5TH ED

# DR. ARTHUR'S NATIONAL COUNSELOR EXAMINTAION STUDY GUIDE

DSM-5 UPDATED

25+ YEARS

Gary L. Arthur, Ed.D., LPC, NCC, CPCS

Providing NCE Preparation Program Since 1985

DR. ARTHUR'S NCE STUDY PROGRAM

# Dr. Arthur's Study Guide for the National Counselor Examination

To secure the

National Counselors Certification (NCC)

and

Licensed Professional Counselor (LPC)


## Gary L. Arthur, Ed.D., LPC, NCC, CPCS

Gary L. Arthur, Ed.D., LPC, NCC, CPCS a Professor Emeritus in the Counseling and Psychological Services Department at Georgia State University has taught counseling courses at the graduate level for forty-two years. He served as the past Coordinator for the Professional Counseling Program and as clinical coordinator for the internship program. He has conducted over 121 two-day training workshops for participants taking the NCE. He has taught all of the courses in the content areas being tested for the NCE. His research interests include clinical supervision, therapist safety, spirituality and health, geriatrics, and assessment.



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# Introduction to the NCE Study Guide

Be sure this is the preparation guide for the examination for which you have made application. Several mental health disciplines require an examination other than the National Counselor Examination (NCE). Other mental health disciplines include psychologists, family counselors, social workers, and many with specific titles such as Licensed Clinical Professional Counselors (LCPC). The NCE is not for all of these disciplines. The National Board administers the NCE for certifying counselors as a National Certified Counselor (NCC). Frequently the NCE is the same examination many states use for their state license. These licensed counselors are frequently called Licensed Professional Counselors (LPC) however some states may use a different title. Be sure you check with your license board for your state. A ready source to begin your search will be the NBCC (www.nbcc.org) website for the state board directory and state licensure home.

Presently