnen & Bera, 1998; Urban, Carlson, Egeland, & Sroufe, 1992), although the working model can be flexible and updated based on thoughtfulness and new experience. Moreover, because caregiving influences development in a broad fashion (Klohnen & Bera, 1998), this perspective may also be useful with issues related to esteem, goal achievement (e.g., Cutrona, Cole, Colangelo, Assouline, & Russell, 1994; Lopez, 1997), or psychopathology (Belsky & Nezworski, 1988; West & Sheldon-Keller, 1994), and in particular settings such as public schools (Pfaller & Kiselica, 1996). Finally, the perspective proposed in this article may not be useful with all clients or all issues and is not intended to replace or subsume other theoretical models. However, it will, it is hoped, be useful to scientist-practitioners and stimulate further research.

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The Supervisory Working Alliance, Trainee Self-Efficacy, and Satisfaction

Nicholas Ladany, Michael V. Ellis, and Myrna L. Friedlander

Theoretically, when the supervisory working alliance is strong, the trainee and supervisor share a strong emotional bond and agree on the goals and tasks of supervision. Tested was Bordin's (1983) proposition that changes in counselor trainees' perceptions of the supervisory alliance over the course of supervision would predict supervisory outcomes. A national sample of beginning practicum- to intern-level trainees were assessed at the beginning and end of an academic semester. Contrary to predictions, changes in the alliance were not predictive of changes in trainees' self-efficacy. However, improvements in the emotional bond between the trainees and supervisors were associated with greater satisfaction.

Along with the proliferation of theoretical models of supervision over the past two decades (Bernard, 1979, 1997; Bernard & Goodyear, 1992; Blocher, 1983; Bordin, 1983; Hess, 1980; Holloway, 1995; Stoltenberg & Delworth, 1987; Watkins, 1997) has come the recognition that no model is able to explain the learning process in supervision more adequately than any other (Holloway, 1992). In all probability, most supervisors tend to work from more than one model (Loganbill, Hardy, & Delworth, 1982), just as most counselors tend to draw on different approaches in their work with clients. Furthermore, as seems true for counseling, common factors across supervision models may play a more significant role in the outcome of supervision than any specific approaches or techniques (Holloway, 1987). According to several theorists (Bordin, 1983; Efstation, Patton, & Kardash, 1990; Ekstein & Wallerstein, 1972; Mueller & Kell, 1972), the supervisory working alliance is potentially one of the most important common factors in the change process of supervision.

Likening the supervisory alliance to the therapeutic alliance in counseling, Bordin (1983) described the need for trainee and supervisor to collaborate by establishing a mutual understanding of the goals (e.g., mastery of counseling skills) and tasks (e.g., observing counseling sessions) of supervision as well as developing a strong emotional bond (e.g., mutual care, trust, and respect). Although there is strong evidence in the counseling literature to support the notion that the therapeutic alliance is a crucial factor in the success or failure of counseling (Horvath & Symonds, 1991), investigators have only recently begun to test Bordin's (1983) proposition that a favorable supervisory alliance facilitates positive supervisory outcomes (Ladany, Brittan-Powell, & Pannu, 1997; Ladany & Friedlander, 1995). Based on Bordin's (1983) model, the present investigation tested the hypotheses that changes over time in counselor trainees' perceptions of the quality of the supervisory working alliance would predict changes in their self-efficacy expectations and changes in their reported satisfaction with supervision.

We decided to study changes over time based on the reasoning that in supervision (Bordin, 1983), as in counseling (Bordin, 1979; Gelso & Carter, 1985), positive outcomes are expected when the working alliance is established early (i.e., between the third and fifth sessions). However, several theorists in the counseling and supervision literature have suggested that changes can be expected in the alli-

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ance over time; that is, a working alliance is dynamic rather than static (e.g., Bordin, 1979, 1983; Gelso & Carter, 1985; Golden & Robbins, 1990; Horvath & Marx, 1990). According to Bordin (1983), the "building and repair" of the supervisory alliance, its dynamic quality, is reflected in the positive and negative experiences that fluctuate throughout the learning process in supervision. Thus, an adequate examination of the supervisory working alliance requires multiple assessments over the course of supervision.

Bordin (1983) outlined eight general goals (or outcomes) expected to result from developing a strong supervisory alliance, one of which includes the mastery of specific counseling skills. We reasoned that the process of mastering specific counseling skills involves the trainee gaining confidence in performing these skills. To study gains in confidence, we selected trainee self-efficacy as an outcome variable. This choice was based on (a) Bandura's (1977, 1982) self-efficacy theory, in which a direct relationship is postulated between one's confidence in performing a set of behaviors successfully (i.e., the strength of one's self-efficacy expectations) and the actual performance of those behaviors; and (b) Friedlander and Snyder's (1983b) research, which demonstrated a relationship between trainee self-efficacy, or the trainee's sense of mastery of specific counseling skills (e.g., writing case reports, conduct individual counseling with individuals having anxiety reactions), and the trainee's expectations for supervision.

When the working alliance is strong, the four major sources of self-efficacy expectancies (performance accomplishments, vicarious experiences, verbal persuasion, and emotional arousal; Bandura, 1977) should be experienced in clinical supervision. The supervisor's teaching and feedback, for example, can improve the trainee's counseling skills, which will in turn strengthen his or her subsequent performance with clients. Role-playing in the supervision session may be a type of vicarious experience that can enhance self-efficacy expectations. Support and encouragement from the supervisor may be forms of verbal persuasion. Indeed, the emotional component of the supervisory relationship as a whole constitutes yet another source of self-efficacy expectancies. Hence, we expected the trainee's level of self-efficacy to be affected positively in the context of a positive supervisory alliance and negatively in the context of a weak alliance.

One research endeavor supports the theoretical relationship between the supervisory working alliance and trainee self-efficacy. Efstation et al. (1990) reported a significant positive relationship between reported self-efficacy expectancies and the perceived strength of the supervisory working alliance. Several considerations need to be taken into account, however. First, because Efstation et al.'s alliance instrument does not correspond to the three factors of the alliance as proposed by Bordin (1983), the research cannot be strictly interpreted to support Bordin's model. Second, because the authors did not take into account trainees' self-efficacy expectancies early in the supervision relationship, they were unable to test the dynamic aspect of the alliance, that is, whether trainees' perceptions early and later in the relationship were related to changes in their self-efficacy expectancies. Finally, previous supervision experience was not taken into account by Efstation et al. Increases in self-efficacy expectations may be due to growth in the supervisory working alliance over the course of the semester or due simply to time spent in supervision. We therefore extended Efstation et al.'s work by (a) testing Bordin's (1983) proposition using an instrument derived explicitly from his model, the Supervisory Working Alliance Inventory (Bahrick, 1990); (b) assessing the three factors of the alliance in relation to self-efficacy expectations at two points in time; and (c) taking into account the trainee's previous experience in supervision.

A second criterion variable was perceived satisfaction with supervision, a variable that has received considerable attention in the literature (Ellis & Ladany, 1997; Friedlander & Ward, 1984; Heppner & Handley, 1981; Heppner & Roehlke, 1984; Holloway & Wampold, 1983; Krause & Allen, 1988; Olk & Friedlander, 1992). Indeed, in the counseling literature it has repeatedly been found that client satisfaction is associated with more favorable perceptions of the working alliance (Horvath & Symonds, 1991). In supervision, relationships have been reported between trainee satisfaction and (a) the congruence between the supervisor's and trainee's perceptions of the trainee's therapeutic competence (Krause & Allen, 1988); (b) patterns of verbal interaction in supervision (Holloway & Wampold, 1983); (c) trainees' experiences of role difficulties in the supervisory relationship (Olk & Friedlander, 1992); (d) trainees' perceptions of the supervisor's expertness, attractiveness, and trustworthiness (Heppner & Handley, 1981); (e) trainees' perceptions of supervisory style (Friedlander & Ward, 1984); and (f) trainee nondisclosures (Ladany, Hill, Corbett, & Nutt, 1996). Much of the attention paid to satisfaction as a factor in supervision is based on the assumption that satisfaction is necessary for trainees to be willing to work hard and ultimately achieve their learning goals in supervision (Heppner & Handley, 1981).

Although definitions have varied, for this investigation trainee satisfaction was defined as trainees' reaction to the supervisor's perceived personal qualities and performance, the judgment of their own behavior in supervision, and the level of comfort when expressing their own ideas in supervision (Holloway & Wampold, 1983, 1984). It seemed logical to expect that trainees would be more satisfied when the supervisory alliance is favorable. When the emotional bond is strong, trainees are more likely to feel comfortable with the supervisor and to view the personal qualities and attitude of the supervisor favorably. When the goals and tasks of supervision are clearly understood, collaboration in supervision is expected to be facilitated and the trainees' comfort with the supervisor and with self-evaluation will be enhanced.

The purpose of this study was to test Bordin's (1983) extension of the concept of the therapeutic working alliance to the supervisory relationship. This investigation was designed to determine whether changes in trainees' perceptions of the supervisory alliance are related to changes

in their reported self-efficacy expectations and their satisfaction with supervision, taking into account trainee experience level. Trainee experience level was included as an additional variable (i.e., covariate) because, although not considered explicitly by Bordin (1983), it seemed to be a potential moderating variable given its salience in the supervision literature (Stoltenberg, McNeill, & Crethar, 1994).

Specifically, we hypothesized that as the supervisory working alliance becomes stronger, that is, as perceived agreement on the goals and tasks of supervision increase and as perceived levels of emotional bonding between supervisor and trainee increase, trainees' reported self-efficacy and satisfaction with supervision will increase. Alternatively, we expected that as the supervisory working alliance becomes weaker, that is, as perceived agreement on the goals and tasks of supervision decrease and as perceived levels of emotional bonding between supervisor and trainee decrease, trainees' reported self-efficacy and reported satisfaction with supervision will decrease. Moreover, we anticipated that each of the three factors of the supervisory working alliance would contribute uniquely and significantly to the understanding of supervision outcome.

METHOD

Participants

Given an estimated average effect size, based on similar past research, of .157 (Efstation et al., 1990; Horvath & Symonds, 1991; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983; Morgan, Luborsky, Crits-Cristoph, Curtis, & Solomon, 1982) a power analysis (Cohen, 1988) was conducted. Results of this analysis revealed that the number of participants required for power to exceed .90, when the experimentwise alpha is .05, was 100.

The final sample of 107 counselor trainees included 35 men and 72 women, averaging 29.91 years, *SD* = 6.41. The racial breakdown of respondents was 86% White, 7% African American, 3% Latino, and 2% Asian American (3% did not report; percentages have been rounded). Most respondents were in counselor education or counseling psychology (59%) or clinical psychology (36%) training programs and were being supervised in college counseling centers (40%), community mental health centers (25%), or Veterans Administration hospitals (22%). Training levels of participants were doctoral (71%) or master's students (29%) who identified themselves as beginning practicum (30%), advanced practicum (20%), or internship/postdoctorate (51%) trainees. As a group, these trainees reported a mean of 22.51 (*SD* = 29.5) months of previous supervised counseling experience. They were currently in individual supervision for a mean of 81 minutes per week (*SD* = 43.3) with primarily male (65%) versus female (35%) supervisors.

Variables

Supervisory working alliance. The Working Alliance Inventory–Trainee version (WAI-T; Bahrick, 1990) is a 36-item self-report instrument that assesses trainees' perceptions of the three factors of the supervisory working alliance (agreement on the goals of supervision, agreement on the tasks of supervision, and an emotional bond). The WAI-T was adapted from Horvath and Greenberg's (1986) Working Alliance Inventory. The original instrument was designed to assess the strength of the working alliance within the therapeutic relationship and is based on Bordin's (1979) model of the therapeutic working alliance. In revising the WAI-T for the supervision context, Bahrick made minor changes to reflect the supervisory alliance (Bordin, 1983). That is, terms like *therapist* and *client* were changed to *supervisor* and *trainee*, respectively; references to *client problems* were changed to *trainee issues* or *trainee concerns*. The three subscales, each of which contains 12 items, correspond to the three supervisory working alliance factors (i.e., goals, tasks, and bond). Items are rated on a 7-point Likert-type scale ranging from *never* (1) to *always* (7). An example from the Agreement on Goals subscale is the item, "The goals of these sessions are important to me." One item from the Agreement on Tasks subscale is "I am clear on what my responsibilities are in supervision." On the Emotional Bond subscale, one item is "(Supervisor's name) and I trust one another" (participants were asked to mentally insert their supervisor's name). For each subscale, scores are obtained by summing the item ratings such that scores range from 12 to 84, with higher scores reflecting higher perceived agreement with the supervisor on the goals and tasks of supervision and a stronger emotional bond between supervisor and trainee.

Evidence for the validity of the WAI-T can be attested to by its negative relationship with supervisee role conflict and role ambiguity (Ladany & Friedlander, 1995) and positive relationship with favorable supervisory racial identity interactions (Ladany et al., 1997). Regarding reliability, previous internal consistency estimates have exceeded alpha = .91 for all the subscales (Ladany et al., 1997; Ladany & Friedlander, 1995). Based on the current sample, the Cronbach's coefficient alpha were .92, .90, and .90 at Time 1 and .92, .93, and .92 at Time 2 for Agreement on Goals, Agreement on Tasks, and Emotional Bond, respectively.

Trainee self-efficacy. The Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983b) is a 21-item self-report measure that assesses trainee self-efficacy. The SEI is based on Bandura's (1977) model of self-efficacy as applied to a counselor supervision context and was designed to assess trainees' perceptions of their counselor self-efficacy expectations, that is, confidence in their ability to perform specific counseling related activities. Trainees rate their confidence in their ability to perform each of the 21 counseling activities on a 10-point scale from *not confident* (0) to *completely confident* (9). Scores range from 0 to 189, with higher scores reflecting stronger perceptions of self-efficacy expectations in counseling-related activities. Regarding validity, the SEI has been found to be positively correlated with trainee experience level, $r = .55$ (Friedlander & Snyder, 1983a). Internal consistency reliability based on Cronbach's coefficient alpha was found to be .93 (Friedlander & Snyder,

1983b). Based on the current sample, the Cronbach's coefficient alpha was . 89 at both Time 1 and Time 2.

Trainee satisfaction with supervision. The revised version of the Trainee Personal Reaction Scale–Revised (TPRS-R; Holloway & Wampold, 1984) is a 12-item self-report instrument that assesses trainees' perceived satisfaction with supervision. Trainees rate the extent to which each item is characteristic of their feelings on a 5-point scale from *not characteristic of my feelings* (1) to *highly characteristic of my feelings* (5). Scores range from 12 to 60, with higher scores reflecting a greater degree of satisfaction with supervision. Satisfaction is operationalized as the extent of the trainee's reaction to the supervisor's perceived personal qualities and performance, the trainee's judgment of his or her own behavior in supervision, and the trainee's level of comfort in expressing ideas in supervision. For the present purposes, directions to the TPRS-R were modified to reflect general ratings. Specifically, rather than rate "your present feelings about the *supervision session you just participated in* [italics added]," participants were asked to rate their "feelings about *supervision with your supervisor over the course of this semester to date* [italics added]." The construct validity of the TPRS-R is supported by significant theoretically predicted relationships between satisfaction and patterns of verbal interaction in supervision, (e.g., less satisfaction was related to negative social emotional behaviors; Holloway & Wampold, 1983) and trainees' perceptions of fewer role difficulties in the supervisory relationship (Olk & Friedlander, 1992). Internal consistency reliability based on Cronbach's coefficient alpha was found to be alpha = .83 (Olk & Friedlander, 1992). Based on the current sample, the Cronbach's coefficient alpha for the TPRS-R was alpha = .86 at Time 1 and alpha = .85 at Time 2.

Demographic questionnaire. The demographic questionnaire, which participants completed at Time 1 only, was used to gather information about their age, sex, ethnic/racial background, primary field of graduate study, year in graduate program, level of training, current degree program, setting, months of supervised counseling experience, months of counseling experience, supervisor's sex, intentions to work with the supervisor the following semester, hours per week of individual supervision, theoretical orientation, and the supervisor's theoretical orientation.

Procedure

Available participants were solicited through personal contacts in counselor education, counseling psychology, and clinical psychology graduate programs in several states (Illinois, Iowa, Maryland, Massachusetts, Mississippi, Missouri, New York, North Carolina, Pennsylvania, and Texas) and the District of Columbia. Potential volunteers were asked to participate (through departmental mailboxes and informal contact) in a study "concerning the process of supervision." Respondents were asked to complete and return the instruments and the demographic questionnaire. Inclusion criteria required participants to (a) complete the packets at both Time 1 and Time 2, (b) complete the packets at Time 1 between the 3rd and 5th weeks of supervision, (c) complete the packets at Time 2 between the 11th and 16th weeks of supervision, and (d) not have been supervised previously by their current primary supervisor. The time intervals selected were chosen because Bordin (1983) proposed the first time period as an early predictor of supervisory outcomes and because the second time period coincided with the end of an academic term, when many supervisory relationships naturally end. To control for ordering effects, the WAI-T, SEI, and TPRS-R were randomized in the questionnaire packet at both Time 1 and Time 2. Participants returned the questionnaire packets to the investigator either by mail or through a contact person at their site. To ensure anonymity but allow for matching across time periods, participants were asked to indicate the last four digits of their social security number. Three hundred twelve questionnaires were initially distributed, and 151 trainees completed and returned them (48% return rate). Forty-four packets did not meet at least one of the criteria listed, resulting in a final sample size of 107 .

RESULTS

Preliminary Analyses

Tests for differential attrition. To assess whether differential mortality/attrition took place, a series of chi-square and *t*-test analyses, which compared the participatory (i.e., final sample) and nonparticipatory (those who did not meet the inclusion criteria or did not complete Time 2) groups, were conducted on the demographic, predictor, and criterion variables. To avoid Type I error, the per comparison alpha was set at $p < .0045$ for the chi-square tests (.05/11), and $p < .0056$ for the t tests (.05/9). These analyses indicated that the two groups did not differ on any of the variables, χ^2s, ps $> .0045$; ts(149), ps $> .0056$.

Covariate

Another analysis was performed to determine if trainee experience level, as measured by months of supervised counseling experience assessed at Time 1, met the criteria for a covariate, that is, no significant interaction effects between the predictor variables and the covariate (Porter & Raudenbush, 1987) and a correlation between the criterion variables and the covariate greater than .40 (i.e., $\rho^2 = .16$; Cox, 1957). As explained earlier, experience level was an important consideration, conceptually, in the design of the study. The empirical evidence, however, indicated that this variable should be eliminated from further consideration. Specifically, although experience level did not interact significantly with any of the predictor variables, the relation between the covariate and the criterion variables was $\hat{\rho}^2 m = .008$, $p = .258$, well below the .16 criterion.

Major Analyses

To test the hypotheses, a multivariate multiple regression analysis was conducted, consisting of three predictor vari-

ables (changes in scores between Time 1 and Time 2 on the Goals, Tasks, and Bond subscales of the WAI) and two criterion variables (changes in scores between Time 1 and Time 2 on the SEI and TPRS-R). A multivariate procedure was used to account for the potential intercorrelation among the SEI and the TPRS-R change scores (Haase & Ellis, 1987). Descriptive statistics for the predictor and criterion variables are shown in Table 1. The intercorrelations between the predictor and criterion variables at both Time 1, Time 2, and across time can be seen in Tables 2 and 3.

Overall, the proportion of the variance in the criterion variables accounted for by the predictor variables was significant (Pillai's trace $\nu = .246$, $F[6, 206] = 4.83$, $p < .0001$), $\hat{\rho}^2m = .106$, where $\hat{\rho}^2m$ is the shrunken multivariate effect size (Cohen & Nee, 1984). Because multivariate significance was reached at the .05 level, follow-up procedures (i.e., univariate analyses and standardized discriminant function coefficients [*sdfc*]) were conducted and examined (Haase & Ellis, 1987).

Trainee self-efficacy. An examination of the univariate *F* tests in combination with the standardized discriminant function coefficients suggested that changes in the three predictor variables were not significantly related to changes in the trainees' ratings of self-efficacy, $F(3, 103) = .641$, $p = .641$, $\hat{\rho}^2 < .001$, *sdfc* (λ): $\lambda_{SEI} = .222$, $\lambda_{TPRS\text{-}R} = .993$. The *sdfc*s indicated that trainee satisfaction with supervision contributed most to the multivariate discrimination. Given the nonsignificant *F* test for the SEI, no follow-up analyses were conducted (e.g., tests to determine whether each predictor variable contributes uniquely to the equation). Thus, the first hypothesis was not supported.

Trainee satisfaction with supervision. Changes in the three predictor variables were significantly related to changes in trainees' ratings of satisfaction with supervision, $F(3, 103) = 10.11$, $p < .0001$, $\hat{\rho}^2 = .213$. Thus, the second hypothesis was supported. Three follow-up analyses were conducted on the TPRS-R to determine the unique variance the predictor variables (i.e., agreement on goals, agreement on tasks, or emotional bond) accounted for in the satisfaction variable. We found that changes in the Bond factor contributed uniquely and significantly to the proportion of variance accounted for in changes of the trainees' ratings of satisfaction with supervision, $F(1, 103) = 5.44$, $p = .022$, $\hat{\rho}^2 = .041$. That is, increases in the emotional bond scores were directly related to increases in trainees' reported satisfaction with supervision. Conversely, decreases in the Emotional Bond scores were related to decreases in the reported satisfaction with supervision. Neither changes in the Agreement on Tasks scores, nor changes in the Agreement on Goals scores, contributed significantly to changes in satisfaction ratings.

Post hoc analyses: Changes in trainee self-efficacy. Although no significant relationship was found between changes in the supervisory alliance ratings and changes in trainee self-efficacy expectancies, our observations of Table 1 suggested that self-efficacy may have increased significantly over time (i.e., from Time 1 to Time 2). Alternatively, WAI-T scores and TPRS-R scores seemed to change little over time. To assess whether changes did occur over time, two repeated measures multivariate *t* tests were conducted whereby Time was the repeated measures factor. The multivariate effect assessing changes over time was not significant in the case of the three WAI-T predictor variables. However, the multivariate effect for changes in the criterion variables over time was significant, Pillai's trace $\nu = .205$, $F(2, 105) = 13.568$, $p < .001$, $\hat{\rho}^2m = .190$. The follow-up analyses revealed that SEI contributed most to the multivariate effect: for SEI, $F(1, 106) = 27.32$, $p < .001$, $\hat{\rho}^2 = .197$, $\lambda_{SEI} = 1.000$; for TPRS-R, $F(1, 106) = .010$, $p = .921$, $\hat{\rho}^2 < .001$, $\lambda_{TPRS\text{-}R} = .054$). Taken together, the results of the post hoc analyses suggested that although no consistent changes over time were found among scores on the three scales of the supervisory working alliance or trainee satisfaction with supervision ratings, reported self-efficacy did increase significantly over time.

TABLE 1

Means, Medians, and Standard Deviations of the Time 1, Time 2, and Change Scores for the Predictor and Criterion Variables

Variable	*M*	*Mdn*	*SD*
Time 1			
Goal	64.27	65.00	11.41
Task	66.42	68.00	10.05
Bond	64.93	67.00	10.77
SEI	124.84	125.00	21.98
TPRS–R	48.51	49.00	7.75
Time 2			
Goal	64.52	68.00	12.36
Task	65.96	69.00	12.04
Bond	65.91	69.00	11.81
SEI	132.75	133.00	20.48
TPRS–R	48.58	50.00	7.88
Change scores			
Goal	0.25	2.00	9.88
Task	–0.46	0.00	10.22
Bond	0.98	1.00	8.48
SEI	7.91	7.00	15.65
TPRS–R	0.07	0.00	6.78

Note. Goal, Task, and Bond = subscales of the Working Alliance Inventory–Trainee version (Bahrick, 1990); SEI = Self-Efficacy Inventory (Friedlander & Snyder, 1983b); TPRS–R = Trainee Personal Reaction Scale–Revised (Holloway & Wampold, 1984). Positive change scores indicate an increase over time, whereas negative change scores indicate a decrease over time. A mean of 0.0 indicates that no change was observed from Time 1 to Time 2.

DISCUSSION

Supervision theorists have begun to emphasize the importance of common factors across supervision models (Holloway, 1992). In particular, the supervisory working alliance has been posited to play a significant role in the outcome of supervision (Bordin, 1983). To test this notion, we investigated the extent to which changes in trainees'

TABLE 2

Intercorrelations of the Covariate and Time 1 and 2 Scores of the Predictor and Criterion Variables

	Time 1					Time 2				
	1	2	3	4	5	1	2	3	4	5
Time 1										
1. Goal	—									
2. Task	.909	—								
3. Bond	.783	.815	—							
4. SEI	.113	.110	.137	—						
5. TPRS–R	.661	.710	.658	.092	—					
Time 2										
1. Goal	.658	.609	.596	–.036	.472	—				
2. Task	.599	.585	.556	.012	.450	.941	—			
3. Bond	.527	.539	.722	–.026	.450	.784	.747	—		
4. SEI	.048	–.002	.103	.731	.073	–.054	–.012	–.049	—	
5. TPRS–R	.610	.631	.678	.078	.624	.709	.694	.748	.036	—
Experience	–.069	–.089	–.179	.279	–.070	–.018	–.001	–.088	.283	–.143

Note. See Table 1 *Note.* Experience = number of months of supervised counseling experience, transformed via the log-base 10. If the correlations coefficient is less than –.35 or greater than .35, then $p < .001$ for $N = 107$.

perceptions of the three components of the working alliance are related to changes in two supervisory outcomes, trainees' self-efficacy expectations and their reported satisfaction with supervision.

Our results supported an aspect of Bordin's (1983) theoretical propositions. That is, one of our two general a priori hypotheses was supported. More specifically, a single component of the supervisory alliance, the emotional bond, was uniquely significantly related to one aspect of supervision outcome—satisfaction. Our results showed that when the emotional bond was viewed as becoming stronger over time (i.e., from early to late in supervision), trainees also perceived their supervisors' personal qualities and performance more positively, they judged their own behavior in supervision more positively, and they were relatively more comfortable in supervision. Conversely, if they perceived the emotional bond to become weaker over time, trainees perceived their supervisors' personal qualities and performance more negatively, they judged their own behavior in supervision more negatively, and they were less comfortable in supervision. These results support the dynamic conceptualization of the supervisory alliance (Bordin, 1983) and suggest that it is important to assess the working alliance over time for the bond factor to have sufficient time to develop.

Conversely, there were no uniquely significant relationships between the agreements on goals and tasks factors of the alliance and reported satisfaction with supervision. One possible explanation is that the three scales of the WAI-T were so highly intercorrelated (i.e., all rs $\geq .67$) that differentiating among them may be difficult even though doing so seems to be theoretically meaningful (see Table 3). Indeed, it may be reasonable to consider the supervisory working alliance to be one general factor, or two factors (agreements and an emotional bond) rather than three specific factors. In the context of counseling, a single overall factor structure for the Working Alliance Inventory (Horvath & Greenberg, 1986) seems to be a viable conceptualization of the therapeutic working alliance (Tracey & Kokotovic, 1989). These propositions could be tested in future supervision investigations.

Regarding trainee self-efficacy, our results showed gains over time in self-efficacy but suggested that changes in the alliance, taken together or considered separately, did not predict changes in self-efficacy. The presence of unknown moderating variables (e.g., peer feedback) cannot be ruled out. Indeed, the overall training context in which trainees work, engaging in many learning experiences and receiving feedback from a multitude of sources, should be considered. In the absence of a strong supervisory alliance, trainees might enhance their sense of self-efficacy through other performance accomplishments, other vicarious or emotionally arousing experiences, or feedback from peers or from clients who benefited from their work with the trainee.

TABLE 3

Intercorrelations of Change Scores on the Predictor and Criterion Variables

Variable	1	2	3	4	5
1. Goal	—				
2. Task	.854	—			
3. Bond	.720	.674	—		
4. SEI	.085	.114	.036	—	
5. TPRS–R	.411	.421	.450	–.034	—

Note. See Table 1 *Note.* These correlations were computed using change scores (Time 2 minus Time 1). If the correlation coefficient is less than –.35 or greater than .35, then $p < .001$.

Our findings have implications for the theoretical, empirical, and practical applications of the supervisory working alliance model. At the forefront is the advisability of equating the therapeutic and supervisory working alliances. Fundamental differences between the two endeavors should be considered carefully (Bernard & Goodyear, 1992; Borders & Leddick, 1987; Leddick & Bernard, 1980). Specifically, trainees are evaluated by their supervisors and, unlike counseling, supervision is not a voluntary experience for trainees.

Despite the fact that evaluation is an inescapable and important component of the supervisory process (e.g., Bernard & Goodyear, 1992; Worthington, 1984), Bordin's (1983) model of the supervisory working alliance does not seem to adequately address it. Indeed, evaluation may moderate the relationship between the working alliance and the outcome of supervision. For example, trainees may not be willing to disclose personal information that they believe will negatively affect the supervisor's evaluation of their performance (Ladany et al., 1996; Olk & Friedlander, 1992). Furthermore, because trainees are required to be involved in supervision as part of an academic training program, they may believe they have less control over what occurs during the supervisory process. The involuntary nature of supervision is likely to have ramifications not only for the emotional bond but also for the trainee's involvement in negotiating the goals and tasks of supervision. Trainees who are dissatisfied with the supervisory relationship may nonetheless be required to complete the semester with the supervisor. Taken together, these two differences from counseling suggest the need for taking a closer look at the theoretical basis of the supervisory working alliance as it applies to clinical supervision.

Results of the current investigation contradict those of Efstation et al. (1990), who found a significant relationship between the supervisory working alliance and trainee self-efficacy, assessed at a single point in time. The different results may be due to the use of different measures of the alliance or to the fact that most of Efstation et al.'s trainees were more advanced than were the trainees in the present sample. More advanced trainees are likely to have a greater sense of self-efficacy and to be less dependent on a single supervisory relationship than are beginners. In general, this discrepancy is curious and warrants further investigation.

Contrary to our expectation, the experience variable did not fulfill the statistical requirements of a covariate. Logically and on the basis of the literature (e.g., Friedlander & Snyder, 1983b; Heppner & Roehlke, 1984; Stoltenberg & Delworth, 1987; Stoltenberg et al., 1994), we expected that the process of maturation as a counselor would facilitate supervisory outcomes to a greater extent for beginning trainees than for their more advanced counterparts, interns and postdoctoral trainees. One possible explanation for the lack of relationship between experience and either self-efficacy or satisfaction is that our measure of trainee experience (months of supervised experience) was not sufficiently precise. Although months of experience is more precise than training level (e.g., practicum vs. intern), an even more precise assessment of experience may be number of previous clients or some combination of experience variables. To illustrate, one trainee may receive 12 months of supervised practicum experience and treat 45 clients, whereas another may work with only 8 clients in a year's time. The first trainee is more experienced clinically than the latter despite their equivalence in number of months of supervised experience. Overall, the lack of findings for experience level seems consistent with the supervision literature that has questioned the validity of purported developmental changes in trainees across experience levels (Ellis & Ladany, 1997, Holloway, 1987; Sumerel & Borders, 1996) and highlights the importance of, and difficulty in, adequately operationalizing the construct trainee experience (Garb, 1989).

Regarding supervision practice, results of the current study can be used to provide tentative suggestions for enhancing supervisors' effectiveness with trainees. Trainees seem to be more satisfied with a strong emotional bond with their supervisors. For example, a stronger emotional bond seems to be related to trainees' comfort with self-disclosing in supervision. Given that self-disclosure is seen as vital in most supervision training models, supervisors may be encouraged to create a positive emotional bond to facilitate self-disclosure. Furthermore, it could be argued that trainees who are more satisfied with supervision will be more likely to continue to be supervised once they have graduated. This process is particularly important given the move toward making supervision an integral part of one's professional career. Another practical implication is that trainees seem to gain in self-efficacy regardless of the quality of the supervisory relationship. As noted, trainees may supplement their training through other methods (e.g., peers), which brings into question the adequacy of supervision in general. Hence, supervisors may consider the specific ways in which they influence their trainees.

Limitations should be noted that stem from the threats to validity inherent in ex post facto designs (Cook & Campbell, 1979). The inability to manipulate the predictor variables or to randomly assign participants to conditions (or to supervisors) threatens the internal validity of this study. The interpretation of the results are limited to descriptive statements regarding the relationship between the predictor and criterion variables. Although Bordin (1983) theorized that the supervisory working alliance facilitates supervisory outcomes, the causal link cannot legitimately be made from our data. Our results suggest that trainees are more satisfied when they have a strong emotional bond with their supervisors. It is unclear, however, whether positive changes in the emotional bond led to greater satisfaction with supervision or whether greater satisfaction with supervision led to positive changes in the emotional bond.

Regarding external validity, the results can be generalized only to trainees with demographic characteristics similar to those of the participants. Ultimately, cross-validating the investigation with another sample of trainees is important. Furthermore, because we examined the supervisory

process from the trainee's perspective, ratings from other perspectives (observers or the supervisor) may have offered alternative results.

Future research is needed to replicate and extend the findings of this investigation. The following suggestions can guide researchers in these endeavors. First, to represent the supervision process more accurately, it seems important to investigate the components of supervision that distinguish it from counseling, namely, evaluation and involuntary participation. Second, we found high intercorrelations among the three scales of the WAI-T both at Time 1 and at Time 2. Further work is needed to determine whether or not the three factors in Bordin's theoretical model are independent. Third, it seems important to assess the influence of individuals other than the trainee's primary supervisor on changes in the trainee's self-efficacy expectancies. Fourth, the theoretical and practical limitations of using satisfaction as an outcome indicator must be considered (Borders, 1989; Holloway & Neufeldt, 1995). It is quite possible that effective supervision is not always the most satisfying supervision (i.e., the struggle inherent in learning may not always be experienced as the most satisfying). Thus, researchers may be wise to examine other relevant supervisory outcomes that do not solely rely on trainee self-report, such as trainee cognitive complexity (Blocher et al., 1985; Casey, 1992), multicultural competence (Lopez, 1997), and client–counselor interactions (Patton & Kivlighan, 1997). Finally, the use of analogue or quasi-experimental designs would allow researchers to control some of the validity threats described earlier (e.g., Sumerel & Borders, 1996). Taken together with the current study, these future investigations would provide more solid groundwork for determining the relevance of the supervisory working alliance to the supervision process.

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Needs and Preferred Style of Supervision Among Israeli School Counselors at Different Stages of Professional Development

Zipora Shechtman and Amira Wirzberger

The study aimed to identify differential needs for supervision and preferred roles and style of supervision among 202 Israeli school counselors with varied experience levels. Results of multivariate analysis of variance procedures indicated that counselors with 7 or fewer years of experience consistently expressed significantly higher needs on all but one of the items studied, compared with more experienced counselors and counselor supervisors. The counselor supervisors were also different from the more experienced counselors. By contrast, in respect of roles and style of supervision, there was more agreement across all 4 levels of experience; all counselors placed important values on the counseling, process, and personalization components, suggesting a basic need for growth-oriented supervision.

The growing number of tasks, responsibilities, and difficulties entailed in the work of school counselors has made supervision a critical factor (American School Counselor Association, 1993), yet there is hardly a systematic means available for providing such continued training (American Association for Counseling and Development: School Counseling Task Force, 1989; Crutchfield & Borders, 1997; Roberts & Borders, 1994). Moreover, there is empirical support for the desire of counselors to receive more supervision (Borders & Usher, 1992; Crutchfield & Borders, 1997; Roberts & Borders, 1994; Usher & Borders, 1993) of a developmental, system, or alternative type (Blocher, 1983; Borders & Dye, 1990; Holloway, 1995). In Israel, school counselors obtain supervision in a variety of forms: individual or small-group peer supervision for novices, training in developmental and prevention programs for all counselors, and professional training in supervision skills to advanced counselors. Nevertheless, all these school counselors expressed a desire to receive more systematic supervision on their work, as revealed in a recent survey (Hadari Research and Development, 1996).

The two basic tasks of supervisors are to decide what to address with the trainees and to find the most functional style to do so (Bernard, 1997). This study focused on the content and area of supervision requested, as well as the style or role of the supervision process preferred by the supervises. We investigated whether such needs varied with the counselor's level of experience in counseling and sought to identify the needs and the preferred roles of supervision that differentiated between counselors at different stages of their professional development.

NEEDS FOR SUPERVISION

Bernard and Goodyear (1992) suggested a broad working definition for psychotherapy or counseling supervision:

> An intervention that is provided by a senior member of a profession to a junior member or members of that profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the clients she, he, or they see(s), and serving as a gatekeeper for those who are to enter the particular profession. (p. 4)

This working definition seems to include the essentials of supervision: who is involved, how they are involved, and the purpose of their interaction (Watkins, 1997). The purpose of the interaction between the supervisor and the supervisee is to help the counselor to become better and more effective regarding conceptual ability, intervention, assessment, and implementation. Among the factors that compose and influence supervisory functioning are the assumptive world of the supervisor, his or her theory or model, supervisory style, roles and strategies, foci, format of supervision, and techniques (Watkins, 1997). Foci and roles of supervision are the two factors most relevant to the present study. Foci

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refer to the subjects or the processes that receive primary attention during the supervision session, and which we named "needs of supervision."

In the school counseling supervision literature, the factors of supervision were described, as early as the 1970s, in the Cube Model for school counselor tasks developed by Morril, Oetting, and Hurst (1974). The model included three dimensions of counselor intervention: the target (individual, groups, institution, and community), purpose (remediation, prevention, development), and method of intervention (direct services, consultation and training, and media).

A variety of political, social, educational, and professional developments have dramatically increased the school counselor's tasks in scope and nature. Consequently, needs of supervision have grown in new directions. Such changing needs have given rise to an expanded model (Crutchfield & Borders, 1997) that refers to job components specifically related to counselor tasks in today's schools. Following this approach, the present study uses four dimensions:

- Clientele (e.g., students, teachers, parents)
- Content of intervention (developmental and preventive programs regarding career education, classroom climate, treatment of abusive behavior)
- Modes of intervention (individual counseling, group counseling, consultation)
- Coping with conflicts (professional overlap, issues of resistance, ethical dilemmas)

We believe that the above needs might be better addressed if they are adjusted to the differential needs of the school counselors. We anticipated that the counselors would differ in the level and area of needs for supervision according to their level of professional development.

PREFERRED ROLES AND STYLE OF SUPERVISION

The Discrimination Model, developed by Bernard and Goodyear (1992), helps to identify the roles and styles of supervision that the supervisors use. The model, which is conceived to be atheoretical (Bernard, 1997), suggests three roles of supervision: counseling, consultation, and teaching; and three styles of functioning: process or intervention skills, conceptualization skills, and personalization skills.

The intervention skills range from the simple to the complex and include all trainee behaviors that distinguish counseling as a purposeful therapeutic interpersonal activity. Conceptualization skills include the trainee's ability to make sense of the information that the client presents, to identify themes, and to choose an appropriate response. Personalization skills include the counselor's personality, culture, and relations with others. The supervisor must also interact with the trainee in ways that are productive to learning and improving clinical skills. The supervisor may choose the teacher role to enhance knowledge or competence in a certain area of counseling. When the supervisor assumes the counselor role, he or she addresses the intrapersonal or interpersonal reality of the trainee. Finally, in the role of consultant, the supervisor becomes a resource for the trainee, while encouraging insight in the counselor about the client or the situation (Bernard, 1997). Such roles of supervision depend on variables related to the supervisee, the supervisor, and the interaction between the two. Attitudes, values, needs, professional background, and past experience of both supervisor and supervisee all affect this process. In addition, the supervision process takes place in different environments, each having a unique structure, organizational climate, norms, and ethics of behavior, which also affect the supervision process (Holloway, 1995).

Highly experienced supervisors are capable of adjusting the process to the unique needs of the supervisee (Borders, 1991; Borders & Leddick, 1987; Holloway, 1995). What has not been explored is the question of differential expectations of supervisee groups (i.e., school counselors) distinguished by their levels of counseling experience. The second research question therefore refers to the preferred roles and style of supervision for groups of school counselors who differ in their level of experience.

DEVELOPMENTAL THEORIES OF SUPERVISION

Developmental models in supervision advocate that supervisors match the structure and the style of supervision to the trainee's level of development (Holloway, 1995). In a comprehensive monograph, Loganbill, Hardy, and Delworth (1982) presented a developmental stage theory of supervision. Three specific stages have been proposed—*stagnation*, *confusion*, and *integration*—each having unique characteristics in respect to the supervisee's behavior and expectations of the supervisor. In the stagnation stage, the supervisee is unaware of his or her incompetence yet is dependent on the supervisor as the major source of knowledge. In the stage of confusion, the supervisee is fluctuating between feelings of failure and feelings of expertise, and, although difficult, it is perceived as the stage of growth. Finally, in the stage of integration, a new worldview becomes apparent, and a more realistic view of self and supervisor is established.

Several theoretical models describing change in trainees' needs during the course of training have been parallel developed. One of the more frequently tested is Stoltenberg's (1981) model, called the Counselor Complexity Model. It proposed that (a) counseling trainees develop in a predictable way over the course of graduate training and (b) counseling supervision environment should be adapted in ways that match the needs of the trainees. Stoltenberg suggested four levels of development:

Level 1: The supervisee is dependent, insecure, with limited insight, and highly motivated. A congruent supervisory environment primarily involves instruction, structure, and support.

Level 2: The supervisee is described as struggling between dependency and autonomy and is beginning to develop in-

sight. His or her congruent environment includes support and to a lesser degree structure and instruction.

Level 3: The supervisee has increased confidence and insight. A congruent supervision environment includes sharing and confrontation.

Level 4: The supervisee is essentially an independent practitioner with a secure professional identity, and supervision is consultive if it continues (Wiley & Ray, 1986).

Several studies tested the validity of this particular model, but the results are inconclusive. Reising and Daniels (1983) claimed to support the model, although they found that trainee characteristics discriminated among levels of experience, but supervisory needs did not. Miars and colleagues (1983) concluded that supervisors seem to provide different environments at different points in training, but that their supervision was much less differentiated than was the optimal training environment proposed by Stoltenberg (1981). Wiley and Ray's (1986) research results suggested that supervisors described themselves as providing different levels of supervision in accordance with the developmental supervision model, although significant differences existed only between Levels 1 and 4.

The literature review of the developmental approach to supervision concluded that counseling supervisees differ in their expectations of supervision according to their professional stage of development. For example, beginning counselors prefer a supervisor-teacher who focuses on specific counseling skills and techniques. Counselors at intermediate levels seek a supervisor-counselor who emphasizes self-awareness and relationship dynamics, and more advanced counselors seek out a supervisor-consultant who operates through a peer-like collegial relationship (Borders & Usher, 1992; Stoltenberg, McNeill, & Crethar, 1994; Usher & Borders, 1993). Heppner and Roehlke (1984) concluded their study stating that supervisees "seemed to evolve in a developmental progression from support/awareness/enhancement issues to more self-discovery, personality threatening types of issues" (p. 87).

Many of these studies were performed with students in training programs, the results of which may differ from those of on-the-job supervisees. The present study explored the needs of employed school counselors, with different levels of counseling experience, in Israel. Such studies, exploring developmental and cultural variables in counselor supervision, are now needed (Crutchfield & Borders, 1997).

We anticipated developmental differences in both components: needs for supervision and the preferred roles and style of supervision. The following hypotheses were established for the study:

- The more experience the school counselor has, the fewer the needs that will be expressed for supervision in all areas, and the areas of needs will differ in the four groups;
- The more experience the school counselor has, the less a need for structure in the supervision process will be expressed, and the preferred roles will differ in the four groups.

METHOD

Participants

Two hundred and two (53%) of the 382 school counselors employed in the northern region of Israel responded to our questionnaires. The ages of the 196 women and 6 men ranged between 23 and 65 years. Participants were classified into four categories:

1. Counselor supervisors, experienced counselors who had completed a 2-year training program in counseling supervision (n = 28, 88% of the 32 counselor supervisors in the total counselor population; age, M = 48.71, SD = 7.13; years of experience, M = 18.14, SD = 5.16).
2. More experienced counselors, with 8 or more years of experience (n = 90, 51% of the 175 more experienced counselors in the total counselor population; age, M = 48.18, SD = 6.22; years of experience, M = 14.89, SD = 5.72).
3. Less experienced counselors, with 3 to 7 years of counseling experience (n = 44, 38% of the 115 less experienced counselors in the total counselor population; age, M = 33.86, SD = 4.36; years of experience, M = 5.68, SD = 1.68).
4. Novices in counseling, employed in counseling positions for no more than 2 years (n = 40, 67% of the 60 novice counselors in the total counselor population; age, M = 28.90, SD = 3.93; years of experience, M = 1.45, SD = 0.50).

Instruments

Needs for supervision. The study used the Needs for Supervision Questionnaire, an expanded version of a questionnaire developed earlier by Wirzberger (1982, 1994). The 50 items were gleaned from long experience in counseling supervision, as well as literature in Israel and the United States (Gladding, 1988; Resh, Porat-Brynin, & Avi-Zur, 1989; Sadger 1987). Counselors were asked, "How much do you feel the need for supervision in the following areas?" Possible responses ranged from 1 = *very little* to 6 = *very much*. Four areas of needs were investigated: (1) clientele, (2) contents of intervention, (3) modes of intervention, and (4) coping with conflicts (seeTable 1 for individual items).

For this study, five professionals (two university professors and three counselor supervisors) were asked to classify 58 items into the four categories. They reached full agreement on the 50 items (see Table 1). Hence, face validity was confirmed by 85% agreement of all judges.

Preferred roles and style of supervision. The study used a revised version of the 41-item Counselor Evaluation of Supervision Questionnaire (Bernard & Goodyear, 1992), based on the Discrimination Model. The original instrument was narrowed down to 26 items as a result of a varimax

TABLE 1

Means and Standard Deviations for Each Item on the Needs for Supervision Questionnaire and Results of Multiple Analyses of Variance and Post Hoc Tests

Item	Group 1		Group 2		Group 3		Group 4		
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(3, 198)*
Clientele (A)									
A1. Students	1.39[a]	0.56	3.23[b]	0.79	4.07[c]	0.45	4.40[c]	0.49	138.81
A2. Administration	1.86[a]	0.89	2.69[b]	0.73	4.38[c]	0.49	4.12[c]	0.82	106.32
A3. Parents	2.43[a]	0.63	2.90[b]	1.02	4.79[c]	0.55	4.77[c]	0.42	107.53
A4. Helping professionals	1.71[a]	0.76	2.42[b]	1.02	4.27[c]	1.02	3.90[c]	1.01	61.21
A5. Teachers	3.25[a]	0.75	3.10[a]	0.73	4.79[b]	0.55	4.67[b]	0.47	98.12
A6. Peers	1.89[a]	0.31	1.76[a]	0.92	4.54[c]	0.50	3.50[b]	0.88	149.92
Contents of intervention (B)									
B1. Career education	1.68[a]	0.86	1.84[a]	1.10	3.64[b]	1.31	4.60[c]	1.05	74.51
B2. Classroom climate	2.07[a]	0.66	2.73[b]	1.11	4.09[c]	1.01	4.65[c]	1.19	51.41
B3. Learning improvement	2.39[a]	0.95	3.29[b]	1.08	4.45[c]	0.99	5.40[d]	0.84	66.08
B4. Abusive behavior	2.07[a]	1.18	2.94[b]	1.53	4.64[c]	0.99	4.20[c]	1.26	30.19
B5. Stress management	1.78[a]	0.87	2.19[a]	0.73	4.00[b]	1.05	3.80[b]	0.99	70.45
B6. Learning disabilities	2.43[a]	1.10	3.60[b]	1.29	4.18[c]	0.95	4.82[c]	1.19	24.96
B7. Sex education	1.46[a]	0.64	2.26[b]	1.29	3.36[c]	0.89	4.05[d]	1.22	39.57
B8. Suicide prevention	2.50[a]	1.45	3.71[b]	1.08	4.54[c]	1.09	5.10[c]	0.84	36.30
B9. Aggression prevention	2.61[a]	1.03	3.64[b]	1.56	4.36[c]	0.78	5.07[d]	0.83	25.89
B10. Child abuse	2.53[a]	1.43	3.53[b]	1.34	4.27[c]	0.97	4.92[c]	0.94	25.28
B11. Eating disorders	2.75[a]	1.32	3.82[b]	1.27	3.54[b]	0.99	4.52[c]	1.30	11.90
B12. Immigration	2.46[a]	1.20	2.49[a]	1.23	3.54[b]	0.90	4.40[c]	1.41	27.98
B13. Divorce in the family	1.96[a]	0.84	2.96[b]	1.31	4.09[c]	0.67	4.77[d]	1.35	43.01
B14. Exceptional children	2.11[a]	0.99	2.80[b]	1.33	3.73[c]	0.76	4.85[d]	1.21	41.16
B15. Military education	1.36[a]	0.62	2.72[b]	1.37	4.09[c]	1.39	5.05[d]	1.19	59.30
B16. Innovations in counseling	4.21[a]	1.22	4.44[a]	1.27	5.27[b]	0.62	5.50[b]	0.71	15.01
B17. Life skill techniques	3.03[a]	1.69	3.73[b]	1.27	5.45[c]	0.66	5.52[c]	0.75	48.33
Modes of intervention (C)									
C1. Individual counseling	1.25[a]	0.44	2.09[b]	1.09	4.27[c]	1.06	2.57[b]	1.34	56.78
C2. Group counseling	1.43[a]	0.50	2.54[b]	0.91	5.00[d]	0.74	4.42[c]	1.03	146.96
C3. Organizational counseling	1.28[a]	0.46	2.55[b]	1.14	4.63[c]	0.89	5.00[c]	1.04	119.13
C4. Team work	1.43[a]	0.63	2.06[b]	1.13	4.36[c]	0.99	4.30[c]	1.13	89.91
C5. Consultation	1.36[a]	0.49	2.23[b]	0.92	4.63[c]	1.08	4.60[c]	0.93	137.51
C6. Testing	2.10[a]	0.56	4.08[b]	1.37	5.00[c]	0.61	5.62[d]	0.70	72.37
C7. Counseling program development	1.18[a]	0.39	2.47[b]	1.16	4.73[c]	0.93	4.80[c]	1.18	110.43
C8. Program evaluation	1.86[a]	0.65	2.92[b]	1.39	4.91[c]	0.67	4.77[c]	0.89	72.30
C9. Counseling process evaluation	1.78[a]	0.68	3.08[b]	1.41	4.91[c]	0.52	5.25[c]	0.67	90.01
C10. Teacher guidance	1.39[a]	0.63	2.44[b]	1.08	5.18[c]	0.58	4.95[c]	0.71	190.36
C11. Parental guidance	1.25[a]	0.44	2.73[b]	1.03	5.09[c]	0.67	5.37[c]	0.67	213.42
Coping with conflicts (D)									
D1. Disagreement with administration	1.50[a]	0.51	2.21[b]	1.21	4.00[c]	0.96	4.37[c]	0.92	74.21
D2. Overlap with psychologist	1.32[a]	0.47	1.83[a]	0.97	3.18[b]	1.04	3.72[b]	1.17	54.70
D3. Teacher resistance	1.82[a]	0.72	2.24[a]	0.88	4.09[b]	1.09	4.92[c]	0.52	130.96
D4. Parent aggression	2.00[a]	0.72	2.89[b]	1.25	4.91[c]	0.67	5.22[c]	0.80	99.34
D5. Conflict with other counselors	1.18[a]	0.39	2.05[b]	1.31	3.54[c]	1.69	3.25[c]	1.46	24.94
D6. Overlap with educators	1.50[a]	0.51	2.21[b]	1.11	3.82[c]	1.04	3.60[c]	1.27	43.09
D7. Parent resistance	1.96[a]	0.64	2.43[a]	1.20	5.00[b]	0.43	5.10[b]	0.74	144.56
D8. Role conflict	1.61[a]	0.63	2.35[b]	1.09	3.82[c]	1.66	4.02[c]	1.18	36.58
D9. Interpersonal conflicts in faculty	1.64[a]	0.49	2.76[b]	1.21	4.54[c]	0.79	4.75[c]	0.74	90.35
D10. Teacher–administration conflict	1.93[a]	0.60	2.90[b]	1.20	4.91[c]	0.52	5.25[c]	0.59	123.70
D11. Student resistance	1.96[a]	0.69	2.98[b]	1.12	5.18[c]	0.72	5.17[c]	0.55	130.30
D12. Priorities in counselor roles	1.36[a]	0.49	2.45[b]	0.98	4.91[c]	0.29	5.15[c]	0.73	235.75
D13. Conflict with special education experts	1.00[a]	0.00	1.52[a]	0.71	3.27[b]	1.43	2.77[b]	1.31	47.01
D14. Conflict with out-of-school professionals	1.00[a]	0.00	1.63[b]	0.84	3.73[d]	1.67	2.60[c]	1.25	47.97
D15. Lack of professional assistance	2.03[a]	0.57	2.93[b]	1.42	4.82[c]	0.72	4.22[c]	0.57	54.87
D16. Ethical dilemmas	1.93[a]	0.90	2.58[b]	1.23	5.09[c]	0.67	5.20[c]	0.94	115.91

Note. Group 1 = counselor supervisors; Group 2 = more experienced; Group 3 = less experienced; Group 4 = novices. The superscripts a, b, c, and d, rank the means in order from low to high needs. The same letter represents means that are not different. The significant differences are represented by the letters as follows: a indicates a significant difference from all the groups; b indicates a significant difference from c and d; c indicates a significant difference from d.

*$p < .001$ for all variables.

rotated principal component analysis (n = 202, based on the study population); five components were identified: counseling, teaching, consultation, process, and personalization. Counselors were asked, "To what extent do the following statements apply to you?" Responses were given on a 5-point Likert-type scale (1 = *very little;* 5 = *very much*). The list of items, broken down into the five components, appears in Table 2. The loading of items on other factors did not warrant mentioning because of the nonexistence of substantial cross-loading. The sixth component of conceptualization did not show in the analysis.

RESULTS

Needs for Supervision

To differentiate the level of needs expressed by the four types of counselors, a multivariate analysis of variance (MANOVA) with type of group as between-variable and the components of needs as within-variables (4 × 4) was conducted. A significant multivariate effect was found, $F(12, 516) = 77.37$; $p < .001$). The univariate effect was significant for all four components (clientele, content of intervention, modes of intervention, and coping with conflict, respectively), Fs(3, 198) = 232.07, 267.04, 329.80, and 400.58; $p < .001$ for all.

To establish the differences between the types of counselors a post hoc analysis based on the Bonferroni procedure revealed the following differences. Regarding all four components, the counselor supervisors were significantly different from all the other three groups; the more experienced counselors were significantly different from the other two groups. However, the less experienced counselors were similar to the novices except for component B (content of intervention) on which the less experienced counselors were also significantly different from the novices (see Table 1).

Because each component contains items referring to unique information, we also looked at the differences among the groups on each item. Four separate MANOVAs on each component were used. The multivariate effects were again significant for all four components, despite the change in the *df:* $F(18, 546) = 47.00$; $F(51, 543) = 18.73$; $F(33, 555) = 27.71$; $F(48, 545) = 17.82$; $p < .001$ for all. The univariate effects were significant on all items in the four components (see Table 1). These results indicated the existence of a difference among the groups but did not tell us which groups differed from which. To establish the specific group differences, a post hoc analysis based on the Bonferroni pro-

TABLE 2

Counselor Evaluation of Supervision Questionnaire and Factor Analyses (n = 202)

Component/Item	Factor Load
Counseling	
1. Enables me to brainstorm solutions, responses and techniques that would be helpful in future counseling situations.	.72
2. Helps me feel at ease with the supervision process.	.65
3. Makes me feel accepted and respected as a person.	.65
4. Is flexible enough for me to be spontaneous and creative.	.64
5. Deals appropriately with the affect in my counseling sessions.	.60
6. Enables me to express opinions, questions, and concerns about my counseling.	.60
7. Enables me to become actively involved in the supervision process.	.45
Teaching	
8. Structures supervision appropriately.	.78
9. Helps me focus on new counseling strategies that I can use with my clients.	.62
10. Prepares me adequately for my next counseling session.	.61
11. Encourages me to conceptualize in new ways regarding my clients.	.58
12. Makes supervision a constructive learning process.	.55
13. Deals appropriately with the content in my counseling sessions.	.49
Consultation	
14. Helps me clarify my counseling objectives.	.71
15. Addresses issues relevant to my current concerns as a counselor.	.69
16. Focuses on the implications and consequences of specific behaviors in my counseling approach.	.68
17. Conveys competence.	.48
Process	
18. Provides suggestions for developing my counseling skills.	.76
19. Provides me with useful feedback regarding counseling behavior.	.64
20. Encourages me to use new and different techniques when appropriate.	.62
21. Provides me with opportunity to adequately discuss the major difficulties I face with my clients.	.61
22. Adequately emphasizes the development of my strengths and capabilities.	.53
Personalization	
23. Challenges me to accurately perceive the thoughts, feelings, and goals of my client and myself during counseling.	.77
24. Appropriately addresses interpersonal dynamics between self and counselor.	.72
25. Allows and encourages me to evaluate myself.	.69
26. Motivates me to assess my own counseling behavior.	.44

cedure was conducted. The counselor supervisors consistently expressed significantly lower needs of supervision than did the less experienced counselors and the novices. On most items they were also significantly lower than the more experienced counselors, except for the following: A5 (working with teachers) and A6 (working with peers); B1 (career education), B5 (stress management), B12 (working with immigrants) and B16 (innovations in counseling); and D2 (overlap with psychologist), D3 (teacher resistance), D7 (parent resistance), and D13 (conflict with special education experts). In sum, the counselor supervisors expressed a relatively low need in most areas of supervision, as expected. Only in a few items were they no different from the experienced group of counselors. Both groups actually expressed a relatively low need for supervision on most items. It is interesting to note the areas of need for supervision that they did mention: B16 (innovations in counseling) and B17 (life skill techniques). Supervisors shared these two needs with the more experienced group of counselors. The latter, however, expressed a relatively high number of needs (average score of 3.6) for supervision also in B6 (learning disabilities), B8 (suicide prevention), B9 (aggression prevention), B11 (eating disorders), and C6 (testing). These two groups consistently differed from the less experienced counselors and the novices on all items, except C1 (individual counseling) and B11 (eating disorders). Between the less experienced counselors and the novices the differences were quite narrow: the novices expressed more needs in the following areas: B1 (career education), B3 (learning improvement), B7 (sex education), B9 (aggression prevention, B11 (eating disorders), B12 (working with immigrants), B13 (divorce in the family), B14 (exceptional children), B15 (military education), C6 (testing), and D3 (teacher resistance). Only in A6 (working with peers), C1 (individual counseling), C2 (group counseling), and D14 (conflict with out-of-school professionals) did the novices express fewer needs than did the less experienced counselors. The highest number of needs (average score of 5 and above) for the less experienced group seemed to be in B16 (innovation in counseling), B17 (life skill techniques), C2 (group counseling), C6 (testing), C10 (teacher guidance), C11 (parent guidance), D4 (parent aggression), D11 (student resistance), and D16 (ethical dilemmas). For the novices, the highest number of needs (average score of 5 and above) appeared in the areas of B3 (learning improvement), B8 (suicide prevention), B9 (aggression prevention), B15 (military education), B16 (innovations in counseling), B17 (life skill techniques), C3 (organizational counseling), C6 (testing), C9 (counseling process evaluation), C11 (parental guidance), D4 (parent aggression), D7 (parent resistance), D10 (teacher-administration conflict), D11 (student resistance), D12 (priorities in counselor roles), and D16 (ethical dilemmas). (See Table 1.)

Preferred Roles/Style of Supervision

To test differences in the preferred style or roles of supervision, a MANOVA on the four groups (as between-variables) and the five roles as within-variables (4×5) was performed. Results of the MANOVA produced a significant multivariate effect, $F(15, 539) = 15.65$, $p < .001$). Only two significant univariate effects were found: in the roles of teaching and consultation (see Table 3).

A post hoc analysis indicated which groups differed from which: counselor supervisors were significantly lower on the teaching role and on consultation than were the other three groups. The more experienced counselors were sig-

TABLE 3

Means and Standard Deviations for Each Component by Level of Experience and Post Hoc Test

Item	Group 1	Group 2	Group 3	Group 4	*F*(3, 198)
Counseling					
M	4.16	4.12	4.01	3.93	2.20
SD	0.51	0.48	0.33	0.46	
Teaching					
M	3.60[a]	3.77[b]	4.25[c]	4.22[c]	66.69***
SD	0.41	0.25	0.14	0.24	
Consultation					
M	3.80[a]	4.09[b]	4.19[b]	4.26[b]	5.65***
SD	0.56	0.52	0.36	0.41	
Process					
M	3.88	3.89	4.04	4.01	1.01
SD	0.77	0.57	0.45	0.44	
Personalization					
M	3.82	3.97	4.03	3.82	2.21
SD	0.29	0.34	0.39	0.75	

Note. See Table 1 *Note*.
***$p < .001$.

nificantly different (lower) from the less experienced counselors and the novices only in teaching. On the other roles there were no differences among the groups.

DISCUSSION

Results of the analyses revealed, in general, three types of groups. The counselor supervisors seemed to be a unique group, the least in need of supervision overall. Supervisors expressed a need for supervision only in a few selected areas including working with teachers, innovations in counseling, and life skills, but even those were quite moderate. Similarly, the more experienced counselors generally showed moderate levels of need for supervision, although higher than that of the supervisors. They shared similar areas of needs with the counselor supervisors but also expressed a few additional needs. The two other groups, the less experienced counselors and the novices in counseling, were similar in their needs, and both expressed significantly higher needs in most areas of supervision than the above two groups (i.e., the more experienced counselors and the counselor supervisors). They differed clearly in the content of intervention, where the novices expressed more interest in supervision than the less experienced counselors on many items. These differences are in keeping with the developmental theories in counseling supervision (Borders & Usher, 1992; Holloway, 1995; Loganbill et al., 1982). Newcomers to the profession need more supervision in almost every area of their functioning and are also highly motivated, whereas the more experienced counselors feel more knowledgeable and confident and need less supervision (Stoltenberg, 1981). It is interesting that school counselors with several years of experience (i.e., less experienced counselor category) still need a lot of supervision, as also indicated in the Israeli survey (Hadari Research and Development, 1996) and in international publications (Crutchfield & Borders, 1997). The more experienced school counselors focus their interest on a few specific areas, and the counselor supervisors express needs for supervision only in areas that are new to them. Why do counseling supervisors, who are only a few years more experienced in counseling, demonstrate less need for supervision? Explanations may include their additional role as supervisors, their professional status, and their unique experiences in the 2-year training program. Their response may reflect high social desirability rather than a censure need; after all, it may be more difficult for them to admit to their need for supervision.

Note the areas in which all school counselors wished for supervision. Regarding clientele, the need for supervision was relatively high in working with teachers, even for the most experienced counselors, and to some extent it applied to working with parents as well. The need for help with teachers may be attributed to the growing diversity in education, which requires educational skills that many teachers do not possess and hence motivates many to turn to counselors for assistance. This in turn creates a greater need for supervision in this type of counseling. In addition, educational psychology has placed heavier responsibility on the family and parents for the difficulties that students display in school; some parents accept such responsibility and hence become more involved in the education of their children and require more guidance from the counselors. Such guidance services require skill on the part of the counselor. Often, the parents side with the child, which leads to resistance and conflict. The implication of these results is a clear need to provide guidance and supervision to all counselors in their work with parents and teachers. Actually, such needs should be addressed much earlier, and they receive more attention in the school counselor training programs in Israel.

The results regarding developmental and preventive programs provide information on which areas of supervision should be strengthened. Again, notwithstanding the overall higher need for supervision of the less experienced counselors, there are several areas in which the experienced counselors were also interested. The most salient was the wish to expand their knowledge of innovations in counseling shared by all four groups. Although this may indicate curiosity and a desire to obtain up-to-date knowledge, it may also imply a sense of difficulty or even disappointment with known methods and a search for new tools. With the growing diversity in education, counselors perhaps face many difficulties for which conventional methods may not be satisfactory. Another area in which even the more experienced counselors felt a need for supervision was learning disabilities. The inclusion or mainstreaming policies practiced now by law, and the general acknowledgment of learning disabilities, has created a situation in which more of these students learn in the regular classroom, making the teacher's role more difficult and requiring the expertise of counselors. The more experienced counselors were also interested in suicide prevention, a growing problem in Western societies, including Israel. Finally, eating disorders have been uncovered as a problem, and because this is a relatively new topic in Israel, it drew the interest of the more experienced counselors as well. All groups showed relatively low interest in supervision in sex education, which is probably the result of its being a long-practiced program in school counseling in Israel.

In general, the findings suggest that counselors thought they were relatively competent in areas that they were trained for and experienced in, which is expected. However, they also imply a need to constantly reevaluate counseling education programs, to ensure that they continue to answer the practical needs of the counselors and provide training based on social and educational developments. For instance, life skill training is an area of interest for all counselors, and indeed it is a growing program in Israel involving most school grades.

Regarding modes of interventions that counselors use, the least required area for supervision was individual counseling (only the less experienced counselors expressed a strong need for assistance in this area). This may be attributed to in-depth preparation and training for individual counseling, which may be at the expense of supervision in other

modes of counseling. It is interesting that one of the areas reported as most in need of supervision was testing in counseling. This is probably related to the clear-cut role of the school psychologist in testing; indeed, this role most sharply differentiates counselors and psychologists working in Israeli schools. The finding suggests that counselors have a need for some instruments or procedures that may help them get to know their clients better. Such developments have recently been published (Hood & Johnson, 1997). Finally, regarding coping with conflict, notwithstanding the overall higher need of novice counselors, it is interesting to note those areas that are of concern to all groups (differences between the groups were not as great as one would expect), namely issues of resistance—by parents, teachers, and students. Even the more experienced counselors, who presumably have more tools for coping relatively effectively with conflicts, expressed some difficulties in dealing with resistance. Resistance can be seen as the tendency to avoid dealing with pain and change, processes that require sophisticated methods of treatment (Gladding, 1988). Parents, in addition, accumulate many disappointments and disagreements with school, which are often expressed in the counseling session. Perhaps more can be done in counselor education and training in this respect, particularly in the area of conflict resolution skills and communication skills.

The second question of this study referred to the preferred style or roles of supervision. The overall finding is similarity between groups, in contrast to expectations. It seems that all supervision components were highly appreciated by all counselors. Only regarding teaching was there a significant difference between more experienced and less experienced and novice counselors: less experienced and novice counselors required more structured teaching, in keeping with results of previous theory and research (Borders & Leddick, 1987; Loganbill et al., 1982; Stoltenberg et al., 1994; Wiley & Ray, 1986). The counselor supervisors differed significantly from the rest of the groups regarding consultation, requiring less supervision of this style. This is incongruent with the literature suggesting that at Level 4 supervisees will be more interested in a consultive style (Stoltenberg, 1981). However, because this was characteristic only of the supervisors and not of the more experienced group of counselors, it may be attributed to the particular features of this group, whose members had undergone 2 years of a consultive style of training. It is particularly important to note that all groups appreciated counseling, process, and personalization, including novice counselors, in contrast to what has appeared in the literature (Heppner & Roehlke, 1984; Loganbill et al., 1982; Stoltenberg et al., 1994; Wiley & Ray, 1986). This may be because our study population was composed of professional counselors, as distinct from students in training programs. As professionals, even novices in counseling may appreciate more interactive processes, and even though they expect to be taught, they do not give up on the other styles. Hence, in providing supervision services to all level of counselors, all roles of supervision must be integrated regardless of the experience level of the counselors, but a less marked teaching style is more appropriate for the experienced counselors.

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

Three groups of school counselors appear that differed in their needs for supervision: counselor supervisors, experienced counselors with 8 or more years of experience, and other counselors with 7 years or less. There was also one difference among the three groups respecting the preferred roles and style of supervision: The less experienced and novice school counselors wanted the supervision to be more structured and teaching-oriented.

Identification of differential needs is important because it helps supervisors meet the needs of more counselors, which in turn increases their motivation to receive supervision (Holloway, 1995). It seems, then, that less experienced and novice counselors need more supervision on a variety of counseling issues and that at least part of that supervision should be provided in a didactic fashion. They are also the supervisees who are probably the most motivated to receive supervision (Stoltenberg, 1981). It is an unwise practice to invite experienced counselors too often for supervision on issues they already feel competent to handle within a heterogeneous group (in terms of experience) and in a teaching-oriented manner, because this may cause disappointment and frustration. Nonetheless, in some matters even the most experienced counselors (i.e., more experienced, supervisors, or both) are concerned about receiving supervision (e.g., innovations, testing), and they should not be overlooked.

Because the study was carried out in Israel, counselors' responses were probably colored by their unique training background, role concept, and the Israeli reality, which limits the generalization of the results. One variable that may particularly influence the results is the large number of female counselors in our sample. Nevertheless, this is a realistic representation of the school counselor population in Israel. Still, as mentioned earlier, research does suggest that experience affects needs for supervision; hence, our study strengthens previous knowledge.

Two limitations of the study warrant mentioning: (a) the lack of comprehensive psychometric properties of the Need for Supervision questionnaire, and (b) its self-report nature. More sophisticated instruments are definitely needed for future study, as well as multimethods of measurement. Although it is important to know what counselors' needs are from their own perspectives, it may also be helpful to gather information on the same questions from other professionals and compare perceptions of counselor needs for supervision. Despite these limitations, trends in needs for supervision clearly appear that are congruent with the developmental theories in counselor supervision.

Several implications arise from this study. First, because the changing roles of counselors affect their needs for supervision, it is crucial to constantly reevaluate this issue. Moreover, the constant growth of needs makes it particularly

important to identify and focus on the most significant ones. Finally, supervision should be offered to counselors in accordance with their needs and interests. For certain topics of general interest, all counselors may be grouped for enrichment programs, but for most of this service, supervision should be adjusted to the particular needs of each level of counselor experience.

Second, the similarity for all groups in the preferred components of supervision is striking. They all appreciated counseling, process, and personalization. Thus, although the less experienced and novice counselors needed more structured learning experiences to enhance their knowledge, all counselors preferred growth-oriented forms of supervision. This suggests that simply providing more learning experiences for less experienced and novice counselors would be a mistake. Their learning process should include all the roles and focus on process and growth, while directing supervision to the differential interests of specific groups. Such services may be provided partly in large groups, but to take advantage of all the supervisory roles, some supervision would have to be provided in small groups or in individual supervision.

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Perceptions of Chicano/Latino Students Who Have Dropped Out of School

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Chicano/Latino drop out was investigated in a qualitative study, conducting focus group interviews with Chicano/Latinos who had dropped out of high school. Participant responses revealed themes of alienation and discrimination in the school setting. The roles of school counselors as multicultural advocates and community-family-school liaisons are discussed.

American public schools are admitting and educating increasing numbers of minority students (De La Rosa & Maw, 1990). However, there is considerable evidence that the educational status of most of these minority group members is lower than that of their White peers (Arbona, 1989; Cummins, 1986; De La Rosa & Maw, 1990).

Specifically, the realities that Chicano/Latinos and other minorities face while in school or while preparing to enter the work environment (i.e., discrimination, undereducation, low expectations, and lower aspirations) may inhibit them from pursuing their vocational interests, which is necessary for equitable participation in the workforce (Arbona, 1990; Fouad, Cudeck, & Hansen, 1984; U.S. Department of Education [USDOE], 1995). This lower educational attainment creates an additional and, if nothing is done, almost insurmountable, barrier to equal participation of Chicano/Latinos in school and in the labor force (De La Rosa & Maw, 1990). The result may be a minority labor force faced with jobs that are incompatible with its members' interests and skills, and, therefore, a labor force with reduced efficiency, productivity, and quality (Offerman & Gowing, 1990).

Of the largest population groups, Chicano/Latinos represent the fastest growing segment of the school-age population. More Chicano/Latinos are of school age (5–19) than are non-Chicano/Latinos, and the percentage of students in elementary and secondary public schools who are Latino and Chicano has doubled in the last two decades (USDOE, 1995). Although both Chicano/Latinos and Whites have made significant educational progress, Chicano/Latinos continue to face serious difficulties in comparison to their majority culture peers (Arbona, 1989, 1990; Cummins, 1986; USDOE, 1995).

Chicano/Latinos are the most undereducated ethnic group in the United States; members of this group have a higher drop out rate and spend less time in school than do Asian Americans, Whites, and African Americans (De La Rosa & Maw, 1990). Fifty-five percent of Chicano/Latino, 18- to 24-year-olds have completed high school, well below the high school completion rate for Whites, 82% (De La Rosa & Maw, 1990). This seems to contradict the USDOE (1995) report that the 10th- to 12th-grade drop out rate for Chicano/Latinos has declined from 19% in 1982 to 12% in 1992. However, the high drop out rate before 10th grade and, to a lesser extent, the influx of recent immigrants who will likely never enter the public schools, suggest that the De La Rosa and Maw report is accurate in its estimates.

Conversely, another measure of school completion is status drop out, or the percentage of 16- to 24-year-olds without a high school or general equivalency diploma (GED; USDOE, 1995). Status drop out is differentiated from rate of drop out in 10th to 12th grade in that it is a cumulative rate that includes all dropouts, regardless of when they last attended school (USDOE, 1997). Status rates are important because they reveal the extent of the drop out problem in the population. For Chicano/Latinos this percentage has stayed the same since 1972, about 31%. When immigration status and length of residency are taken into account, Chicano/Latino status drop out rates are slightly more than double those of non-Chicano/Latinos (i.e, 24% of second generation Chicano/Latino vs. 11% non-Chicano/Latinos), suggesting that high, status drop-out rates may not be solely a function of recent immigration (USDOE, 1995).

It should come as no surprise, then, that Chicano/Latinos have the lowest school completion rate of any of the major population groups. The National Council of La Raza reported

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that in October 1988, 31% of Chicano/Latinos and 18% of African Americans ages 18 to 19 were dropouts (De La Rosa & Maw, 1990). The situation worsens for older Chicano/Latino students; 43% of Chicano/Latinos over the age of 19 do not have a high school diploma (De La Rosa & Maw, 1990).

Moreover, Chicano/Latinos spend less time in school overall, entering later and leaving earlier than their African American or White peers (De La Rosa & Maw, 1990). Even while enrolled, many Chicano/Latino students remain out of school because of increasing suspension rates. Note that the suspension rates for Whites are decreasing (De La Rosa & Maw, 1990). Researchers have suggested that a cultural mismatch between student and school may result in alienation or drop out from school (Pang & Barba, 1995; Trusty 1996).

BACKGROUND FOR THE CURRENT STUDY

From 1993 through 1994, Chicano/Latino students from Minnesota public schools had a drop out rate of 12%, almost four times higher than the corresponding overall drop out rate for all students of 3% (Minnesota Department of Children, Families & Learning, 1994). The Minnesota Spanish Speaking Affairs Council (SSAC) in collaboration with the governor's office issued a request for proposals to study Chicano/Latino dropout. In addition, the SSAC was concerned with the academic needs of migrant children whose families traveled to Minnesota from Texas and Mexico. The Chicano/Latino Learning Resource Center of the University of Minnesota was a successful bidder, with a two-part, qualitative/quantitative-based proposal.

Part 1 of the study, reported here, conducted a series of focus groups with Chicano/Latino students who had dropped out of school within the past 5 years. The purpose of these interviews was to elicit from the participants reasons why young Chicano/Latinos in Minnesota quit school, to compare these reasons with the results of similar studies conducted nationally. The purpose of Part 2 of the study was to develop a profile of the Chicano/Latino dropout that could be used in a survey of fifth and eighth-grade students (Davison Avilés, Guerrero, Howarth, & Thomas, 1997).

METHOD

Participants and Procedure

Participants in Phase 1 focus groups were Chicano/Latinos who dropped out of a Minnesota high school within 5 years before the study and were between the ages of 16 and 24. There were 33 female and 39 male participants (n = 72). Participants were from four urban and six rural school districts. The groups had up to 14 members; the average group had approximately 7 members. In addition, community members and leaders who assisted in recruiting dropouts were interviewed. Their comments are noted in the text.

Group members were recruited from Minnesota public school districts with the largest percentages of Chicano/Latino students. These districts (see Table 1) were identified using the Minnesota Department of Education's report on ethnic student enrollment. Districts with 100 or more Chicano/Latino students were chosen to participate in the study.

TABLE 1

Focus Group Participants

School District	Number of Chicano/Latino Participants	
	Women	Men
A	3	3
B	5	1
C		
Group 1	3	4
Group 2	3	4
D	2	5
E	7	10
F		
Group 1	5	2
Group 2	2	2
G	2	3
H	1	5

Note. Average group size = 7.20. Range = 14. Participant districts have been assigned alphabetical letters to preserve anonymity.

Focus group participants from urban and rural school districts (including Minneapolis and St. Paul) were recruited through contacts with community leaders and cooperative school personnel from rural school districts.

Discussions with school counselors in rural districts led researchers to employers and parents who in turn identified students who had dropped out. Interviews with community leaders in several rural areas, as well as the parent and school information, revealed that the food processing industry employed large numbers of Chicano/Latino workers. A bilingual research team member familiar with many of the rural areas in the study visited several food processing plants and, with the employer's assistance, identified and interviewed prospective participants. Approximately half of the food plant workers contacted eventually participated.

Participants were interviewed without regard to the district where they last attended school, although it had to be in Minnesota. Focus group participants were informed of the voluntary nature of the interview and consent was obtained from each participant.

Group Procedure

The purpose of the focus groups was to elicit from the participants some of the reasons why Chicano/Latinos in Minnesota quit school, to compare these reasons with the results of similar studies conducted nationally and to develop a profile of the Chicano/Latino dropout that could then be used to survey perceptions of fifth- and eighth-grade students.

Group facilitators were experienced bilingual counselors from the Chicano/Latino Learning Resource Center at the University of Minnesota, with at least a master's degree in counseling or a related field. Before holding the focus groups, a training session for facilitators was conducted by

consultants to the research team to ensure a similar procedure for each group.

Group interviews began with general open-ended questions about family and home environment. These questions were designed to establish rapport with participants and to encourage candid participation. Facilitators then guided discussion around the following three questions:

1. What were some reasons you dropped out of school?
2. What could have prevented you from dropping out?
3. What would you say to a brother, sister, relative, or friend who was considering quitting school?

These questions were chosen for their direct relationship to the topic of interest (i.e., Why Chicano/Latinos drop out). In a similar study, Marin (1995) conducted open-ended individual interviews with Puerto Rican students and noted that students who dropped out reported feeling alienated from school and being retained in earlier grades. However, Marin queried individual students and did not indicate whether students were directly asked why they dropped out.

Luzzo (1993), in studying ethnic differences in perceptions of barriers to career development, asked direct questions regarding barriers but used written questionnaires rather than interviews. The current study is unique in that both direct questions and group interviews were used. The combination of a group format and parsimonious questioning strategy allowed for interaction and processing among participants. The result was a transcribed database rich in personal insight and perceptions, which, later analyses revealed, closely paralleled outcomes of national quantitative studies.

The current data set was based on field observations taken from extensive group interactions with the participants. However, consistent with ethnographic, participant–observer techniques, there was no attempt to influence participants in any way (Dooley, 1995). The phenomenological reality of the participants' daily lives—their subjective view of their families, schools, and towns—provided a clear, firsthand view of why Chicano/Latino students drop out.

The focus group interviews were recorded on audiotape. Consent forms and tapes were secured in a locked file accessible only to research team personnel.

Data Analysis

Group tapes were transcribed twice, once each by two bilingual research assistants independent of each other. The two transcriptionists wrote a final transcript after reaching a consensus on its content. The process was time-consuming but ensured accuracy in meaning when participants spoke in Spanish or switched between Spanish and English. Transcripts were copied and disseminated to research team members. Themes were independently derived from group transcripts by each team member and then discussed by the research team. The aggregate themes were then discussed, and final themes were chosen by consensus.

The ethnic, academic, and gender diversity of the team allowed for analysis of focus group data from varying perspectives. Each theme identified by team members was written into an outline describing the discovery process that evolved during the focus groups. Note that although there was some variation in the aggregate themes, there was consensus on the final themes. Differential interpretations and perceptions by research team members of the participants' comments allowed for triangulation on certain themes. Accurate details or, conversely, mistaken understandings that might have eluded the scrutiny of a single observer, appeared in the confluence of diverse viewpoints. This advantage of qualitative design is well documented (Dooley, 1995; Morse & Field, 1995).

Groups were held in local community centers, community agencies, town halls, a school district office, and a community college. Holding the groups locally allowed group participants to become acquainted with research team members in a known environment. We assumed that collecting data in a more familiar setting reduced the disruption of the research intervention and encouraged participants to be candid and forthcoming with their ideas

RESULTS

Participant responses to why Chicano/Latino students drop out took the form of several themes that arose consistently across all groups. These group themes addressed problems in attendance, participation in school activities, alternative educational programs, expectations of teachers and staff, and personal situations such as pregnancy and perceptions of racism. Additional comments from community leaders or parents, or both, are also included in this section.

Group Themes

Attendance and credits. The majority of focus group participants reported that most of the Chicano/Latino students who drop out do so because of difficulty in obtaining the credits necessary for graduation. Insufficient credits were not reported to be a result of failing grades but a consequence of days missed from school, incomplete make-up work from days missed, and poor school–home communication.

Most respondents indicated several reasons for absenteeism, including migrant family travel, work schedules, and disinterest in course work. Some group members reported difficulties and misunderstandings when dealing with school policies on absenteeism. These difficulties took the form of what might be described as structural barriers in the schools that prevented them from meeting the needs of migrant or minority children.

For example, group members indicated that when they were reported missing (having missed 15 days of school without a legitimate excuse), they were confronted with a "bewildering", detailed account of prerequisites they needed to make up the days, to graduate, or both. The Chicano/Latino group members consistently reported losing credits for an entire trimester, semester, or school year, in a per-

ceived shuffle of regulations and lack of sensitivity to the particular needs of migrant or working students. Group members stated that if the school district had been more flexible in accommodating their work schedules (especially during fall harvest) that they would have stayed in school.

This theme is consistent with other reports that indicate that, as a group, Chicano/Latino students spend less time in school than do their African American or White peers by entering it later and leaving it earlier (De La Rosa & Maw, 1990; USDOE, 1995). Furthermore, Chicano/Latino and African American students nationwide earn fewer Carnegie units, a standard measure of high school credits earned, than do White students (De La Rosa & Maw, 1990).

These accounts imply that when confronted with graduation based on earned credits, many Chicano/Latino students feel graduation to be an impossible task. Group discussions suggested that the penalty for missed days became too weighty in the perception of the student. In the minds of the students, the choices were (a) retention in grade level, (b) face an insurmountable task in trying to make up lost time, or (c) to discontinue school all together. Many group members, perhaps because of their transient lives, did not seem to perceive the connection between graduation and consistently earning high school credits. Most students simply never faced the reality of a traditional 4 years of high school.

Chicano/Latino participants also indicated that the lack of communication between home and school generated a discrepancy in what the student and parent(s) understood to be a legitimate absence and what the school recorded as a legitimate absence. This is consistent with literature describing environmental barriers to effective transitions of immigrant and migrant students (Arredondo, 1984; Cardenas, Taylor, & Adleman, 1993).

Related discussion in the focus groups revealed that when absence was frequent, but not technically excessive enough to require the loss of the school year or part of it, completion of make-up work simultaneous with ongoing classes became a barrier to school completion. Students wanted to focus on the information needed to continue successfully in a class and were frustrated with having to produce missing assignments. Although motivation to stay in school fell as frustrations rose, group members were consistent in their answers to Question 3 regarding advice to sibling and peers: "stay in school."

Participants noted that changing their own motivations and a more flexible stance on the part of the school regarding work would have helped them stay in school. These findings are consistent with two studies describing cultural and cognitive flexibility as effective student responses to obstacles to school completion (Pang & Barba, 1995; Trusty, 1996). Overall, however, participants seemed to have little specific knowledge of how to affect the school system or how to stay in, reflecting the misunderstandings discussed above.

Participation in school activities. Reports suggested that there were perceived barriers to participation in school activities. The barriers were both economic and racial. The cost of participating in some activities or simply owning the "correct" clothes kept many individuals away from school activities and, in some cases, from regular school attendance. Other group members suggested that Chicano/Latino students were not encouraged, and very often discouraged, from participating in sports, dance line (i.e. a cocurricular after school activity involving physically demanding choreographed dance routines), and other extracurricular activities.

Audiotape transcripts also revealed that participants understood that engaging in school activities was an important motivating factor for remaining in school. In response to the discussion questions, focus group members advised siblings and peers to get involved, but at the same time voiced frustrations with the barriers described above. "Let us . . . [participate]" was a common refrain. It is known that extracurricular activities contribute to educational success and that Chicano/Latino students participate less than do other students in school-based extracurricular activities (De La Rosa & Maw, 1990).

Alternative programs. In the focus groups, respondents consistently referred to the "alternative school," an academic program, in general defined as the option offered to Chicano/Latino students who were migrants or special needs students who were required to "catch up in classes." Group members defined the alternative school variously according to their situation. Nevertheless, certain aspects in the definition were reported frequently.

The problem with alternative school participation, according to participants, was the perception that the program required the student to be self-directed, although the student wanted and needed direction from the school. This apparent educational mismatch was a recurring subtheme in many focus group discussions.

The respondents also perceived that the alternative school first removed students from the mainstream classroom and then failed to meet the needs of the students. The student was then directed to obtain a GED. At no time was there an expressed goal by school personnel to return students to the mainstream classroom and earn a diploma. Furthermore, De La Rosa and Maw (1990) reported that when compared with White students, Chicano/Latino students were underrepresented in gifted and talented classes and overrepresented in remedial (below grade level) math and science classes. The movement of Chicano/Latino students away from the mainstream and into alternative and remedial classes seems to be correlated with dropping out.

The following examples concerning alternative programs and Chicano/Latino students, although anecdotal in nature, are important pieces to the puzzle of Chicano/Latino dropout. The first example concerns a group participant placed in special education in the seventh grade. Through sixth grade, this Latina had participated in mainstream classes but dropped out when she was placed in special education classes. Her perception was that "school was hard and the teachers did not want to help." As in earlier examples of educational mismatches, the student was frustrated by placement in a program intended to help. Unanswered is the question of why this participant's needs were not recognized for 7 years. The high percentage of minority students

placed in remedial or special education programs makes suspect the placement of this individual and others like her in special education.

The second anecdotal example concerning alternative school programs occurred in a discussion with a community program worker. The worker was often called on to translate for students who were placed in the English as a Second Language (ESL) program in the school. On more than one occasion, the community worker noted placement of students in the ESL program who were fluent in English. Apparently, students were placed in the program on assumptions based on surname and physical appearance.

There is ample support in the literature for the efficacy of ESL programs (Cummins, 1986, 1989; De La Rosa & Maw, 1990; Ovando & Collier, 1998. However, when such programs are misunderstood and misused, the programs suffer in credibility and children receive inappropriate academic interventions. Once again, the process of matching the needs of Chicano/Latino students to school resources is ineffectual.

The third anecdotal example is taken from a community member who helped in recruiting dropouts. This person's children attended Minnesota schools, and his grandchildren are currently enrolled in the Minnesota school system. In this review, the respondent issued an articulate and passionate plea for the schools to stop placing "Mexican children" in special programs. His belief was that Mexican students have trouble as soon as they enter the educational system because "the school wants to place them in special programs."

The community member disapproved of special programs because the children were not comfortable and, in fact, embarrassed to be in special classes. He also stated that placement in special classes did not seem to address whatever problems the school believed would be solved by this placement, because these students continued to have problems in high school.

The firm belief of this community member was that if his children and grandchildren were to succeed in school, then they needed to be included in a "normal" classroom, surrounded by students from families with higher educational backgrounds. Inclusion has recently been debated as an educational practice (Barry, 1995). Early research in this area suggests that inclusive education has beneficial effects on the academic and social outcomes of special needs children (Baker, Wang, & Walberg, 1995). To the extent that Chicano/Latino students are overrepresented in special education, the words of this community member seem especially timely.

Expectations of teachers and staff. Participants reported that lower expectations for Chicano/Latino students by school staff and teachers resulted in lower graduation outcomes. As a general theme, many focus group members recalled principals, counselors, and teachers who revealed negative attitudes about them as students. For example, one group member described how teachers expressed surprise verbally and through facial expressions when a Chicano/Latino answered a question correctly in class. Other negative attitudes were reported as a matter of differential treatment by authority figures in the school. An example was given of how a hall monitor frequently questioned Chicano/Latino students but ignored other students.

These two perceptions seemed to come from respondents' impressions that, beginning in elementary school, Chicano/Latino students felt they were treated differently but did not know why. Some respondents reported perceiving differential treatment based on race. Most group members reported the impression of differential treatment but did not seem to associate this treatment with overt racism. They stated that they were not part of the in-group because they were Mexican.

Regardless of how the perception was reported by different focus groups, evidence pointed to marginalization as the core issue. Existing on the fringes of school participation, low expectations by teachers of Chicano/Latino students in the classroom and differential treatment by school authorities resulted in a focus of "not being good enough," regardless of the effort put forth by the Chicano/Latino student. This is consistent with Cummins (1986, 1989) assertion that educational reform has been unsuccessful because the inequitable power relationships between teachers and students and between schools and communities have remained essentially unchanged.

Facilitated out. Possibly the most important finding in this study was the view that Chicano/Latino students who left high school were not dropouts. Rather, group members consistently and distinctly reported what can best be described as being *facilitated out.* The combination of lowered teacher expectations and encouragement on the part of school personnel to opt out of mainstream education facilitated a steady exodus of Chicano/Latino students out of the school system.

Respondents also indicated that principals and counselors were direct in how they demonstrated lowered expectations for Chicano/Latino students. The most frequent response from focus groups was that they dropped out because principals and counselors "told me that I wouldn't graduate." In addition, expectations of failure from administrators began early in the educational career of Chicano/Latino students. At the elementary level, one participant reported that their expected failure began by the teacher "telling my parents I was a problem child."

The label of "problem child" escalated in later years into expectation of failure in two ways. First, respondents consistently reported differential discipline for Chicano/Latino students. One participant indicated that Chicano/Latino students were likely to be disciplined for infractions, which, when committed by Whites, were likely to be ignored. Further discussion on this topic revealed differential discipline and also that the problem child label continued for Chicano/Latino students into the middle and secondary school years.

Furthermore, De La Rosa and Maw (1990) reported that Chicano/Latino students are more likely to be suspended than are African American or White students. Consistent with reports from all of the focus groups, these authors indicated that suspension prohibits equitable participation in regular educational activities. As a result, suspended students fall behind in subjects and leave school.

The second expectation of failure, supported by principals and administrators, encouraged Chicano/Latino students to opt out of mainstream education in favor of alternative schools, GED programs, or Job Corps. Participants reported that, because the school failed to clearly communicate details of alternative programs, they (participants) did not always understand that these programs removed them completely from mainstream school and limited their educational futures.

The use of the term *facilitated out* is intentional in this situation and requires explanation because the definition is important to an understanding of a general theme in the focus groups. An assumption made by many educational researchers studying children who fail to earn a high school diploma is that the individual drops out of school. That is, in an epidemiological sense, the student's problems are seen as evidence of characteristics that the student brings to school and the student drops out because of these characteristics (Richardson, Casanova, Placier, & Guilfoyle, 1989).

However, many respondents revealed that, in one form or another, they were actually encouraged and facilitated to leave mainstream education. Recalling an earlier example of negative expectations persisting from elementary school to high school, it seems that negative expectations and subsequent facilitations are not defined by individuals but are intertwined with the school system itself.

A few people in the focus groups reported that they had dropped out of school even while they were receiving encouragement to remain. Although these individuals were few, there were reports of individual teachers helping students by providing them with extra materials and time. To be specific, one respondent seemed to have a personal relationship with her children's teacher, reflecting the beneficial effects of a positive home–school connection.

Along with feeling that direct actions facilitated them out of school, participants in the focus groups also reported feeling pressure in school because of stereotypes assigned to them by other students and teachers. Respondents indicated that other students and teachers expected them to act in particular ways. The assumption was that Chicano/Latino students would act in a bad or negative way, including using drugs, having fun as a primary purpose in life, being tough and fighting, and, finally, dropping out.

Pregnancy. Kirsch and Jungeblut's (1986) study on the Educational Testing Service (ETS) survey on literacy in America indicated that Chicano/Latinos were less likely than African Americans or Whites to report dropping out because of pregnancy. However, because the ETS study took the form of a survey, sociocultural values associated with pregnancy were not addressed and insight into Chicano/Latino teen pregnancy was lost.

Women in the focus groups, unlike those in the ETS survey, often reported dropping out of school because of pregnancy (one man reported dropping out to work to support a pregnant girlfriend). This could be accounted for by the smaller sample size of the focus groups or the areas in which the focus groups were located. Respondents who reported that they dropped out of school because they were pregnant were asked to elaborate.

Further queries regarding pregnancy revealed that pregnancy seemed to be a response to frustrations with school rather than simply the reason for dropping out. Many respondents reported getting pregnant and dropping out in the context of preexisting problems with the school. Group facilitator probes revealed that these Chicanas had "problems with other students" and were "getting into fights," stating that they "just didn't want to have any problems anymore."

Pregnancy seemed to be the vehicle these women used to escape a troubling and problematic school environment. Apparently, pregnancy was neither an accident nor the behavior of a promiscuous adolescent; it was, on some level of consciousness, a choice. In a related study, Merrick (1995) suggested that, for African American girls, adolescent childbearing may be a career choice consistent with a normative life path in African American culture.

Pregnancy before graduation weakened the already tenuous relationship between Chicana/Latinas and school. Respondents reported they would have completed school if there had been support for student mothers, and, in one case, for a student father. Group members specified daycare, parent education, and health education as possible areas of support. Because respondent mothers in every case requested support to return to or remain in school, the value of completing an education seemed apparent.

Community impact on persistence in education. The attitudes and perceptions of the community outside of the school were also reported to affect participation in school. Reports of negative community responses to Chicano/Latinos in the school took several forms. One of the most frequently addressed was the relationship between law enforcement officials and school administration. Several focus groups reported that law enforcement personnel and the school principal determined if and how students would continue in school before consulting students or parents. Focus groups also reported that principals called the police "in on fights" between White and Chicano/Latino students as early as elementary school. The fights were often initiated by racial name calling between students. Respondents indicated that the principal referred only the Chicano/Latino students to the police.

The perception of many respondents was that the community held the same stereotypical notions about Chicano/Latinos as did the school system. One group member stated that whenever Chicano/Latino youth gathered in public, regardless of the reason, the community and police saw it as troublemaking. When these students became parents, they saw and felt that their children faced the same racial discrimination they had faced. One group member reported taking her child to school and hearing another mother tell her son that the Mexicans in school were "spics."

Respondents indicated that negative perceptions of Chicano/Latinos in the school and community were exacerbated by the lack of Chicano/Latino personnel in the schools. This applied also to Chicano/Latino role models in

the community. A White community leader demonstrated a complacent attitude in the community regarding Chicano/Latino role models when he did not know that the one Chicano/Latino administrator who "addressed the needs of that group" had left the district several years earlier.

Therefore, the issue of differential treatment based on race asserted by group members may be because of a lack of community awareness that minority groups are not being represented. The interview just described was consistent with repeated group sentiments of alienation and discrimination, however unintended.

There are so few Chicano/Latino role models that when one appears a collective amnesia settles in and the needs of this minority community are forgotten or, even worse, seen as solved. In addition, because Chicano/Latino community members themselves are often educationally or economically marginalized, the path to becoming a role model is often blocked or too long to finish.

RECOMMENDATIONS

Recommendations from this study fell into three areas: (a) a recommendation to shift drop out paradigms, (b) direct recommendations from participants, and (c) recommendations based on group themes. In each of these areas, school counselors are in a unique position to help students use inherent cultural strengths and overcome barriers to academic success.

Paradigm Shift: From Epidemiology to Empowerment

Education researchers and writers (including those working in school districts) have typically used an epidemiological model to explain success and failure in school. In this model, education is the vaccine that will prevent or stop the disease of dropping out (Richardson et al., 1989). Associated with this model is the belief that the problem is inherent in the student. The student possesses demographic, socioeconomic, or behavioral characteristics that put her or him at risk for dropping out of school.

There are several problems with the epidemiological model of drop out risk. One major difficulty is that school or individuals can often do little to change such "predisposing" factors as minority status, poverty, gender, or language difference (nor, it will be argued, should individuals want to change certain factors).

In addition, Richardson et al. (1989) argued that using this model limits educators' and school counselors' options in dealing with the drop-out problem because in an epidemiological sense its cause is in the students, thus excluding schools and communities as possible areas for intervention. However, school counselors are uniquely positioned to address school–community issues in that they often are (or should be) designated home–school–community liaisons. School counselors as liaisons are not a new phenomenon and models exist to implement such programs (Atkinson & Juntunen, 1994). In addition to the counseling, consulting, and coordinating functions counselors typically undertake, the liaison role organizes home and community resources not usually found in traditional guidance programs.

An important function of the liaison role is that of cultural interpreter: the school counselor interprets the ethnic minority culture of the family to the school and larger community and also explains the school culture to the family. In addition, the school counselor may refer ethnic minority families to appropriate community institutions and agencies and, when needs are not met or injustices recognized, advocate for ethnic minority students and their families (Atkinson & Juntunen, 1994).

Finally (as noted in the focus groups), labeling minority children in the majority school setting as deprived or at risk often carries with it the possibility of greater damage to the child than do the events or circumstances that originally brought about the designation (Richardson et al., 1989). It is essential that counselors and educators understand that for many racial/ethnic minority children, the decision to remain in school or drop out is as much a function of social and cultural factors as of academic ones. Labels that stereotype may be misleading and obscure areas of cultural, social, and academic strength (Chodzinski, 1994).

Note, however, that even background characteristics differ in their impact, especially in the context of their combination with supposed risk factors. The epidemiological model seems to understate the risk for Hispanic students who, although they have proportionately fewer risk factors than do other culturally different students, have higher drop out rates than do their minority cohorts (De La Rosa & Maw, 1990). It seems that a simple linear combination of risk factors is not enough to account for the lowered educational attainment of Chicano/Latino students.

The key to improving the educational or occupational opportunities of minority students in general may lie in shifting from a deficit perspective to one of empowerment or bicultural competence in theory, research, and intervention (Cummins, 1986, 1989; Rotheram & Phinney, 1987). The central tenet in the empowerment model is that majority–minority societal group relations, school–minority community relations, and educator–minority student relations exert a major influence on school performance.

Consistent with this empowerment model, a more recent conceptualization regards "at risk" as an interactive construct that derives from the social-constructivist model of risk analysis (Richardson et al., 1989). According to this view, at-risk status may be seen as "a combination of personal and background characteristics of a child and the social and academic context of the school" (Richardson et al., 1989, p. 9).

School counselors play a crucial role in improving and sustaining majority–minority group relations as described by Cummins and others (Herring, 1997; Pedersen & Carey, 1994). In addition to acting as student advocates, counselors can improve their own multicultural competencies while acting as powerful change agents by engaging in mediation and consulting with other professionals in the school system. Learning and demonstrating knowledge and under-

standing of diverse cultures (including immigration and acculturation) and linguistic backgrounds makes the counselor more credible and accessible to Chicano/Latino and other culturally diverse students (Atkinson & Juntunen, 1994; González, 1997).

Recommendations From Participants

Focus group participants were consistent in their advice. These Chicano/Latino students, most of whom still wanted their GED, stated five ideas for change. Schools should

1. "[I]nclude Chicano/Latino history and culture in schools as something to take pride in."
2. Teach culturally diverse and inclusive history and treat all students the same (i.e., "Que nos traten igual que a como todos los tratan").
3. Encourage participation in sports and community (e.g., "Get involved in some sports sports . . . with the community . . . do something that builds yourself up").
4. Provide credible Chicano/Latino role models for students (e.g., "Somebody successful, if he [she] would come in and tell us his [her] story").
5. Hire Chicano/Latino teachers and teachers who care about all students (e.g., "Yeah, like I know there is something called *Stand and Deliver*, about a [Chicano] teacher . . . that really motivated me . . . he's really caring about his students").

The participants quoted above were chosen because their statements reflected the general attitude of most groups. The uncanny parallel between the participants' sentiments and recommendations made by experts in the field was not planned. The similarities are, once again, a powerful and insistent call to counselors, educators, communities, and families to go beyond awareness. It is time now to act and interact, to use the expertise held by persons on every side of the drop out issue.

A richly diverse group, Chicano/Latinos often share customs and values. In the context of reasoned generalization, and with the caveat that the wise school professional will avoid stereotyping, counselors need to learn about the values held by the various racial/ethnic groups that make up the Chicano/Latino population. Several authors have suggested that cultural values regarding respect, empathy, the importance of family and formal, traditional gender relationships often affect the relationships Chicano/Latino students have with the school (Herring, 1997; Pedersen & Carey, 1994; Sue, Ivey, & Pedersen, 1996).

Recommendations From Focus Groups

The focus group themes centered on three areas for change or improvement: (a) structural support, (b) school–home link, and (c) accountability of interventions with Chicano/Latino students.

Structural support. This is support in terms of the services and policies of the school district. Group members (and, indirectly, their parents) were often unsure of the attendance policies of their home schools. Clearer guidance by bilingual specialists, simplified procedures, bilingual forms, and increased flexibility of school attendance policies would be helpful.

For students who must work or follow their migrant families, flexible school hours (i.e., summer classes) would support academic persistence. In addition, simple, bilingual planning forms, supported by multiculturally trained, bilingual staff would help students and their families stay aware of credits needed to graduate. A note of caution should be made: *simplified* must not be interpreted as "special forms for simple people." School bureaucracy can be formidable and any attempts to clarify administrative procedures will no doubt be welcome by all.

Finally, structural support in terms of school-based day care and health and parent education for student parents were recurring concerns for focus group participants. Many women stated that they wanted to stay in school but could not because they had no one to help them as they started their new family. Parenthood should not determine educational acquisition.

School–home link. The recommendation to improve the school–home link arose out of the frequent miscommunications described by focus group members. The availability of a multiculturally sensitive, bilingual school counselor, home visitor, or social worker might help alleviate some of the large gaps in communication that seemed to be common for participants (currently, this link is a tenuous one). Extra care should be taken to avoid clashes or misunderstandings, particularly when discipline or law enforcement is involved.

Accountability in terms of outcomes of interventions with Chicano/Latino students. The following interventions with Chicano/Latino (or any minority) students should be carefully monitored: alternative programs, special education, and job programs that replace mainstream education. Job programs are especially important to consider because many Chicano/Latino students need to work to help support their family. If, for example, a job program helps Chicano/Latino students find work and provides an academic program resulting in a diploma, then it must be monitored for accountability in meeting stated goals.

There is a powerful message to schools, communities, and families on the need for wide sweeping changes in the academic and personal lives of Chicano/Latino children. De La Rosa and Maw (1990), in their report for the National Council of La Raza, stated:

> Without meaningful improvement in the education of Hispanics, individuals will be consigned to lives of low skills, minimal employment opportunities, limited participation in mainstream society, and continued poverty. Employers will lose potential productivity and international competitiveness, and society as a whole will pay the price of wasted human resources in increasing social welfare costs. (p. 3)

The connection between Chicano/Latino students' educational and career status and tomorrow's workforce is a direct one that will affect not only the opportunities for

minorities to participate more fully in the economic and educational mainstream of American society, but the well-being of the society in general.

CLOSING REMARKS

A limitation of the study was that even in consensus it was possible that biases were kept. For example, one of the most powerful themes that arose from the groups was that of being facilitated out of school. Perception of oppression in the schools may be more likely to be interpreted as a theme because of the teams' professional experiences with this phenomenon.

Other limitations are limited access to dropouts in the school districts studied, the possibility that gender effects in the mixed gender groups may have obscured the results, single session groups, and a lack of trust on the part of some participants. This last limitation is unlikely because of participant familiarity with team members. Nevertheless, it is possible that some members were distrustful of outsiders and that a single group intervention was not enough to overcome that distrust. Such possible limitations should be carefully considered by those interested in conducting similar types of studies.

A final note, several undergraduate and graduate assistants participated in this study, assisting in focus groups and providing office support for the study. All were student employees at the Chicano/Latino Learning Resource Center and all were Chicano/Latino. All of the graduate and undergraduate students participating in this research were funded by a grant from the Spanish Speaking Affairs Council of the State of Minnesota. Thus, indirect outcomes of this study were providing employment and valuable academic and research experience for several Chicano/Latino students. These types of experiences are important factors in retaining Chicano/Latinos in higher education and in subsequent graduate school applications of Chicano/Latino students (Davison Avilés, 1996).

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A Voice From the Trenches: A Reaction to Ivey and Ivey (1998)

J. Scott Hinkle

A reaction to Ivy and Ivy (1998) is offered by a counselor educator and practitioner. Mental disorders, diagnosis, the Diagnostic and Statistical Manual of Mental Disorders, *fourth edition (*DSM-IV; *American Psychiatric Association, 1994), and the medical model versus the developmental model are discussed in relation to counselor education and training, diagnostic bias, and the future identity of professional counselors.*

It is a pleasure to respond to Ivey and Ivey's (1998) article regarding the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition (*DSM-IV,* American Psychiatric Association, 1994), the medical model, and developmental counseling. I have divided my reaction into sections including a general reaction; mental disorders, diagnosis, and the *DSM* (used in this article to refer to the general nomenclature system as it has been developed in successive editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*); medical versus developmental models; diagnostic bias; counselor education; and final comments and suggestions.

A GENERAL REACTION TO IVEY AND IVEY

The counseling field is desperately in need of thought-provoking articles like that of Ivey and Ivey (1998). Not only does their writing stimulate us to think as a profession, they ask each of us to analyze what it is we do as counselors, supervisors, and educators. However, the Iveys' article has broader implications for our discipline. It represents a contribution to the profession that may be used by some counselors in helping people make changes in their lives, something we believe the counseling profession has demonstrated little accountability for, with most of the major theories emanating from psychiatry, psychology, and marriage and family therapy. Our profession, counseling, would be in a much better position today, both in the eyes of the public and other professional service providers, if more of us were thinking and sharing our thoughts as do Ivey and Ivey. Although I have objective criticisms of their propositions and some suggestions of my own, the Iveys have articulated a method for thinking about counseling that is distinct from that of other helping disciplines.

MENTAL DISORDERS, DIAGNOSIS, AND THE *DSM*

I have come to the conclusion after reading Ivey and Ivey's article that they are quite concerned about semantics, and I believe unnecessarily so. In all my years of counseling, teaching, and supervision, I have never referred to a client as *disordered,* nor have I referred to them as "being off the *developmental* track." Therefore, I would like to comment about the MD (mental disorders) word. First, it is important for counselors to use terminology used in the larger mental health system in order to be recognized as competent treatment providers. This recognition process (e.g., using *DSM* terminology) gives the counseling profession an avenue for demonstrating an ability to assist people with conditions referred to in the *DSM-IV*. Moreover, it is necessary to "speak the language" in order to have access to employment, reimbursement for services from managed care and insurance companies, and professional credibility.

Second, substance abuse and mental disorders, both of which are listed in the *DSM,* are major public health problems in the United States (Levin, Glasser, & Haffee, 1988) affecting about 45 million people. Employers have been

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spending up to 25 cents of every health care dollar on substance abuse and emotional and behavioral services, by far the fastest growing portion of health care expenditures in the United States (Manderscheid & Sonnenschein, 1992, 1996; Reiger et al., 1993). In 1990, these problems were estimated to have cost the United States $273 billion, including treatment, lost productivity, social welfare, and criminal justice, accounting for about 12% of our total national health care costs (Rice, Kelman, Miller, & Dunmeyer, 1990). Furthermore, the population with severe mental illness or disorders can be conservatively estimated to include between 4 and 5 million adult Americans, or approximately 3% of the adult population (this does not include the children and families directly involved). It is estimated that almost a quarter of a million of these people are homeless on any given day. Approximately one million are residents of nursing homes, while approximately 50,000 to 60,000 live in mental hospitals, and about 50,000 are inmates of prisons (Manderscheid & Rosenstein, 1992; National Institute of Mental Health, 1992; Strahan, 1990). Moreover, up to 30% of the general population in the United States are at a lifetime risk of developing a problem described in the *DSM* (Scottenfield, 1993). Unquestionably, these people are diagnosed and treated every day by a variety of professionals, including counselors.

The DSM *and the Diagnostic Process*

Counseling as a profession has experienced major expansions, from the traditional school setting into private practice, mental health agencies, and hospital settings (Dial et al., 1992; Gladding, 1992), necessitating that counselors report a *DSM* diagnosis for clients within the mental health system as well as with private insurers, managed care, or for clients participating in government programs. The foundation of effective counseling is the establishment of a valid diagnosis (Bihm & Leornard, 1992; Malgady, Rogler, & Costantino, 1987), including diagnoses listed in the *DSM*. As a result, there has been an increase in the number of graduate counseling programs requiring course work in abnormal behavior, psychopathology, and diagnosis (Cowger, Hinkle, DeRidder, & Erk, 1991; Hinkle, 1992). Furthermore, use of the *DSM-IV* (APA, 1994) has dramatically increased in counselor education training.

The *DSM* is not the only psychodiagnostic nomenclature in existence, but it is the most popular and is here to stay. Although Ivey and Ivey object to its terminology (e.g., "disorder"), counselors have used the *DSM* for years and will continue to do so (i.e., counselors have been working with people experiencing disorders described in the *DSM* for some time). For example, depression and anxiety are the most common clinical symptoms associated with presentation for counseling services. Furthermore, alcohol and drug issues among adults and adolescents are treated everyday by counselors in mental health clinics, colleges and universities, and public schools. Understanding a diagnosis and the various implications associated with it is imperative to the effective delivery of counseling services for people with problems found within the pages of the *DSM* (Hinkle, 1992).

Ninan (1990) has indicated that on a basic level, a diagnostic system should serve many functions. It should prevent confusion in communication about clients with the same constellation of symptoms within a framework of individual variations. It should help define a homogenous group of clients for clinical research studies. It should also classify a group of clients for the definition of treatment issues in a clinical setting as well as have some predictive capacity. Despite the limitations that Ivey and Ivey have pointed out, the *DSM* system meets these basic criteria and is currently the best system we have. Contrary to the Iveys' depiction, the counseling profession has clearly recognized the importance of the *DSM* system by including it in counselor education programs, certification and licensure examinations, and accreditation standards. Many graduate programs advise even school and college counseling majors to take a "*DSM* course."

The *DSM* has gained unexpected recognition over the past 18 years since it has evolved into an atheoretical and less biased classification system. The current *DSM*'s nonetiological and descriptive nature is purposefully intended not to alienate potential users with diverse theoretical orientations, including counselors (Eysenck, Wakefield, & Friedman, 1983). Although it has limitations, the *DSM* system has been a major facilitator of research efforts in numerous diagnostic and clinical areas that might have remained obscure if they had not been included in the *DSM* nomenclature (Kutchins & Kirk, 1989). For example, since 1980 the *DSM* nomenclature has been the catalyst for major theoretical, technical, and medical advances in treating various mood, anxiety, and personality disorders. All counselors, and clients, should be grateful for this.

Diagnosis and Children

It is my hope that school counselors will continue to be trained to use the *DSM* and not shun it as suggested by Ivey and Ivey. Educational estimates indicate that from 3% to 5% of all school children may have serious behavioral or emotional disorders that are described in the *DSM*, but fewer than 1% of children nationally are actually identified for special education purposes and treatment (Hinkle & Wells, 1995; Knitzer, Steinberg, & Fleisch, 1990). Recent findings have indicated that schools are major providers (50%) of counseling services for children with a *DSM* diagnosis (see Downing & Harrison, 1992). School counselors are assisting these children but need to do more in terms of identification (diagnosis) and intervention (counseling). Clearly, school counselors are in a unique position to identify students with significant mental health problems, and their understanding of the *DSM* can facilitate this. Furthermore, school counselors are finding it necessary to be familiar with diagnosis in order to communicate effectively with referral agencies, private practice counselors, school psychologists, special educators, and medical professionals

(Hohenshil, 1992). In fact, most of my child clients have been diagnosed by their school counselor before coming to my office, which facilitates their effective treatment.

Furthermore, Ivey and Ivey have mentioned attention deficit hyperactivty disorder (ADHD) but give no clear explanation for how their developmental model effectively treats this condition. Clearly, I do not see ADHD as an issue that is solely developmental; indeed, I see ADHD as a set of behaviors of which development is only a part. According to the Iveys' model, if it is not entirely developmental, school counselors would not be adequately trained to help children with this problem. If school counselors do not possess the vocabulary and skills to deal with children with issues that are not essentially developmental, then who needs school counselors (an issue that is being debated in many states)? Most teachers can lead "developmentally appropriate" classroom activities that cover "age appropriate" developmental issues. Trained school counselors can do, and are doing, more than this. What is a school counselor to do with an ADHD referral from a teacher? I hope they would not respond by saying, "I'm sorry, but this is not a developmental issue; therefore, I cannot help the child, or you."

Advantages and Disadvantages of the DSM

The *DSM* system has advantages and disadvantages. From a positive perspective, the *DSM* provides a common language among health service professionals for discussing client problems and increasing the understanding of psychopathology that can affect people as they develop. A *DSM* diagnosis assists with clinical accountability and treatment planning and identifies clients with issues beyond the counselor's area of expertise (Seligman, 1990).

Disadvantages of the *DSM* system may be noticed by some counselors when they read the manual and have the feeling that all human life is a form of mental illness. For instance, adolescence itself can be interpreted as a mental disorder in the *DSM-IV* if a teenager is oppositional and defiant. Other disadvantages include the promotion of a mechanistic or "cookbook" approach to diagnostic assessment, the false impression that the understanding of mental disorders is more advanced than is actually the case, an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in-depth understanding of the client's problems (Hinkle, 1992; Seligman, 1986; Williams, Spitzer, & Skodol, 1985, 1986), and the use of the *DSM* as a billing system for counseling services.

In addition, labels, including those in the *DSM*, may subject people to stigmatization or bias. In addition, the *DSM* may be inconsistently or unreliably used. It is helpful to remember, however, that medical diagnoses are unreliable in all health care fields. For example, when cause of death diagnoses are compared with autopsy results, accuracy varies from 45% to a high of 61%. However, validity is the critical issue here (Eysenck et al., 1983). The validity of a diagnosis as well as the efficacy of a counseling procedure can be increased by obtaining necessary information (interviewing) and organizing the information (diagnosis), leading to an effective method of helping people (counseling) (Shea, 1991).

As if the disadvantages regarding the *DSM* were not enough to distract us from identifying client problems, adequately defining what constitutes a mental disorder continues to be debated. Wakefield (1992) has argued that the *DSM* concept of mental disorder would better serve people if it were referred to as a *harmful dysfunction*. He bases this on the assumption that diagnosis may be used to control or stigmatize some behavior that is more socially undesirable than disordered (see Eysenck et al., 1983). This may be a reasonable name change. Call it what we may, my adolescent client with a terrible fear of being left alone is still *phobic*, or *distressed*, or *incapacitated*, or experiencing a *harmful dysfunction*, or even a *mental disorder*. It is difficult at times to establish an arbitrary level at which "normal" ends and "disorder" begins (Caine, 1993). The critical issue for me is the notion that "not normal" does exist, can be extremely distressful, and can greatly interfere with development over the life span. Counselors cannot avoid or ignore such divergence from a development path.

Use of the DSM

As an initial step in counseling, diagnosis becomes an ongoing, dynamic process that generates working hypotheses and should never be a static event. In other words, appropriate use of the *DSM* should enhance the developmental process of building diagnostic data. It is essential that diagnosis be understood and taught as a process and as an integral part of effective counseling (Fong, 1993, 1995). Of the human service providers available in our country, I can think of one group of practitioners who are very effective at such a process—counselors. I supervise counselors every week who make accurate diagnoses and provide effective treatment for their clients (many of whom have *DSM* diagnoses), and all of these students have had a course in human development and in the *DSM*.

Many counselors, counselor educators, and supervisors believe that the *DSM* rigidly follows the so-called medical model, even though the majority of the disorders listed in the *DSM* are not attributable to known or presumed organic causes (Sue, Sue, & Sue, 1990). Another troubling aspect of using the *DSM* for some counselors is that they believe counselors should follow a developmental model (e.g., Ivey & Ivy, 1998) and not diagnose and treat pathology (Hohenshil, 1992, 1993). Some of these individuals also believe that the use of a *DSM* diagnosis contradicts other counseling models, especially the psychodynamic, humanistic, and family systems approaches (Denton, 1990). Yet other counseling professionals contend that labels cause the dehumanization of clients, which may lead counselors to devalue clients, discredit their concerns, and disengage from authentic interaction (Benson, Long, & Sporakowski, 1992; Ginter, 1989; Hohenshil, 1992). It is important not to misuse the construct of *mental disorder* or misuse the

term. All of these concerns are especially troubling if there is a lack of evidence that a diagnosis is useful to create a prognosis, select treatment, or influence outcome in the first place. I applaud the Iveys for stimulating me to condense these limitations for reflection.

THE MEDICAL MODEL VERSUS THE DEVELOPMENTAL MODEL

The Medical Model

It is interesting that about half of all individuals with *DSM* diagnosable problems are treated by primary care physicians, a fourth by nonmedical professionals (including counselors), and another fourth go untreated (Maxmen & Ward, 1995). Medical settings are the second most frequent service location providing services for children at risk for behavioral and emotional problems (Leaf, 1993). Among the 700,000 persons with severe mental health problems who have never seen a mental health professional, about two thirds have seen a doctor or other health professional for a *DSM* disorder (see Manderscheid & Sonnenschein, 1992, 1994, 1996). Thus, primary care physicians are an essential part of the mental health service system for people with mental and emotional problems and are often the only source of health care of any kind (see Manderscheid & Sonnenschein, 1992, 1994, 1996).

Unfortunately 50% to 80% of the "disorders" in the *DSM* go undetected during primary care visits due to a variety of patient, doctor, and system factors (Miranda & Munoz, 1994). Furthermore, "counseling and psychotherapy" in primary care settings have received little attention, although medical providers report counseling most of their patients with mental disorders (Cawley, 1994). Thus, many people who need counseling visit a doctor rather than a counselor. Although doctors miss many of the "counseling" issues, my assumption is that some doctors have a positive effect on their "clients." Rather than deny or defy their training, it may behoove our potential clientele, and our profession, to collaborate with physicians rather than complain about their science.

Unfortunately, the literature on coordination of services with medical providers is extremely limited and suggests little about how this might affect outcomes. It is quite likely that many individuals would benefit from counselors coordinating care with physicians. It would benefit counselors to improve relationships with primary care providers. For example, counselors are rarely the only professionals working with clients experiencing bipolar symptoms (i.e., vacillating mania and depression) and are usually one of several helping professionals involved in successful treatment (Withrow & Hinkle, 1990). Counselors need to realize that working interprofessionally is essential to effective treatment. If counselors are not a part of the "team," our clients can be shortchanged on services they deserve.

Mental disorders according to the medical model describe disease processes, not people. Ivey and Ivey are on to something: The *DSM-IV* does follow a medical model—if you are a medical practitioner. If you are a counselor, the *DSM* may not be a manual of diseases, but simply a description of harmful behaviors, dysfunctions, mental disorders, developmental roadblocks, or whatever one chooses to call them. The *DSM* does not recommend the prescription of medication or hooking clients up to electrodes, or any other treatment method for that matter. The *DSM* is a descriptive nomenclature derived from accumulated studies and clinical anecdotes regarding classes of people who seem to have a great deal in common, including symptoms, signs, and life course (Morrison, 1995). Furthermore, expert opinion used in the developmental process of the *DSM* comes from medical and nonmedical professionals. The fact that the *DSM* is now in the fourth revision indicates that it is a dynamic document growing with input from various practitioners—just as developmental theories have grown over the years. The counselor's role, after establishing a diagnosis, is to do counseling—to help people make desired changes or obtain needed outcomes. Ivey and Ivey stated that the *DSM-IV* only leaves you with a diagnosis, and they are correct. Diagnosis is the *DSM*'s intent. It is not a treatment manual; it actually refrains from suggesting treatments—*that is the counselor's task*. The *DSM* is not based on an evaluating or valuing structure. The only value-assigning factor related to the diagnostic process is the people who use it. If Ivey and Ivey perceive the *DSM* as problematic in that it fuels stigmatization, they should address the counselors who stigmatize their clients. The *DSM* is only a system for diagnosis; the people who assign a value to diagnosis are the problem.

Standards of care or treatment delineate the minimum professional performance expected in relation to a particular problem (Beamish, Granello, Granello, McSteen, & Stone, 1997), but there are few standards of care developed for the counseling profession (Granello & Witmer, 1996). Although establishing standards of care within the counseling profession is a frustrating, confusing, and controversial task (Ferran, 1992), a few procedures would be applicable to "a list of standards." (For instance, counselors' ability to generate hypotheses about their cases cannot be ignored. Gathering information from multiple sources including skillful clinical interviewing and the subsequent formulation of an accurate diagnosis would be a good place to start.) Furthermore, diagnosis and identifying problems that include medical issues were among major work behaviors reported by mental health counselors in a recent national survey (National Board for Certified Counselors, 1996).

Ivey and Ivey have reported that personality styles are adaptive attempts to find a way to operate within a complex and confusing world. I think many counselors would agree. But diagnosing a child with ADHD (not a personality style, by the way) does not necessitate medication therapy. In fact, I hope most counselors do not have the same position regarding ADHD as the Iveys express. I personally prefer every treatment alternative to medication (often using parent training, behavior modification, and classroom management quite successfully) and resort to

medication consultation with a physician if these methods have limited efficacy.

I believe a major shortcoming of Ivey and Ivey's presentation of their theory is their use of medical, Freudian, and *DSM* terminology to describe their own theory (e.g., *Axis I*, *defense mechanisms*, *unconscious*). Their presentation may not be that much at odds with the *DSM* and their so-called medical model because they support their theory by labeling human problems as "Axis I" or "Axis II," or "Axis I as the result of Axis II." The fact that they use this terminology to explain their theory offers little credibility or support for their ideas. If the Iveys believe that dropping the term *disorder* will enhance the practice and expansion of counseling, just drop it from the vocabulary and let us move on to matters that are more pressing for counseling as a profession.

The Iveys have suggested that Axis I diagnoses are the result of Axis II personality style failure (this certainly does not sound very positive). I do not understand how mental retardation, schizophrenia, learning disorders, autism, cognitive disorders, and posttraumatic stress disorder (PTSD) are the result of characterological failure. Moreover, it is unfortunate that Ivey and Ivey are not more successful in treating individuals with personality "style" problems. My students are taught effective skills for establishing treatment plans for all their clients; furthermore, we never use the labels Axis I and Axis II to define our clients. They are simply "a person with a depressive episode" or "a person with a dependent personality." Furthermore, the Iveys suggested that we respect and honor our clients with personality disorders because their personality has a survival function. But, how does the personality "style" labeled "antisocial" (e.g., murderer) have a positive, survival function that counselors need to "respect and honor"?

In summary, the medical model should not be a problem for counselors. The medical model belongs to physicians and nurses. If you are a counselor who does not want to use the *DSM*, then do not. But if you choose not to, then you should design another method for identifying client issues, prognosticating accurately, initiating accountable care, as well as refrain from complaining about not receiving third party reimbursements.

The Developmental Model

The developmental model posited by the Iveys is where I take the most discerning look at their approach to counseling. "Developmental thinking" has a long history and is shared by practitioners from various helping disciplines (e.g., developmental psychology). When all the initial theorizing is completed, and in some cases when developmental theory is the major contribution to the case, the counselor still has to do something (i.e., counseling), and few of us are paid to do something else (i.e., development). A method for integrating "development" into an environment that uses *DSM* terminology to communicate is to conceptualize the *DSM* from a developmental perspective. In fact, the format of the *DSM* is developmental (e.g., sections on infant, childhood, adolescent, adult, and older adult disorders). Excluding counselors from this portion of the mental health care professions would be detrimental to the future of counseling.

I believe that Ivey and Ivey's pathological versus developmental framework is an effort to solve the problem of how to define counseling as unique and credible. The more appropriate framework is that counseling is unique by virtue of the term itself—*counseling*. Counselors are different from other helping professionals because we focus on the art and science of connecting and bonding with individuals, families, and groups and "sharing the reality of their human experience," whatever that reality may be, and help them find ways to change. When all this fuss about development is over, maybe we can fall back on counseling. This development versus pathology debate will get the counseling profession nowhere. Counseling's credibility will lie in the ability to meet people where they are and diagnose their problem, whether it is career indecision, addiction, inadequate parenting, borderline personality, ADHD, or anything else for which a client may need our help. Then, using developmental theory as one of many theoretical constructs, we can treat, guide, facilitate, and help clients find better ways of functioning.

It used to be that the easiest way to practice was to view all clients and all problems as essentially similar and to apply a standard counseling approach. This strategy advocates the "one size fits all" approach to counseling. Some counselors continue to use this approach with a developmental model as their chosen approach. In the past, when only a limited number of treatment strategies were available and little literature about treatment selection and tailoring treatment was known, this strategy was defensible. However, this view is no longer theoretically or economically sound or useful (Carlson, Hinkle, & Sperry, 1993). It is important to remember that no single approach is superior to another, but neither are all treatments equally effective or equally ineffective (Hester & Miller, 1985).

Ivey and Ivey have indicated that some counselor educators prefer to define counseling as serving normal individuals with developmental issues. I believe that this definition of counseling would be adequate for those individuals who only work with "normal" people and, therefore, choose to use only a developmental model. The Iveys have surmised that this puts American Counseling Association (ACA) members in a quandary regarding the health care marketplace—and they are right. One way to escape this dilemma is for these individuals to focus on normal individuals with "developmental issues" and leave the counseling concerning "the other people" to counselors who recognize the value of the *DSM*. (I and my counselor colleagues have written numerous articles about effective counseling with avoidant personality disorder, Alzheimer's disease, bipolar disorder, encopresis, conduct disorder, and other disorders listed in the *DSM* in an attempt to assist counselors with treatment; e.g., Hinkle, 1990.)

One major theme of Ivey and Ivey that I oppose is the focus on a "counseling and development debate." I believe that counseling is just that—counseling. Defining counseling only in terms of development does not tell one very

much. Are psychologists and social workers not interested in enhancing individual and social development? Are marriage and family therapists and psychiatrists not concerned with the development of their clients and patients?

Differentiating counseling from other helping disciplines using only the developmental variable will end in argument and disbelief. Practicing counselors are concerned about pathology, but not from a myopic perspective. People develop difficulties (and in many cases pathology) at various times during their developmental life span (Hinkle & Kline, 1996). Effectively dealing with pathology does not preclude using a developmental framework. Furthermore, an understanding of the developmental course of numerous disorders is an important aspect of prevention, accurate diagnosis, and treatment. An orientation of counselors only to development, as opposed to including pathology (Brown & Srebalus, 1988), does not enable counselors to effectively deal with the burgeoning mental health concerns of our society. Surely counseling has a rich perspective to offer, and it needs to be reflected in our counselor training, practice, and literature.

Development in and of itself is a good idea, but few counselors are paid to do it (by out-of-pocket payment or insurance reimbursement). This does not mean that development is not important and should not be included in the conceptualization of treatment planning and counseling. For example, sharing a parenting technique with a family that already has significant problems (e.g., ADHD) may prevent the development of a future problem, for example conduct disorder, dropping out of school, or career problems (Hinkle & Kline, 1996). This example uses a developmental theme, but the counseling may focus on parent training, behavior management, learning to use good judgment, career development, as well as possible medical and school consultation.

To further illustrate my concern with Ivey and Ivey's article, I believe that the development versus remediation debate is not a theoretical argument but an artifact of human nature (there are times in almost everyone's life when remediation, or "clinical" counseling, may be needed). Furthermore, problems of a human nature exist within a multicontextual format that may be clearly developmental in nature, or require a remediation focus (i.e., construction, deconstruction, reconstruction; Steenbarger & LeClair, 1995). People develop difficulties (and in many cases pathology) at various times across the life span. As a result, interdisciplinary practices (e.g., counseling, medicine, and diagnosis) are often necessary. Social context is critical to diagnosis and treatment, as Ivey and Ivey have pointed out. However, some endogenous depressions are fueled by biological factors that not even our best research minds understand fully at this time. Although the *DSM* is largely idiosyncratic, the multiaxial system allows for medical/biological conditions and social/environmental diagnosis.

It seems that labels are all right with Ivey and Ivey if their meaning is discussed with the client. I hope that we are all doing this, regardless of whether the label comes from the *DSM* or elsewhere. Ivey and Ivey have proposed that counselors transcend pathology. Have physicians transcended the common cold? I recommend that we focus transcendence on moving to a place where counselors are considered viable treatment providers for people with difficulties in living, regardless of the problem's label. If a psychiatrist refers a "patient" to me and calls the problem "paranoia," I can counsel the client just as well if the diagnosis is labeled as "experiencing a developmental conflict within the context of the environment that is perceived to be attempting to poison his or her food." Moreover, I do not understand what I perceive to be contradictions in Ivey and Ivey's presentation. For instance, *DSM* labels are referred to as both negative and useful. Ivey and Ivey (1998) suggested that personality disorders are merely "styles," (p. 338) and then referred to one of the styles as "paranoid" (p. 338; a label in the *DSM*). I believe that bipolar symptoms, schizophrenia, transexualism, or Alzheimer's disease are something more than simply developmental *distress*. Furthermore, to my knowledge, referring to a client's "distress" as "depression" has never "victimized" a client that I have worked with. Rather, many such clients have been relieved when I have made an accurate diagnosis and provided effective treatment.

Ivey and Ivey have inferred that the counselor's task is to unravel the developmental history and logic underlying personality style. Although this may be needed for some client situations, it is a global counseling task that I would not encourage. Unraveling developmental history in many cases is not necessary or warranted. I cannot imagine a group counselor successfully unraveling developmental history without the group "coming apart at the seams." However, I do agree with the Iveys that change is needed. I recently treated a fourth grader who was "experiencing distress regarding his assigned daily context" (he refused to go to school). I saw him and his family four times with 100% success (he went back to school). I did not unravel one thread of developmental history, but I did ask his father to take him to school rather than his mother. Rather than relying on a developmental history, I will simply take my counseling lead from the client. (In this case the student needed to engage his father and disengage from his mother.)

Many of Ivey and Ivey's developmental assumptions about helping are quite basic and shared by a variety of helping professionals (e.g., working with clients where they are, considering developmental history). For this reason, in reaction to the Iveys, I do not see their theory as controversial at all. It seems to be an amalgamation of common sense about helping people, which *is* a contribution to counseling theory. I see many aspects of their "theory" as a summary of particular aspects of counseling. The Iveys' theory, however, allows for little introspection and illumination—it would be beneficial if Ivey and Ivey would expand their ideas to incorporate concrete methods for becoming more effective change agents.

A NOTE ON COUNSELOR EDUCATION

Counselor education training needs to ensure that students are adequately prepared to meet the needs of the individuals they serve, including people with problems that are diagnosed using the *DSM* (Hinkle & Kline, 1996). On one hand,

I support Ivey and Ivey's ideas; our students should integrate developmental information, as well as other important information, in the classroom and at their internships. However, an analysis of my own department's training of doctoral students revealed that 97% have been supervised at their internships by practitioners with degrees other than counseling (i.e., psychiatry and psychology). My hunch is that our program is not that much different from others in this respect. If the Ivey's are concerned about developmental counselor training and the lack of development practiced by other professionals, I would encourage them to lead the charge to change the practice of our students being supervised by professionals who are not consistent with the Iveys' philosophy. On the other hand, I respectfully suggest that the reasons for allowing our students to be supervised by other professionals is twofold. First, they receive good supervision from other professionals who also have an understanding of human development but are not consumed by it. This also contributes to counseling being a part of the mental health system mainstream. Being regarded as a key part of the mental health service "team" assists counselors with making a positive impact rather than excluding ourselves from the network. Second, there are few doctoral-level counselors in practice to provide supervision (which could also be interpreted as perpetuating a second-class citizenship for counselors within the helping professions).

To be comprehensive about a developmental method associated with helping others, counselor education needs to take a close look at what trainees are taught and how they are supervised. Educational programs that educate and train "professional helpers" (e.g., psychiatrists, psychologists, social workers, psychiatric nurses, marriage and family therapists, and counselors) with the most current knowledge regarding behavioral and emotional problems and effective interventions are likely to determine how mental health care will be delivered in the next century (Dial et al., 1992). It is imperative for counseling as a profession to be a part of this process. Continuing to be caught up in a development versus "everything else" debate will add to counseling's lack of credibility.

The *DSM-IV* is atheoretical and utilitarian to the extent that it attempts to meet the diagnostic needs of all professionals regardless of disciplines. However, most of the definitive professional literature regarding diagnosis and the *DSM* is provided by psychiatry and psychology, although counselor educators do provide some information to the literature regarding treating mental disorders. Counselor educators need to critically examine their knowledge and use of the *DSM*, in general, and its social, political, and economic value and limitations, more specifically. Contributing to this literature from one perspective or another will be healthy for our profession. Ivey and Ivey have begun a debate that can do nothing but good for counseling, and ultimately for our clients.

BIAS AND THE *DSM*

Some of Ivey and Ivey's comments referring to bias and use of the *DSM* make sense to me. Clearly, the less information a counselor knows regarding a client's culture, the more opportunity for diagnostic error (Hinkle, 1994). An accurate diagnosis depends on cultural and linguistic sensitivity (Malgady et al., 1987), and counselors using *DSM* diagnoses may wield considerable power regarding decisions about people. For example, clients of lower socioeconomic class may experience, define, and manifest problems of living differently from people with economic means and social status, requiring great sensitivity when making a diagnosis. The Iveys are correct: The *DSM*'s lack of focus on social context may in some cases perpetuate stigmatization among certain groups of people. However, let us not forget that even the sex and race of the counselor can have an impact on diagnosis (Loring & Powell, 1988) as well as treatment outcome. Pointing a finger at the *DSM* is an erroneous gesture if the developmental perspective itself is subject to the same concerns. Do certain socioeconomic groups have characteristic developmental issues that lead to bias? For example, groups of people who are economically disadvantaged might require their children to work or not go to college. This certainly sounds like developmental bias to me. Counselors choosing to use the *DSM* need to be critically aware of the various implications associated with its use as well as the impact a *DSM* diagnosis may have on treatment—within and outside of the counseling process (Hinkle, 1992). Moreover, the *DSM-IV* is not for amateurs; having a list of criteria is no substitute for professional training. If you do not know how to use it effectively and are not aware of its limitations, do not use it (see Morrison, 1995).

Ivey and Ivey have referred to the recent inclusion of information regarding diagnostic bias in *DSM-IV*. The fact that culture, age, and gender factors have even been addressed in the *DSM-IV* is a significant step toward minimizing diagnostic bias. This augmentation to the *DSM* is important because it suggests that accurate diagnosis depends on ethnocultural and linguistic sensitivity (Culbreth, Rosen-Grandon, & Hinkle, 1998; Malgady et al., 1987). Keeping this information in mind throughout the diagnostic process will enable counselors to arrive at a fully formulated and accurate picture of the client (Polanski & Hinkle, 1998).

It should be obvious to all readers that the *DSM* may not be uniformly applicable to all cultures. Although the *DSM* has been widely used throughout the world, it is not assured that *DSM* language, largely used by American and European practitioners, translates into other cultures (Morrison, 1995). Furthermore, inherent in any diagnostic process is the possibility of error, for example, giving a client a diagnosis when the disorder is not present or giving the wrong diagnosis (false positive), or not detecting a disorder or not making a diagnosis when a disorder is present (false negative) (Fong, 1993, 1995). The sociocultural implications of such error, as sensitively suggested by Ivey and Ivey, should not be overlooked by counselors. All professionals using *DSM* diagnoses can be affected by various forces (e.g., political and economic efforts). For example, third party interests (i.e., insurance carriers) may bring non-

scientific values into the diagnostic process (Zubin, 1984). It seems that the Iveys would agree that there must be more than a superficial consideration of cultural issues within the diagnostic nomenclature. Cultural issues warrant adherence to the same strict standards applied to diagnostic guidelines throughout the *DSM-IV* (Culbreth et al., 1998). I like to believe that of all helping professionals, counselors are the most sensitive to culture associated with diagnosis.

Rather than cast the *DSM* "baby" out with the "bathwater" because of its lack of cultural orientation, two of my graduates and I have suggested that the next edition of the *DSM* expands its presentation of cultural differences so that it may be more accurately integrated by all practitioners and provide less potential harm to clients whose treatment may depend on precise diagnosis. Culbreth et al. (1998) have suggested a new scale titled the Global Assessment of Culture, Age, and Gender Scale (GACAG). This scale would be used in a fashion similar to the Global Assessment of Functioning, Global Assessment of Relational Functioning, and Social and Occupational Functioning Assessment Scale on *DSM-IV*'s Axis V. When needed, our proposed GACAG scale would be used within the context of a diagnosis; however, it would not be limited to any particular axis along the multiaxial system. This would alert other practitioners that the diagnosis must be considered within the context of the culture, age, and sex of the particular client. I believe this type of approach to the inherent problems with diagnosis is more productive than becoming tangled in semantics (e.g., medical vs. developmental vs. *DSM*).

CONCLUSION

Development is one of the distinguishing emphases of our profession, but it cannot stand alone after a century of applying and modifying psychological, counseling, and medical knowledge and techniques that are known to be effective. I would no more throw out developmental theories than any other theory that integrates well. However, I would not adopt a singular theory at the expense of being able to continue the development of metatheories that should be allowed to evolve, or develop, over the years.

Some of my objections to Ivey and Ivey can be reduced to semantics and perspective. However, I believe that many of their ideas are potentially detrimental to the counseling profession and limit counselors more than they already are (e.g., regarding employment opportunities, professional reputation, credibility, and competence). First and foremost, all of our clients deserve the best treatment they can obtain, and I firmly believe that they can receive such service from counselors. As Maxmen and Ward (1995) have indicated, we treat illnesses-that-happen-to-be-in-people rather than people-with-illnesses, necessitating counseling practice that is characterized by artistry, intuition, philosophy, ethics, and science, as well as a developmental perspective and diagnosis, each with its own contribution.

For counselors to remain competitive for increased wages, for jobs with managed care organizations, and for acceptance in the interdisciplinary health care market, they must be able to compete at a level comparable with other mental health service providers. This means they should have the ability to make accurate diagnoses and apply effective treatments. Furthermore, counselor training programs should ensure that trainees are adequately prepared to meet the needs of all people, including those individuals with problems defined in the *DSM*, and that they have the educational and training background necessary to practice in the public sector (Dial et al., 1992), including our schools. Rather than cast the *DSM* out, let us demonstrate how to use it accurately and with sensitivity; furthermore, let us show that once a diagnosis is made, regardless of who makes it, counselors know what to do about it.

Ivey and Ivey have indicated that what they see in client behavior is the logical result of developmental history. This is a rudimentary, logical point that I believe most practitioners assume; however, they may use a more definitive term than *developmental* to describe their activities. They would no more deny the developmental aspects of a client's behavior over time than they would the biological (medical), psychological (cognitive/emotional), or environmental (contextual) aspects of the client's behavior. Every client problem has a developmental and historical component. Let us not stake our profession on just this element of what we do. Let us demonstrate to the public that we help change people's lives using counseling skills and that we are sensitive to human development (in that order).

In my opinion, development is not the central, missing piece of the theoretical framework for helping people change. This perspective about professional helping only perpetuates one-size-fits-all approaches and adds to our professions' lack of credibility as effective treatment providers. Several years ago, ACA dropped the term *development* from its name because we, its members, do not do development; we do counseling, and development falls under counseling—it does not stand next to it as an equal. The development part is important and tacitly understood (e.g., the American Psychological Association is not called the American Psychological, Behavioral, and Cognitive Association). Furthermore, the prescription the Iveys use is quite troublesome; the adherence to one model limits counselor competence and diminishes who we can work with. Quite frankly, defining a theoretical perspective for the entire counseling profession is unrealistic.

In conclusion, Ivey and Ivy (1998) have stated, "If you can't find something positive in the client's behavior and history—refer!" (p. 337). I agree. But I would modify this somewhat: "If you can't find something positive in the client's behavior and history, whether you are a counselor or another service provider, whether you conceptualize the client issues using development, or the *DSM*, or both, and, don't know how to effectively and efficiently help the client, then refer, and find another line of work!" To be fully effective and efficient, a counselor cannot limit himself or herself to a developmental perspective.

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Toward a Developmental Diagnostic and Statistical Manual: The Vitality of a Contextual Framework

Allen E. Ivey and Mary Bradford Ivey

Counselors of all types need an understanding of and an ability to work with issues described by the Diagnostic and Statistical Manual of Mental Disorders, *fourth edition (*DSM-IV; *American Psychiatric Association, 1994). The traditional approach to the* DSM-IV *tends to locate the problem in the client, whereas a developmental approach focuses on the client in social and historical context. Specific recommendations for organizing a comprehensive treatment plan are presented. The authors endorse an educational and developmental role for counselors.*

Although we have many important differences with J. Scott Hinkle (1999), we appreciate his thoughtful response to our article "Reframing *DSM-IV:* Positive Strategies From Develop mental Counseling and Therapy" (Ivey & Ivey, 1998). He presents the case for a traditional view of the *Diagnostic and Statistic Manual of Mental Disorders* (*DSM-IV;* American Psychiatric Association, 1994). We differ strongly with this frame of reference because it unnecessarily pathologizes the person, needlessly separates diagnosis from treatment, and fails to acknowledge the unique position and potential that counseling professionals have for providing innovation and leadership.

We first summarize the essence of our original article briefly so that a clear point of reference is available for the reader. We then respond to Hinkle's comments discussing areas of agreement. Because Hinkle failed to discuss developmental treatment issues, we elaborate on the developmental frame and discuss the vitality of a contextual view of diagnosis and treatment. We also share practical specifics of how we generated a comprehensive developmental approach to severe distress. We firmly believe that counselors do work and can work with complex human issues using a positive approach to the *DSM-IV* and help the mental health professions move toward increased multicultural sensitivity.

OUTLINE OF A DEVELOPMENTAL APPROACH TO THE *DSM-IV*

In our article, we made the following main points.

All professional counselors must work with so-called psychopathology. We say "so-called" because the American Counseling Association (ACA) can best approach severe distress through a positive developmental tradition. What the psychiatric and psychological professions call "disorder," can be best described as a logical response to developmental history. Simply put, counselors bring much to the table when it comes to working effectively with complex problems. Our language system and way of thinking offers a strength for assessment and treatment that is missing from more traditional approaches.

A particular strength of the DSM-IV *may be found in the listing of characteristics of each diagnostic category.* Examining these carefully, it is obvious that they are often lists of behaviors and attitudes that make considerable conceptual sense. At the same time, we noted that the list of "disorders" at times becomes laughable (for example coffee nerves 305.90 and jet lag 307.45). A major task for ACA will be making developmental sense of the *DSM-IV* and working with difficult issues while making unique contributions to the mental health field. It is clear that the *DSM-IV* is here to stay. With Hinkle, we say ACA must begin serious debate regarding our role in the complex area of severe human distress.

One issue that must be faced is that the *DSM-IV* offers mixed blessings. The category system is useful in understanding and explaining an important and complex part of the human condition, but words such "paranoid," "anti-social," and the like are indeed problematic. It would be pleasant if an alternative and satisfactory terminology were available, but until it arrives, professionals need to work with what exists and redouble efforts to avoid pathologizing the individual.

The DSM-IV *contains in its diagnostic listings important developmental clues.* A review of Axis II, personality styles or "disorders" reveal that the words "child attachment disorder" is related to the majority of terms listed here such as

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schizoid, *borderline*, and *narcissistic*. This is an important clue indicating that an individual's developmental history relates to present behavior. Again, it is here that ACA can take a leadership position. It is possible to make explanatory sense out of the *DSM-IV* diagnostic categories and to start the process of developmental assessment and treatment from a positive frame of reference.

Hinkle apparently misunderstood a vital aspect of our developmental argument. Drawing from theoretical work by Masterson (1981) and Mahler (1975), we emphasized attachment theory implications for severe child, adolescent, or adult distress (Bowlby, 1969, 1973, 1988) stating the following:

1. Environmental or biological insult (may lead to)
2. Stress and physical/emotional pain which is a threat to attachment and safety (this, in turn, may lead to)
3. Sadness/depression (may lead to)
4. Defense against the pain, and in severe cases Axis II personality styles (which may lead to)
5. Axis I defensive structures

For example, the Axis II behavioral/attitude complex termed *narcissistic* might evolve in the following fashion: Biological vulnerability coupled with a difficult family and environmental history leads to severe stress with impact on physiology and immune system functioning as well as deep emotional scars (see, for example, Butler, 1996; Sherbourne, Hays, & Wells, 1995). These developmental concerns, in turn, lead to deep sadness and underlying depression. The depression itself is so painful that the personality style termed *narcissistic* becomes a defense mechanism against the pain of the depression. Finally, the narcissistic behavioral and attitude complex under severe stress may decompensate to severe Axis I clinical depression, mood disorders, and substance abuse (as shown in the *DSM-IV* itself; see Table 3, p. 340, in Ivey & Ivey, 1998).

In effect, developmental childhood and adult attachment issues and attachment theory are vital parts of a positive approach to the *DSM-IV*. The word "attachment" figures prominently in Axis II discussion (see Table 3, p. 340, in Ivey & Ivey, 1998). ACA members are in an ideal position to work in a prevention model to support positive life-span development. Attachment theory research is closely related to educational concerns.

Posttraumatic stress is a critical developmental concern. The *DSM-IV,* however, talks about posttraumatic stress "disorder." We would argue again that the symptoms of posttraumatic stress are the result of severe developmental stressors, and they represent a logical response to developmental history. Our view and that of our theoretical foundation, Developmental Counseling and Therapy (DCT), is that severe environmental stressors underlie much of what is termed *pathology*. The result of this is placing the problem in the person rather than in the environmental situation, either present or past. DCT posits that virtually all severe issues are the result of interplay between person and environment, whereas the *DSM-IV* and the mental health professions still tend to locate the problem in the person.

Drawing from this theoretical statement, our original article presented specifics for developmental treatment, citing our own work and that of others going back many years. Hinkle chose to ignore this important part of our discussion. We have found that the *DSM-IV* categorizations, if thought through developmentally, help us to diagnose and understand our clients more fully. The developmental model is useful in understanding the origins of severe distress. With this understanding, we are better prepared to institute developmentally appropriate treatment plans.

The last section of this article elaborates on how we came to the developmental frame of reference for working with the *DSM-IV*. But before moving to this important dimension, we examine places where we agree with Hinkle's commentary.

AREAS OF AGREEMENT

There is a great need for counselor education and ACA to discuss and evaluate the place of the DSM-IV *in our curriculum, in our theory, and certainly in our practice.* We anticipate that Hinkle would agree with us that working with severely stressed clients needs to become more central to ACA professionals' thinking and practice. School counseling, for example, does not always give sufficient attention to the *DSM-IV*. Yet, in Mary Ivey's practice in the schools, she was required to work with a significant number of children who could be placed in many diagnostic categories. Furthermore, her experience with children has been that when she referred them to professionals who claimed expertise in working with so-called disorder, the children were often returned to the schools with only a label for their problems. Semantics (names and labels) are not enough, and, as a school counselor, Mary Ivey sometimes had to undertake major responsibility for counseling such children. On the other hand, fortunately, some professionals provided very helpful treatment for children and, in addition, provided suggestions so that the work of the school counselor could be integrated with external psychiatric or psychological treatment. Given this fluidity and the uneven competence of medical and psychiatric professionals and psychologists, a school counselor will often be the person who is ultimately responsible for seeing that the child is given attention. Ideally, of course, we need a fully cooperative relationship between and among the varying helping professionals.

Clearly, in such situations it is counselor education's responsibility to better prepare students to deal with complex issues. We hope that Hinkle would join us in encouraging the entire field to give more attention to this complex area. Hinkle apparently misunderstood us when he comments that we would shun the *DSM-IV*. We strongly agree with his comment "Clearly, school counselors are in a unique position to identify students with significant mental health problems, and their understanding of the *DSM* can facilitate this" (Hinkle, 1999, p. 475). We would add that counseling professionals are an important and often central part of the treatment team.

There is a place for the medical model. The contributions of this model have been immense. Although we strongly endorse developmental counseling and psychological treatment whenever possible, we also recognize that medication and remedial treatment are at times appropriate. This is an area in which ACA needs to examine itself more fully. How can we work with, rather than against, our medical colleagues? One important contribution we can make is helping physicians (and psychologists) increase their developmental expertise. And counseling treatment in concert with medical professionals from a counselor who understands and can work with the *DSM-IV* will be more effective.

Multicultural concerns regarding DSM-IV need more attention. There indeed has been progress in making the *DSM-IV* more culturally aware; nevertheless, the *DSM-IV* still operates from a primarily Eurocentric perspective. Hinkle makes a useful point when he suggests the addition of a new approach—the Global Assessment of Culture, Age, and Gender Scale—that would enrich understanding and use of Axis V. In the long-term, this type of work can be a major contribution of ACA to the larger mental health professions. We hope that at some point in the future, we will see a truly culture-centered, contextually aware *DSM-IV*.

The multicultural competencies (Arredondo et al., 1996) are an area in which counseling professionals can make a significant contribution to the *DSM-IV*. It is time that counselors took the multicultural competencies and applied them directly to assessment and treatment within the *DSM-IV* framework. The multicultural competencies, in particular, lead us to focus on contextual issues and help us become aware that placing the problem in the client without consideration of external issues can lead to inappropriate and even damaging treatment. Witness the women, Native American Indians, and African Americans treated for depression, substance abuse, or other issues without consideration of how oppression in the form of sexism or racism has affected their mental health. Building on the multicultural competencies is where counseling professionals and ACA can provide a major contribution. Axis V issues need to take a central place, rather than a secondary role, in a revised and more culturally aware future *Diagnostic and Statistical Manual.*

We think some critical issues have been defined. Clearly the *DSM-IV* is important for the future of the counseling profession. There is need for considerable careful debate on these important issues as we head toward the future. Shall we comply with the status quo or take a leading position of our own? We believe we limit ourselves by accepting a traditional model such as that proposed by Hinkle.

A CONTEXTUAL VIEW OF DIAGNOSIS AND TREATMENT

Despite an agreement on the importance of the *DSM-IV,* a central area of disagreement with Hinkle is the definition and place of developmental concepts. In particular, we disagree with the idea that diagnosis is necessarily separate from treatment. We believe the developmental idea, inherent in the ACA and counseling psychology disciplines, provides a foundation for a comprehensive understanding of the *DSM-IV,* one that enables both beginning and experienced professionals to comprehend a systematic approach to understanding the origin of a client's present difficulties, anticipating current and future behavioral difficulties, and developing comprehensive treatment plans. Important in the developmental idea is awareness that development occurs in a social context. Individuals develop in families within a cultural context.

A SUMMARY OF CONTEXTUALISM

The traditional view of the *DSM-IV* places pathology in the individual and fails to take developmental and systemic issues into account. It is here that we find the traditional point of view particularly limited and limiting. Clearly, it is the individual who internally harbors the depression, the phobia, or other form of severe distress. What we are seeking, however, is a broader view that enables us to see the client in context, the self-in-relation (Baker Miller, 1976). Individuals develop in families within a community and a cultural context.

A new view of self is gradually evolving—Ogbonnaya (1994) talked about the person as community. Each human being internalizes multiple experiences. Our experience is more complex than that of the traditional autonomous and unitary self. Traditional views of self used by the field are inadequate not only for multicultural issues but also in their descriptions of the real richness of the individual.

The contextualized self includes relational dimensions of personal and family developmental history, community and multicultural issues, and physiology. A comprehensive understanding of the person requires multiple contextual dimensions. Out of the self-in-relation can come a broader view of client treatment that requires the counselor to think about multiple avenues. Treating a client out of social context can be a limiting view. The *DSM-IV* and the traditional view tend to see the client and the client's issues as primarily located in the individual and thus direct treatment with minimal attention to context. (Axis V and the increased interest in multicultural issues in the latest *DSM-IV* are moves toward contextual awareness but have thus far had minimal impact.)

Counselors tend to be developmentally oriented and often have responsibility for promoting humane environments in schools, colleges, and communities. We tend to be oriented to prevention through group guidance, consultative activities, and community awareness. However, counseling training remains individually focused with insufficient attention to integrating contextual issues into a comprehensive base of treatment. Nonetheless, due to our closeness to our communities, ACA professionals are in an ideal position to advocate for a broader view of treatment.

HOW WE GENERATED THE DCT APPROACH TO WORKING WITH SEVERE CLIENT ISSUES

Hinkle's response to our article was subtitled "A View From the Trenches." This seems to be an indirect way of saying

that we are working solely in theoretical terms and abstract ideas. Yes, we have developed a theory over time, but the theory has always been based in practice and empirical evidence. We welcome this opportunity to share our work in the field and review research on the DCT model.

This discussion outlining our developmental position on the *DSM- IV* goes back in history to Allen Ivey's original work in the Veterans Administration and to Mary Ivey's work with severely distressed children in the schools. This practical experience, coupled with writing on microskills, developmental theory, and practice, led over the years to the position presented here. We both stress that the practice came before the theory. After the theory was generated, further practice and empirical research led us to the position outlined in our writing on the *DSM-IV*.

In a Veterans Administration Hospital, A. Ivey was seeking to apply microcounseling and skills training to both short- and long-term inpatients (Ivey, 1973, 1991b). Depression was one of the most common diagnoses, and A. Ivey worked frequently with returning Vietnam Veterans as well as a variety of patient types. At that point, effective medications were only beginning to be introduced. The basic mode of treatment used was communication skills training using microskills concepts. The program was effective and resulted in rather rapid release of patients, some of whom had been in the hospital more than 10 years.

Retrospective review of the early work with skills training reveals that a multiple level DCT approach was used. Table 1 presents a summary of the multiple levels available for working with depression. We have found that presently existing interventions may be classified within four cognitive/emotional developmental orientations: sensorimotor, concrete, formal, and dialectic/systemic. In addition, DCT offers specific treatment alternatives of its own with a special emphasis on contextual issues.

Before this developmental, contextual model was fully apparent, A. Ivey was using the framework (although it did not have the name DCT at that point). Rather quickly, he found that "single-shot" interventions (medication, therapy, etc.) tended to be ineffective or to "wash-out" fairly quickly over time. He gradually began to use a multidimensional treatment framework, which is now best described through the language system of DCT.

At the concrete level, microskills communication skills training with videotape feedback was central. Each veteran in consultation with therapists generated their own skill training plan. Study of videotapes of patients soon revealed that body awareness, particularly in the form of relaxation training, was needed as well as Gestalt activation exercises to stimulate clients. These sensorimotor techniques became basic to the treatment program. Patients progressed well with these behaviorally focused techniques, but it was the "cognitive click" of patients making formal operational reflective self-statements such as "I can do it" or "I can manage my own behavior" that seemed to move the patient out of the hospital. Review of these three steps, of course, reveals a comprehensive cognitive-behavioral program founded on a sensorimotor body awareness.

TABLE 1

Depression: Treatment Interventions Organized Around DCT's Information Processing Systems

DCT System	Example Treatment Alternative
Sensorimotor	Medication, meditation, body work (relaxation, nutrition, exercise, yoga), imagery, Gestalt, holistic work with traditional healers
Concrete	Skills training, drawing out client concrete narratives through listening skills, desensitization hierarchies and training, positive strengths and stories from the narrative and DCT perspectives, assertiveness training, completing an automatic thoughts inventory or REBT A-B-C-D-E-F analysis, thought stopping, ethnic/racial or feminist narratives
Formal	Reflection on any of the above sensorimotor or concrete methods. Person-centered theory, psychoanalytic/psychodynamic treatment, cognitive portion of CBT, logotherapy, psychoeducational workshops focusing on self-esteem
Dialectic/systemic	Reflection of how any of the above may have been developed in a family, cultural, or gender system; trauma work that focuses on how the external world relates to internal experience; feminist therapy; consciousness-raising groups; examination of countertransference or projective identification; psychotherapy as liberation; involvement of traditional healers in counseling process

Note. DCT = developmental counseling and therapy. REBT = rational emotive behavior therapy. CBT = cognitive-behavioral therapy. From "Reframing *DSM-IV:* Positive Strategies From Developmental Counseling and Therapy," by A. Ivey & M. Ivey, 1998, *Journal of Counseling & Development, 76,* p. 345. Copyright by the American Counseling Association. Reprinted with permission.

At the time of patient release from the hospital, Allen Ivey met with the family to make plans for the future. In the context of the family interview, he saw signs of the patient already deteriorating in the pressure of the family system. This then led to involving the family more completely in the treatment plan in and out of the hospital. The basic discovery at this point was that patients exist in a social system and there is need to work on that social system as well as with the client. The word "with" is important because both the project and DCT stressed importance of clients being involved in selecting the nature of treatments in a coconstructive fashion with the counselor or therapist.

DCT terms these interventions *dialectic/systemic* in that they require the counselor or therapist to direct interventions beyond the individual and work with the patient to change oppressive external conditions. At that time, Vietnam Veterans began to appear in the hospital with varying diagnoses that now fall under the term *posttraumatic stress "disorder."* Was the weakness in the client, the system (Viet-

nam), or in interaction? Are we working with a person or a person-in-system, a self-in-relation?

Attacking systemic issues in treatment requires a new approach. At the VA Hospital, this involved interventions focused at the dialectic/systemic level, including group and individual consciousness-raising, helping veterans to see how their distress was related to external factors, thus enabling them to find an appropriate balance of internal and external locus of control. The impact of family, community, and war experiences were reviewed. It became clear that interventions with family and community (and, of course, the hospital) were needed at both a prevention and a remedial level.

Out of these highly practical experiences rose the DCT framework, which focuses on the need for multiple interventions. Traditional concrete and formal operational cognitive-behavioral interventions need to be supplemented with sensorimotor and dialectic/systemic strategies. Some clients respond best to a single intervention at one DCT level, whereas others change best with another orientation. As time permits, multiple level interventions are likely to be the most lasting and effective.

Medication, a sensorimotor strategy, may at times be an effective treatment—DCT points out that the individual is a system and any intervention in one part of the system affects the whole. Thus, one might expect behavioral interventions, for example, to affect more than just concrete behavior. Many interventions offered by the profession are multilevel. For example, Beck's (1976) cognitive therapy and Foa and others (Foa, Hearst-Ikeda, & Perry, 1995; Foa, Rothbaum, Riggs, & Murdock, 1991) who work with rape trauma survivors use three level strategies (sensorimotor, concrete, and formal), but they have given minimal attention to broader systemic issues. However, their multilevel strategies are more likely to produce lasting change. We suggest that bringing in dialectic/systemic contextual issues would strengthen the power of the therapy. Yes, Beck's sensorimotor images, concrete stories about cognitive patterns, and formal reflection can be useful in producing change, but unless systemic issues are considered, the focus is still on the problem-in-the-person and not on accounting for the way that broader systems affect the development and maintenance of stress.

Developmental history also plays an important part in client and patient issues. Some Vietnam veterans ended up in hospitals, whereas others who experienced very similar war trauma seemed to proceed with their lives fairly effectively (recognizing, however, that many Vietnam veterans experienced delayed recall of their trauma). It is here that unraveling developmental history can be especially useful. Not only can Vietnam veterans share their difficulties with war experience, they can also share life experience. Understanding the client's development in family and social context enables a richer understanding of their very real uniqueness. It is surprising to find that when the definition of the individual is expanded to mean a person-in-relation, individuality is increased. A contextual psychology dignifies and illuminates the individual self.

Needless to say, there is also a biological dimension to development. The preceding discussion is focused on environmental events and history. Although Allen Ivey's first intervention was often to have a patient taken off drugs, we nonetheless recognize that medication can be used effectively with depression and other severe stressors, particularly in the early stages when the depression is out of control. Furthermore, we believe that some clients are biologically "wired" to respond differently than others. Some people have a rapid and strong startle response and will respond to environmental contingencies differently. Given this reality, medication and respect for the medical model are essential. Counselors must be able to cooperate with medical staff.

In a school situation, there are parallel processes operating. When a child had a behavioral problem in the classroom, Mary Ivey knew that something else was likely to be happening. The child might be exhibiting disruptive behavior, but what was going on in the total system? Was there a conflict with the teacher, were there issues with classmates or peers, or perhaps an impending divorce in the family? It might be tempting to label the child as ADHD or as oppositional. Medication, individual therapy, or both could be used with the child, and behavioral change might be expected. However, when one takes a broader systemic view, then the treatment approach changes. Sensorimotor (body awareness, relaxation, imagery), concrete (behavioral contracting, skills training), and even some reflective formal operational treatment methods (self-concept work) still need to be done with the child, but if systemic issues are not taken into account, the child is left alone and lasting change becomes extremely difficult.

It is through action at the developmental and dialectic/systemic levels that counseling can make particularly unique contributions. By seeing the child in social context, a wide array of developmental and systemic interventions can be implemented that make a real and long-term difference. Rather than accepting an easy diagnosis, the counselor can set forward with a broad-based treatment plan with medication used only as a last resort. Cooperation with multiple professionals may be necessary so that various aspects of the treatment plan can be implemented.

The complexities of handling severe distress are many. We have found that the conceptual framework of DCT has enabled us to conduct more comprehensive assessments of both children and adults and to establish effective, broadly based treatment plans.

This, of course, offers a challenge to the way the counseling profession traditionally teaches and thinks about counseling and therapy. Rather than finding the one "correct approach" or selecting a "theory of choice," the educational task becomes learning multiple ways of helping clients, realizing that not only cognitive-behavioral therapy is important, but that humanistic, psychodynamic and psychoanalytic approaches are useful complements. We, as counseling professionals, need to learn about medication and how to collaborate with other professionals. At the dialectic/systemic level, we also need to move out of our offices and into the

community. Furthermore, we need to learn feminist therapy, multicultural counseling and therapy (MCT), community psychology and community counseling. The demand for a broad-based expertise is high and certainly challenging to existing professionals and new recruits to the field.

Our belief is that counseling needs to continue its focus on normal development, but to realize that severe stress and the categorization system of *DSM-IV* are also part of normal development. The majority of people experience severe trauma at some point in their lives. The reality of what is termed *mental illness* is rather prevalent in our society. When counseling professionals talk development and context, this is not taking the easy route. The human condition demands that we increase our awareness and capability with the true complexity of counseling and therapy.

THE VITALITY OF A COMPREHENSIVE CONTEXTUAL APPROACH TO TREATMENT

Hinkle seems to argue against integrating treatment with diagnosis. We find that the diagnostic system of the *DSM-IV* is helpful in planning comprehensive and organized treatment plans for clients. We also find that the multilevel treatment plans made possible by DCT enable a new flexibility and encourage client and family participation in the selection of treatment alternatives. This is where the theoretical and integrative aspects of DCT are perhaps most effective in that a rationale for treatment selection can be clearly stated.

Depression, for example, is an area to which DCT gives considerable focus. The *DSM-IV* listing of characteristics of depression is helpful. In addition, we acknowledge that medication and cognitive-behavioral therapy are both effective in treating this form of distress—so effective in fact that it is easy to believe that depression exists within the individual.

Depression is an issue underlying many *DSM-IV* categories. For this reason, in our teaching and writing we emphasize the importance of having specific ideas on how to understand and work with depression. We presented DCT's multiple approach to depression in our 1998 article, and it is reproduced here again. Although we recommend that counselors develop expertise through the multilevel dimensions of treatment, it must also be recognized that few of us will be able to "do it all." Thus, establishing coordinated treatment plans with other professionals may be the most appropriate direction for the future.

To increase counselors' expertise in working with clients with severe distress, we advocate integrating theory, practice, and understanding of difficult treatment issues throughout the curriculum. For example, in teaching counseling theory early in the course, we work to help students understand depression. We stress its multiple possible origins, the fact that depression is related to multiple *DSM-IV* diagnoses and that depression is one of the most treatable issues. From this foundation, we work with students to generate treatment plans—most often in a collaborative endeavor with other professionals. We think it is important to integrate the *DSM-IV* understanding with counseling skills, counseling theories, group counseling, and other courses.

For a deeper understanding of the frame of reference presented in our article on the *DSM-IV,* we also suggest that it might be useful to review other theoretical and practical suggestions such as Ivey (1986, 1991a), issues of child abuse (Ivey & Ivey, 1990), specifics on depression in Rigazio-DiGilio and Ivey (1990), adolescent substance abuse (Boyer, 1996), those with learning disabilities (Strehorn, 1998), and eating problems (Weinstein, 1994). Research and practice on DCT and the developmental model has focused on the more difficult issues we face in counseling.

In short, a substantial amount of theory, research, and practice specifics exist supporting the DCT developmental model. Each construct and assumption was developed to ensure the possibility of empirical testing. We also want to comment on our debt to education and other developmentalists. Schools of education and counseling theorists have made many important contributions that we need to acknowledge and be proud of. In particular, we note that cognitive development, attachment theory, and even life-span development concepts seem to have their origins in education schools and colleges. We need to take pride in our educational and developmental history and recognize our distinctiveness rather than mimic psychology and psychiatry. We can best work with experts from other fields if we recognize our own competence.

Semantics are important. Hinkle dismisses the idea that severe distress is a logical response to developmental history as being unnecessarily concerned with semantics. Hinkle seems comfortable with terms such as *mental disorder, pathology,* and *mental illness*. Our rejoinder is that language defines our universe and our actions. Thomas Szasz, years ago, in his important book *The Myth of Mental Illness* (Szasz, 1984) made the same point. If people are to be viewed as the problem, then the language of disorder is appropriate. If a more contextual and forward-moving approach is to be taken, then it will be necessary to reconceptualize thinking about these issues. Language is important and defines reality.

As is well known, most counselors take some form of humanistic position on the helping profession. Caring is an important dimension of counseling, and the language of pathology is uncomfortable to many. For this reason, some counselors-in-training and counselor educators resist the *DSM-IV* as being too distant from our professional values and history. Not only must our courses begin to include more information about this area, but we need to give serious thought as to how we can reach those many members of the broader counseling profession to help them gain an appreciation of the necessity of finding ways for working with clients with severe distress.

Although we would like to see a positive developmental language and thinking system associated with the *DSM-IV,* we also think it is important that the entire field develop increased expertise and knowledge about our unique approach to severe distress. To produce a long-lasting change

in the way we think about the *DSM-IV* will not be easy. The language of "mental illness" and individual "pathology" is firmly entrenched in the mental health professions. Let us hope that ACA can be part of a new direction for the future.

SUMMARY

Space does not permit us to respond to all the issues raised in Hinkle's commentary. In essence, we believe the most important are the following.

The *DSM-IV* and working with severe client distress is an important part of the task of the counseling professional. ACA has given insufficient attention to this central issue. On this point, we join with Hinkle in urging increased attention to the dialogue regarding this issue.

Traditional approaches to the *DSM-IV* tend to place the problem in the individual and fail to consider adequately contextual issues such as individual developmental history in a family, community, and cultural context. The counseling profession's major contribution may lie in helping mental health professionals see severe distress in social contextual dimensions.

Treatment need not be separated from diagnosis. Although the *DSM-IV* represents important work in clarifying client symptomatology, we need to think in more detail about how we can suggest specific treatment alternatives. Moreover, treatment implications are too often thought of as individualistic rather than systemic, comprehensive, and contextual.

There is dignity and value in the educational model. Rather than apologize and seek to emulate other professionals, let us own our educational roots. The DCT model offers many specific suggestions for conceptualizing and treating complex and difficult client issues. But, it is only one of several developmental frameworks generated by a counseling, counseling psychology, and school of education framework.

Counseling psychology and counseling professionals developed the multicultural competencies. The competencies offer us a framework for examining the present status of the *DSM-IV* and leading the mental health professions toward a new future. We endorse examining this area as the important next step to a contextually aware future of working with severe distress.

Semantics are important. Words frame our world. Shall we, as professionals, succumb to a negative, destructive language system, or shall we work with that system to change it in a positive way? Ultimately, we need a *Diagnostic and Statistical Manual of Mental Health*. But until we reach that ideal stage, we will find ourselves working with the *DSM-IV* and its future descendants. For the moment, it seems necessary that we "hold the contradiction" and work with the language system of the *DSM-IV*. As we evolve a positive reframing of so-called disorder, we can perhaps help move the field toward an emphasis on mental health rather than mental illness. Shall we in the counseling field lead or shall we follow? Shall we own our educational and developmental expertise or will we be merely followers in a narrow and traditional model?

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Assessment of Clinical Supervisor Competencies

Hildy G. Getz

As the field of clinical supervision develops, there is expansion of conceptual models and methodology of practicing supervision. The evaluation emphasis in supervision has been on assessing the supervisory relationship and the supervisee. This article presents a focus and process to assist those training clinical supervisors to assess the competencies of the supervisor.

With increased development and professionalism in the counseling field, there is greater focus on assessment and measurement of clinical work at all levels. First, this is true at the client level because there is more focus on diagnostic criteria to assess the client and more emphasis on developing specific treatment goals and outcomes, often accompanied by time frames. Insurance companies and managed care panels are requiring diagnoses documented by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychiatric Association, 1994) and specific treatment plans and evaluation.

Second, there is a need to assess and evaluate counselors. Clinical supervisors in academic training programs and in the field are required to provide this evaluation. Supervisors' ultimate responsibility is to clients, and therefore they must ensure that counselors in training are accurately assessing clients' needs and their counseling progress. But supervisors must also carry a responsibility for the supervisees' learning and professional identity, and they are charged with serving as gatekeepers to the counseling profession. Clinical supervision is increasingly seen as a critical component in counselor development across the professional life span—beyond academic training programs and initial counseling positions. State regulation boards are shifting more responsibility to supervisors who must attest to their supervisees' competence. Supervisors and their supervisees are expected to set measurable goals for the counselor about counseling and case conceptualization competence that can be presented as summative evaluation to personnel affiliated with university training programs, licensure boards, certification bodies, and agency or school system administrators.

Finally, at the highest level in the hierarchy, counselor educators who are training supervisors must evaluate these supervisors. Supervision has become a separate process with its own conceptual framework and methodology. Bernard and Goodyear (1998) offered the following definition of *clinical supervision* that is used in this article:

> An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the client(s) she, he, or they see(s), and serving as a gatekeeper of those who are to enter the particular profession. (p. 6)

The Association for Counselor Education and Supervision's (ACES) Supervision Task Force on the Establishment of Standards for Credentialing Clinical Supervisors has issued draft recommendations (Getz, 1997). This new document, in addition to The Standards for Counseling Supervisors (ACES, 1990) and the Ethical Guidelines for Counseling Supervisors (ACES, 1993), provides the direction and impetus to hold supervisors to a certain level of competency. Shifting the focus to supervisor competencies is vital. The professionalization of clinical supervision has led to a proliferation of books and articles on the subject, but there is still a lack of direction on assessment of the supervisor.

COMPETENCIES OF SUPERVISORS AS THE ASSESSMENT FOCUS

Traditionally, there has been a lack of formal training for supervisors, a fact that Hoffman (1994) described as the mental health profession's "dirty little secret" (p. 25). Historically, the context of supervision was tied to counseling theory. Thus, most supervisors were oriented to the approaches and techniques that evolved from their own or their supervisors' therapeutic approaches (Boyd, 1978). Currently, supervisor training is considered very important, and a number of authors have presented integrative approaches to supervision developed independently from a specific psychotherapy. Hart (1982) took a broad perspective when he described three models. In the *skill development model*, the goal is to increase the supervisee's skills and conceptual understanding of clients. There is a teaching type relationship with a focus on the client followed by a focus on the supervisee's approach to helping the client. In the *personal growth model*, the goal is to increase the insight and affective sensitivity of the supervisee. The relationship is more like counseling with a focus on the supervisee's personal feelings and thoughts about interpersonal relations with clients. The *integration model* has a goal to

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assist the supervisee to integrate acquired skills and personal awareness into effective relationships with clients. There is a collaborative relationship with a focus on the supervisee–client unit or interaction, followed by a focus on the supervisor–supervisee interaction. Bernard's (1979) Discrimination Model has three supervisor roles—teacher, therapist, consultant—and three basic foci—process (counseling skills), personalization skills (personal aspects), and conceptualization skills (case analysis). Holloway's (1995) Systems Model described the supervision tasks of helping the supervisee with counseling skill, case conceptualization, professional role, emotional awareness, self-evaluation, and the supervision functions of monitoring/evaluating, advising/instructing, modeling, consulting, and supporting/sharing. Taibbi (1995) wrote about a four-stage process of supervision with the supervisor as teacher, then guide, gatekeeper, and finally as consultant. In all these descriptions of supervision, the primary focus is on the competencies of the supervisee, not the supervisor-in-training. One structured proposal for supervisor training is found in Bernard and Goodyear's (1998) *Fundamentals of Clinical Supervision*, but still assessment of supervision competencies is not specified.

Competency-based supervision training implies that supervisors are taught to obtain the requisite ability to function specifically in a supervisor role. The Standards for Counseling Supervisors (ACES, 1990) described the knowledge, competencies, and personal traits that characterize effective supervisors. The curriculum guide for training counseling supervisors (Borders et al., 1991) was designed to meet these standards. The authors of this guide suggested that the standards reveal seven core curriculum areas: Models of Supervision; Counselor Development; Supervision Methods and Techniques; Supervisory Relationship; Ethical, Legal, and Professional Regulatory Issues; Evaluation; and Executive (Administrative) Skills. Borders et al. (1991) also suggested three sets of learning objectives for each of these seven areas: (a) self-awareness, (b) theoretical and conceptual knowledge, and (c) skills and techniques. The result is a 7 by 3 matrix with 21 types of learning objectives, supplemented by a list of more that 200 specific learning objectives. It is a very cumbersome set of recommendations that is criticized for its complexity (Russell & Petrie, 1994).

The goal of this article is to present a supervision training approach that incorporates specific methodology to teach and assess the competencies of supervisors. Assessment of didactic work can be accomplished through tests, papers, and other methods. Application of new knowledge in actual supervision comes when counselors start doing supervision. It is in this experiential component that it becomes more important and more difficult to determine how each competency will be operationalized and assessed. The trainer of supervisors-in-training needs to assist the trainees in developing individualized plans to gain the knowledge and skills they need in their particular supervisory experience. The trainees need a series of experiences over time to receive consistent feedback on their practice. This process can then result in concrete and specific summaries of supervisors' competencies.

MEASUREMENT OF COMPETENCIES

The structure for supervision assessment described here (Getz, 1997) was developed through 15 years of training counselors to become supervisors. This training and assessment has been conducted in higher education, public schools, and community mental health agencies. The structure is described for group training of supervisors, the most typical approach due to its time and cost efficiency. It can easily be adapted to one-on-one instruction of supervision. For the purposes of this article, the supervisor-trainer will be referred to as the "instructor," the supervisors in training will be "SITs," and the counselor in training will be called the "supervisee."

Preliminary Procedures

The instructor includes didactic material (e.g., reading, lectures, and watching videotaped supervision sessions of skilled supervisors) primarily at the beginning of the training to give the SITs an overall view of the practice of supervision. As in all aspects of counseling and supervision, a positive relationship between the instructor and the SIT is crucial. Therefore, building rapport and sharing background experiences related to supervision are all-important. Anxiety about the new learning process can be assessed through discussion or a listing of aspects of anxiety, or both. In addition, the SIT Self-Assessment of Supervision-Related Knowledge (Borders & Leddick, 1987), an instrument that is a systematic review of the multiple relevant experiences the SIT will have had as counselor, teacher, consultant, researcher, and peer supervisor, is administered to assist in creating affirmation and confidence. There is a parallel process working throughout the training. The instructor models the same structure that will occur between the SITs and the supervisees, and this modeling should be discussed throughout the process.

The seven core supervision competencies are presented to SITs as the following evaluation criteria:

1. Models of supervision
2. Counselor development
3. Supervision methods and techniques
4. Supervisory relationship
5. Ethical, legal, and professional regulatory issues
6. Evaluation
7. Executive (administrative) skills

The SITs are told that a summative evaluation describing behaviors they have demonstrated in each competency area is required for the end of training. The heart of the evaluation, though, is an ongoing process of forming goals toward competency achievement. Goals are set by the SIT with the help of the instructor and the SIT peer group and evaluated throughout the process. These goals may be overriding broad goals, such as "use a variety of supervision methods," or SIT-specific goals that emerge as specific needs, such as "conduct a role-play with my supervisee in which she takes the role of the client and I take the role of counselor to demonstrate the use of interpretation." Each goal

involves a *g*oal statement, an *a*ction step, and *e*vidence of progress (i.e., GAE). Further examples of the "GAE" process are included throughout this article.

The initial training and assessment focus with the SITs relates to Competency 5: Ethical, Legal, and Professional Regulatory Issues. SITs are required to read and study the Ethical Guidelines and Standards for Counseling Supervisors. The instructor assists them in developing an informed consent document. McCarthy et al. (1995) presented a good example of a supervision informed consent. Assessment of the informed consent document should be made by the instructor to be sure that the SIT explains the supervision process to the trainee. The consent should include (a) the purpose of supervision; (b) information about the supervisor that includes credentials and qualifications and approach to supervision; (c) the structure and practical aspects of the supervision process; (d) the nature and specifics of the evaluation, which will occur through learning contracts; and (e) permission to record sessions on audio- or videotape.

The SIT must also assist the supervisee in developing a counseling informed consent document that parallels the supervision consent form by describing the counseling process, the credentials of the counselor, the structure of the counseling process, and permission to record. The SIT must document that they have required the supervisee to read and review the ethical guidelines for counselors.

The instructor initially provides clear structure for the sessions that the SIT has with their supervisee. The SIT has an ethical responsibility to ensure that the supervisee has clear expectations about how the supervision will be conducted. The outline for an hour-long session between the SIT and the supervisee follows (times are suggested).

1. Case history presentation: information about the client and the presenting problem, history of presenting problem, and previous attempts at problem solution (5 min; this may be an update if the supervisee has presented the case previously)
2. Case conceptualization: client goals, desired outcomes, and counseling approach (5 min)
3. Supervisee's reaction: information about the supervisee's reaction to the client and the counseling process (5 min)
4. Request to SIT: how the supervisee desires help and what supervision approach is desired (5 min)
5. Supervisee's presentation of progress on their specific goals accompanied by action steps and evidence (5 min)
6. Viewing the videotape (15 min)
7. Supervisor's feedback (10 min)
8. Summarization: (a) future direction for the case, and (b) supervisee's future goal(s) related to counseling skills, case conceptualization skills, emotional and cognitive self-awareness, and professional role (10 min)

Another preliminary procedure is developing the documentation necessary throughout the process, Competency 7: Executive (Administrative) Skills. For the beginning SIT who can benefit from a model, the format for progress notes that the SIT will write after each supervisory session is provided. In addition to general comments and reflections, the SIT clearly delineates a goal, evidence of progress and future direction for the client, for the counselor, and for herself or himself as the SIT. This allows the instructor and the peer group of SITs to assess progress at all clinical levels.

Finally, the instructor provides the structure for the supervision of supervision sessions so that the SIT has a roadmap to present to the instructor and supervision peer group (see Appendix A). This is the vital component of assessment for competencies of the SIT. Clear expectations and specificity are equally important at this level. The opportunity to measure the competencies revolves around the SIT's supervisory session with their own supervisees. Videotaping can be used as it is used with clinical sessions. The structure is designed so that the SIT's presentation about a supervision session with their supervisee and the feedback from the instructor and supervision peer group lasts about 1 hour.

The Structure for Each Training and Assessment Session

Supervisee information. The SIT presents information about the supervisee. First, this information should focus on Competency 2: Counselor's Development. On the basis of Stoltenberg and Delworth's (1987) three developmental-level models, the SITs rate the supervisees from Level 1 to Level 3 on self-and-other awareness, motivation, and autonomy, respectively. They also rate the supervisee's developmental level on theoretical orientation, assessment, case conceptualization, treatment goals and plans, relationship building, intervention skills, diversity management, and professional ethics. On the basis of the developmental assessment, the supervisee's initial goals are formulated for improving skills, conceptualization, and self-awareness. The action steps and outcome results should be clearly specified for purposes of Competency 6: Evaluation. For example, the supervisee specifies the goal of improving confrontation. The action step might then be a practice role play of confrontation in the supervision session, and the evidence of this would be viewing a videotape when the supervisee actually confronts a client. The following is an illustration:

> SIT: I have documented that my supervisee has progressed in counseling conceptualization and intervention skills, but when asked about how she is reacting to her clients, she seems to block. I'm not sure what to do now.
> Peer SIT: I have used a counselor reaction form that my supervisee fills out and that has helped him become more aware of himself. You might want to try that because you can measure whether your supervisee is able to respond more to this form over time.

Supervisor information. The SIT presents information regarding the focus and role in the supervision session. The SIT should be able to articulate and demonstrate knowledge and application of Competency 1: Models of Supervision. The chart in Appendix A reflects a combination of several models. It is the responsibility of the SIT to describe what foci and roles were present in parts of the session and in the overall perspective as well. Practice in all

four focus behaviors and all four role behaviors should be demonstrated over time. The following illustrates this:

> SIT: In this tape, I believe that I focused on case conceptualization skills and functioned mainly in a consulting role.
> Instructor: Your supervisee is such a beginner, she may need more direction.
> How can you teach her the techniques to write an initial case conceptualization?

Supervision methods. The SIT describes Competency 3: Supervision Methods and Techniques that were used or might have been used in the supervision session. These should include a variety of methods. Teaching approaches may include review of initial evaluations, treatment plans, case notes, microskills training, and modeling. Interpersonal process recall is used to focus on supervisee self-awareness. Role-playing and the use of metaphorical objects are examples of experiential techniques. The SIT should practice methods that come less easily, as the following illustrates:

> SIT: My supervisee is not able to videotape her counseling sessions. When I listen to the audiotapes I can't assess my supervisee's attending behavior. I imagine she doesn't convey much warmth because that's the way she comes across in our sessions.
> Peer SIT: Have you considered doing live supervision?

Supervisor's reactions. The SIT examines his or her own reactions to the supervisee and the Supervisory Relationship, Competency 4. The SIT describes the use of power and authority, delineates where the relationship is on the continuum of hierarchy/egalitarianism and dependency/autonomy, and assesses the supervisor and supervisee patterns of anxiety. The impact of existing gender, cultural, and other demographic differences is explored. The SITs look for ways to obtain feedback regarding the supervisory relationship. Williams (1994) developed a supervision feedback form that can be used after each supervision session. The Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990) is another helpful instrument. At this point, demonstrating an awareness of parallel process is often helpful. This concept (Ekstein & Wallerstein, 1958) refers to the concurrent similarities in the dynamics of the SIT–supervisee and the supervisee–counselee, especially concerning learning problems. The following is an example of this:

> SIT: I'm feeling frustrated that my supervisee shuts down and doesn't confront her counselee about progress on her goals.
> Peer SIT: Even though you say you are frustrated, it seems you too haven't confronted your supervisee about this. So the parallel process seems to be happening.

Request of peer supervisors. The SIT requests help from the peer supervisors and the instructor by specifically identifying a goal, problem, or issue about which she can initiate some action or change. The SIT also requests how the feedback can occur; for example, role-play practice or assigning peers different roles as they view the supervision videotape. Feedback will be given on the previous goals that the SIT has stipulated. The following is an illustration:

> SIT: I need help in responding to my supervisee when he continually asks what I would do with the counselee. Would two of you role-play to see how you handle this?

Viewing the videotape. The group and the instructor view the videotape.

Peer feedback. Final peer feedback is given to the SIT who listens, clarifies, and summarizes. An emphasis is placed on articulating each of the SIT's strengths.

Future direction and goals. Finally the SIT is asked to reflect on their supervision competencies and to clarify their goals for the next supervision sessions. The SIT is assisted in developing the action steps and evidence for their goal, as the following illustrates:

> SIT: I know that a new goal I have is to assert myself in requiring that my supervisee comes prepared for the next supervision session.
> Peer SIT: How will you do that?
> SIT: I will call her and tell her before the session.
> Peer SIT: I think that step will change the nature of your relationship so that your supervisee is clear about what you expect.

At the end of the training, each SIT presents a summary of all the goals addressed as they pertained to the different competencies. Examples of these goals are found in Appendix B.

SUMMARY AND CONCLUSION

Participants in this supervisor training and assessment process have reported tremendous learning, whether they were beginning level or more advanced level supervisors. Once familiar with the structure and the need to include the different components into supervision, SITs found their own rhythm and flexibility, their own style of relating to the material to be covered in each supervisory session. They have claimed a new sense of confidence and professionalism when they are able to articulate their competencies and their roadmap for supervision.

Assessment of the competencies of supervisors has been insufficient thus far. Central to the important ethical responsibility, that of monitoring client welfare, is the competence of the supervisor who greatly affects the competence of the supervisee. This process for training and assessment of supervisors has been described in a way that allows it to be easily conducted as a university-based supervision course and in other supervision training settings. This process also creates a practical framework that can be adapted for supervision competencies in other fields. This assessment methodology, framed within the powerful supervisor–supervisee relationship, gives meaning to the support and structure that are vital at all levels of training clinicians.

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APPENDIX A

Supervision of Supervisor in Training

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APPENDIX B

Clinical Supervisor Competencies and Components

Competency 1: Models of Supervision

Goal: To demonstrate knowledge and application of the Discrimination Model (Bernard, 1979).
Action Step: During the supervision sessions, I fulfilled supervisory roles congruent to the needs of the supervisee. In some sessions, I played the role of a consultant, for example when the supervisee wanted feedback on her work with a depressed client. The teacher role was demonstrated when I shared my experience in interpreting the Beck Depression Inventory.
Evidence: This was reported in progress and process notes and in a videotaped session with the supervisee.
Goal: To prepare the supervisee for supervision by explaining the model of supervision that I will use.
Action Step: I gave a handout and explained the discrimination model in the first supervision session.
Evidence: This was demonstrated in the videotape of the first supervision session.

Competency 2: Counselor Development

Goal: To assess both the supervisor's and the supervisee's level of development in several areas (personal awareness, learning/work ethic, autonomy, motivation, confidence, etc.).
Action Step: I used a rating scale of 1 to 3 for subjective placement of the developmental level in each area.
Evidence: A comparison of rating scales by supervisor and supervisee was made. I viewed the session videotapes and progress notes for point-by-point illustration of developmental gains.
Goal: To assess supervisee's growth and confidence with counseling.
Action Step: I observed, advised, and modeled for the supervisee. We conducted pre- and postassessment of counseling skills.
Evidence: This was demonstrated from the skills and confidence assessment forms we both filled out.

Competency 3: Knowledge and Use of a Variety of Supervision Methods and Techniques

Goal: To use a variety of techniques for interacting with the counselor in an effort to provide the most purposeful and meaningful assistance.
Action Step: I varied the use of role play, modeling, reflecting, confrontation, silent chair, homework assignment, and reading material depending on the specific need of the counselor and the specific need of the counselor's client.
Evidence: I charted the use of these techniques by viewing the videotapes and through review of the progress and process notes.
Goal: To demonstrate knowledge of several supervision methods during the supervision process.
Action Step: There was movement from the cognitive to the affective to the behavioral realm when appropriate during supervision sessions.
Evidence: I listened to tapes of supervision sessions for feedback and suggestions.

Competency 4: Awareness of Supervisory Relationship Characteristics and Issues: Intervention Strategies to Facilitate Positive Interaction

Goal: To maintain ability to interact equitably when appropriate and to demonstrate assertiveness when necessary.
Action Step: I got out in front of the supervisee verbally when necessary and confidently redirected the dialogue back to the topic when important issues had not been completely covered.
Evidence: I tallied and charted the times when this occurred.
Goal: To establish an awareness of cultural differences.
Action Step: I discussed and processed with the peer supervision group the ways in which my Nigerian background affected my work with my supervisee to determine if my cultural bent toward directness seemed problematic.
Evidence: I self-disclosed with my supervisee how our approaches to conducting initial interviews was different. I am more direct, but I shared appreciation for my supervisee's approach as well.

Competency 5: Knowledge and Response to Ethical, Legal, and Professional Regulatory Issues

Goal: To ensure that the supervisee is well-informed about legal/ethical issues in counseling and supervision.
Action Step: At the first meeting, I provided a detailed informed consent form and a legal/ethical issue form.
Evidence: After my reading these documents out loud to the supervisee, while recording our session, we both signed the documents.
Goal: To demonstrate and share knowledge of ethical principles.
Action Step: I discussed appropriate sections of the American Counseling Association's (ACA, 1995) *ACA Code of Ethics and Standards of Practice* such as confidentiality and duty to warn, monitored my supervisee's cases to cover vicarious liability, and discussed the agency's policy on crisis management and after-work services.
Evidence: My supervisee was given a copy of the ACA code of ethics, and this action was reported in my progress notes. I kept a log of my supervisee's cases and signed case notes. Also, my supervisee was reminded that I was available for consultation for any major concern, even if it was not at our regular supervision time.

Competency 6: Evaluation Methods and Procedures Regarding the Counselor's Cases, the Counselor's Skills, and the Supervisor's Skills

Goal: To develop and use effective teaching of case conceptualization skills to the counselor.
Action Step: I developed a "counselor-friendly" form for case conceptualization that offers a step-by-step progression.
Evidence: Written evaluation of the supervisee's case conceptualizations was completed.
Goal: To present the evaluation process.
Action Step: Expectations were made known through the consent form and the learning contract.
Evidence: Copies of these agreements were given to the instructor and the class.

Competency 7: Executive or Administrative Skills—Record Keeping and Collaborating With the Institutions Involved

Goal: To develop and maintain ongoing contact with the site supervisor.
Action Step: When doing site visits, I contacted the site supervisor and was available at any time for consultations.
Evidence: Progress notes were documented.
Goal: To maintain appropriate records.
Action Step: I wrote process and progress notes and had an audiotape or videotape of each meeting with the supervisee.
Evidence: These were shared with the instructor and the supervision group.

The Development of the Spiritual Focus in Counseling and Counselor Education

Geri Miller

This article summarizes the Association for Spiritual, Ethical, and Religious Values in Counseling's (ASERVIC's) history with the American Counseling Association (ACA) and the Summit on Spirituality. It includes comments on the importance of spirituality in counseling and the rewarding aspects of infusing spirituality into counseling from the perspectives of Mary Thomas Burke, Eugene Kelly, and Judy Miranti. The article concludes by exploring issues related to fusing spirituality with counseling and presents recommendations.

The spiritual dimension is a necessary and beneficial component in mental health counseling. Frequently clients are concerned about spiritual issues in their lives and want to discuss these issues as a part of counseling. For counselors to be prepared to address these spiritual concerns, both the American Counseling Association (ACA) and counselor education training programs need to incorporate the spiritual dimension in a planned, thoughtful manner. To effectively and ethically address spirituality issues in counseling, counselors need guidance from the ACA, particularly the division of the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC). Understanding ASERVIC's important role in the development of guidelines incorporating the spiritual dimension in counseling, requires a brief review of the individual histories of ASERVIC and ACA and how the two histories became interwoven.

In 1952 the American Personnel and Guidance Association (APGA) was founded. In 1983 its name was changed to the American Association for Counseling and Development (AACD), and in 1992 it became the American Counseling Association (ACA). The following summary (up to the 1980s) of ACA's relationship with ASERVIC, a division of ACA, is drawn from Bartlett, Lee, and Doyle (1985).

In 1961, three groups merged to become the National Catholic Guidance Conference (NCGC): (a) the Catholic Counselors in APGA, a special interest group formed in 1955 that met each year before the APGA convention; (b) the founders of the *Catholic Counselor* (now ASERVIC's *Counseling and Values*), a publication that was started by the Catholic Counselors in APGA in 1956; and (c) the National Conference of Guidance Councils, a group of diocesan councils formed in 1958 to look at guidance and counseling in parochial schools. (This group originated in 1951 when the Archdiocese of New York formed the Catholic Guidance Counsel.) They merged to become a part of the larger organization of APGA. In 1973 the NCGC became APGA's 10th division, a division that brought attention to counseling issues focused on religion and values. In 1977 the NCGC became the Association for Religious and Value Issues in Counseling (ARVIC). This name change was a result of a leadership relationship with the APGA and some informal pressure from the APGA; the group was no longer an organization for Catholic professionals but a focal point for examining counseling in terms of its religious and values issues (Bartlett et al., 1985).

In the mid-1980s, ARVIC leaders realized the term *religion* in its title was not encompassing enough, so there was discussion at the national board level and state membership levels about adding the word "spiritual." After 3 years of discussion as well as careful consideration of a membership survey regarding the name change, the board of directors voted at the 1993 ACA convention to add the words "spiritual" and "ethical" to ARVIC resulting in the name change of the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC; Wagenhofer, 1993). ASERVIC continues to provide leadership to ACA on spiritual, ethical, and religious values. No other division has spirituality as the main focus of its mission. Because of this important focus, ASERVIC plays a critical role in ACA's recent commitment to a diversity that includes spirituality.

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To understand ACA's recent commitment to emphasize the spiritual aspect of counseling, phone interviews were conducted with three individuals whose involvement in ASERVIC and ACA enables them to provide an insightful overview: Mary Thomas Burke, Eugene Kelly, and Judy Miranti (see the Appendix for brief biographical information). They discussed (a) the importance of spirituality in counseling; (b) the roles of ASERVIC, the Summit on Spirituality, and the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) in the process of fusing spirituality into counseling; and (c) personal rewards they have experienced as a result of their involvement.

IMPORTANCE OF SPIRITUALITY IN COUNSELING

There is increasing evidence of counselors' need to be knowledgeable and competent in the area of spirituality in counseling. CACREP standards are currently in the process of being revised with the intent of incorporating spirituality competencies. (The standards are scheduled to become effective January 1, 2001.) In addition, ACA has developed a position paper asserting a commitment to diversity that specifically includes spirituality. The challenge for ASERVIC will be to define the competencies regarding spirituality. To further the argument for the importance of including spirituality in the counseling process, the three interviewees were asked to lend their voices to the current discussion.

Reflecting on the progress that has been made, each interviewee summarized his or her views as to the importance of including spirituality in the counseling process.

Burke: Spirituality is an integral part of a person's life. Everyone is looking for meaning in life which comes from the spiritual dimension of one's life. Many people have questions and struggles with spirituality, which they bring to counseling. Counselors need to be prepared to address these issues with their clients, or they will be doing them a great disservice.

Kelly: It is important for counseling to include spirituality because the evidence we have from research and clinical experience is that the area of spirituality is very important for many people. For example, wellness models state that spirituality is a part of human development. It makes sense for a counselor to work on spiritual issues when they emerge and are relevant in counseling. Although not everyone accepts spirituality as a part of reality or considers it important, we need to understand that it may be an important part of counseling, perhaps for many clients. Many clients hurt with loneliness, guilt, shame, and anger. Spirituality, when authentically present, provides a way to move toward meaning in life, even when it is painful. Spirituality can provide the client with a source of benevolence toward oneself as well as a context for social support such as a religious or spiritual community. Counselors, who have a religious bent, need to be alert that religious experiences may have a negative as well as a positive impact for clients and help those who have negative experiences to work through the impact of those experiences.

Miranti: Spirituality is a natural, life enhancing, developmental process that gives purpose and meaning to life. We should not have to wait to be asked to facilitate the spiritual aspect of our clients. While it is unethical for us to impose our beliefs on our clients, we can explore spiritual themes in the context of helping our clients enhance their lives by finding meaning in them. We need to look at themes that have been a meaningful part of a person's life and encourage the presence of those themes. In order to be sensitive to our clients, we need to be aware of our own views of spirituality in order to help our clients define spirituality in their own lives.

These views both clarify and underscore the need for infusion of a spiritual focus in both counseling and counselor education. The exploration of this fusion began with the Summit on Spirituality.

SUMMIT ON SPIRITUALITY AND SUBSEQUENT SESSIONS

While editing *Counseling: The Spiritual Dimension*, Burke and Miranti began to talk about convening a summit on spirituality. The summit was the outcome of discussions among leaders of ASERVIC who wanted to gather ideas on how to infuse spirituality into the counseling process. It was decided that a summit was the best way to gather such ideas. It took 1 year to plan the summit, and 13 of the 15 individuals invited to the summit were able to attend. These invited individuals, from various ACA divisions and across the United States, were chosen because they had written books or articles on spirituality in ACA journals. The 2½ day Summit on Spirituality, endorsed by ASERVIC, was held in October 1995 in Belmont, North Carolina, and was hosted by Mary Thomas Burke and Judy Miranti.

Two important areas that the Summit on Spirituality addressed were (a) defining or describing spirituality and (b) exploring the key counselor competencies regarding spirituality. Day 1's general discussion on spirituality (how it fits in people's lives, and into counselor education) resulted in a draft description of spirituality that was redefined on the 3rd day. Although total agreement was not reached for a definition of spirituality, the consensus description follows (this definition appeared in *Counseling Today*, "Summit Results in Information of Spirituality Competencies," December, 1995):

> [T]he animating force in life, represented by such images as breath, wind, vigor, and courage. Spirituality is the infusion and drawing out of spirit in one's life. It is experienced as an active and passive process. Spirituality also is described as a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual towards knowledge, love, meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one's capacity for creativity, growth, and the development of a values system. Spirituality encompasses the religious, spiritual, and transpersonal. (p. 30)

On the 2nd day, the incorporation of spirituality into counseling practices and the ethics of incorporating spirituality into counselor education were explored and a list of 10 competencies emerged (using the eight CACREP core areas as guidelines).

After the Summit on Spirituality, four subsequent sessions were held at ACA and the Association for Counselor Education and Supervision (ACES) conferences to clarify issues related to the infusion of spirituality into counseling. At the 1996 ACA Convention in Pittsburgh, for instance, approximately 40 people attended a forum focusing on the refinement of the spiritual competencies. In October 1996 at the ACES winter conference in Portland, a session on infusing the spiritual dimension into the CACREP core curriculum was held and attended by approximately 35 counselor educators and supervisors. Out of these two meetings emerged 9 competencies (the original 10 were revised to 9). The CACREP committee will review these 9 competencies for the purpose of incorporating them into the revised CACREP standards. These competencies are as follows:

> In order to be competent to help clients address the spiritual dimension of their lives, a counselor needs to be able to: 1) explain the relationship between religion and spirituality, including similarities and differences, 2) describe religious and spiritual beliefs and practices in a cultural context, 3) engage in self-exploration of his/her religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of his/her belief system, 4) describe one's religious and/or spiritual belief system and explain various models of religious/spiritual development across the lifespan, 5) demonstrate sensitivity to and acceptance of a variety of religious and/or spiritual expressions in the client's communication, 6) identify the limits of one's understanding of a client's spiritual expression, and demonstrate appropriate referral skills and general possible referral sources, 7) assess the relevance of the spiritual domains in the client's therapeutic issues, 8) be sensitive to and respectful of the spiritual themes in the counseling process as befits each client's expressed preference, and 9) use a client's spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference. (Burke, 1998, p. 2)

At the 1997 ACA Convention in Orlando, a 3-hour program was held discussing the competencies and examples of how to incorporate them into each area of the CACREP core. At this point, Phases I and II of the Summit of Spirituality were complete. Phase I of the process of fusing spirituality into counseling was the Summit on Spirituality where a definition/description of spirituality and a list of competencies were drafted. Phase II was to find ways to incorporate spirituality into CACREP criteria. At the 1998 ACA Convention in Indianapolis, a session was held with approximately 35 people in attendance where the focus was on assistance needed to inject spirituality into the practice of counseling. This session was a bridge to Phase III that focuses on infusing spirituality into counselor education through the development of training materials and curriculum guides. At their 1998 meeting in Indianapolis, the ASERVIC Board voted to support an extensive survey with ACA members to determine their needs in this area with the goal being a multifaceted training summit that will assist in incorporating spirituality as an integral part of the counseling practice.

In summary, each of the three interviewees discussed the most rewarding aspects of being involved with the aforementioned process of incorporating spirituality into counseling:

Burke: It has been rewarding for me to meet people with similar interests, hear people say that our efforts are meeting a need, and seeing our efforts fill a void in our profession. We are "blazing a trail" in the area of spirituality in counseling. There has always been a need, but it is only now that the need is being really acknowledged by our profession. We are being looked to by the public to help our young people explore these issues. I hope we do not neglect this opportunity of leadership because ACA has a golden opportunity to make a mark on the counseling profession.

Kelly: This experience has been a very enriching one for me spiritually, emotionally, and intellectually. I have learned a lot about spirituality/religion research as well as what is being done clinically with regard to incorporating spirituality into counseling. In my own clinical work, I have found that the spiritual dimension can be respectfully and carefully incorporated into counseling so that it is enriching to people. Finally, I have also learned a lot in terms of my own teaching. I teach a course at George Washington, "Spiritual, Religious, and Values Issues in Counseling." I have watched how this course has impacted students in their clinical work. The course seems to give students permission as well as skills and knowledge to work on these issues in counseling. It also encourages a respectful alertness in students to issues of spirituality which arise in their counseling work with clients.

Miranti: I want to continually look at how I relate to others, how sensitively aware I am. I have realized that the only movement for change for someone is the internal movement. The power in the therapeutic relationship lies in the presence, acceptance, and facilitation of spirituality that goes beyond any theoretical model. Change can occur for a client if the counselor is sensitive, respectful, and willing to be present with the client in order to facilitate their growth.

ISSUES AND RECOMMENDATIONS

The historical development of spirituality being incorporated into counseling and counselor education is an encouraging one. The events from the initial inclusion of the National Catholic Guidance Conference in the American Personnel and Guidance Association through the current Phase III of the Summit on Spirituality speak to a willingness to dialogue within ASERVIC and between ACA and ASERVIC to make the inclusion of spirituality in counseling respectful, compassionate, and ethical. The involvement of ACA members in the process points out the interest in a spiritual component of counseling. Now as ASERVIC enters Phase III of the Summit on Spirituality, the challenge that faces both ASERVIC and ACA members is how to include spirituality in counseling—and counselor education—to make it a reality. The willingness of ASERVIC to survey ACA members to develop a training summit for this purpose is vital.

The proposed changes to CACREP standards are likely to result in a number of questions that counselors need to face both individually and collectively. These questions may include the following:

1. *How do we help people develop a spiritual identity?* This question invites dialogue about techniques that can be used that are respectful to the client/student, problem, and situation. Although there may be some general techniques that emerge from a training summit and perhaps a model of competencies required of counselor education programs in the county, each counselor/counselor educator will need to face how these general techniques can be respectfully and ethically applied to the idiosyncrasies of each person, problem, and situation.

2. *Do we have a right and an obligation to help people develop a spiritual identity?* Dialogue will be required here to sort out if, when, and how counselors have a right and obligation to enter into this process. A counselor comfortable with the idea of fusing spirituality into counseling should be very aware of his or her own motivation for doing so and the potential bias of his or her own spiritual views on the counseling process. At the other extreme, a counselor who wants to avoid the inclusion of spirituality should examine how such avoidance may negatively affect the client. These same cautions apply to the counselor educator incorporating spirituality into a counselor education program.

3. *How does context affect application?* Dialogue is required in the area of context in two ways. First, information is required regarding the dilemmas counselors and counselor educators face in the different contexts in which they work. Some examples of these contexts include the type of organization in which they work (school, community, university), ethnicity of the client/student, counselor/counselor educator, and geographical setting (rural/urban). Both similarities and differences among contexts need to be understood better to guide counselors and counselor educators on the infusion of spirituality into their setting. Second, counselors and counselor educators need to learn how they are comfortable operating in a spiritual context with an awareness of their own spiritual development: Are some religions/spiritual views more easily worked with than others? Are some infusion techniques more comfortable to use than others?

SUMMARY

Because the history of ASERVIC's relationship with ACA involves dialogue and collaboration, this history creates confidence for me in the process of incorporating spirituality into counseling. ASERVIC and ACA have worked well together historically at forging new concepts and areas necessary to keep counselors current in addressing client issues. Although the meetings of Phase I and Phase II were necessary for respectively describing spirituality/developing competency standards, and examining ways to infuse spirituality into CACREP standards, the attendance of counselors at the meetings also demonstrated the interest in addressing the spiritual dimension in counseling. ACA and ASERVIC will now need to finalize a definition of spirituality, develop a model of incorporating spirituality into counselor education programs, and provide opportunities for counselors to discuss any questions or concerns they may have that are related to spirituality's role. Particularly regarding techniques, both quantitative and qualitative research will need to accompany the proposed inclusion of spirituality into counseling. Researchers will be required to focus on identifying which specific counseling techniques are helpful, in which settings, and with which populations. Only by using techniques anchored in research will counselors and counselor educators be able to rely confidently on the use of these techniques and trust that the definition of spirituality and model of infusion into training will be both ethical and effective.

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APPENDIX

Brief Biography of the Counselors

Mary Thomas Burke. Burke is a professor and coordinator of graduate counseling at the University of North Carolina-Charlotte. She served as president of the North Carolina ASERVIC and the North Carolina Counseling Association in addition to serving as president of ASERVIC, and the ACA and CACREP liaison to the National Board for Certified Counselors. She currently serves as chairperson of the CACREP Board, president of Chi Sigma Iota International, and president of the North Carolina Counselor Educator and Supervisors Association. She coedited *Ethical and Values Issues in Counseling* and *Counseling: The Spiritual Dimension* with Judy Miranti. Both books were published by the American Counseling Association. She is a member of the Sisters of Mercy of North Carolina and currently serves on its governing council.

Eugene Kelly. Kelly is a counselor educator and professor in the School of Education and Human Development at George Washington University. He has been a member of ASERVIC for many years. He was involved in the Summit on Spirituality held in Charlotte, North Carolina, in 1995.

Judy Miranti. Miranti is a counselor educator and dean of graduate studies at Our Lady of Holy Cross College in New Orleans, Louisiana. She has served as ARVIC president, a member of the ACA Governing Council, and president of Chi Sigma Iota. She has found publishing and editing in the area of spirituality a fulfilling challenge. She has also found a very professionally fulfilling association with ASERVIC and ACA. She is trained in marriage and family systems. She has been married for 23 years and has a 21-year-old son.

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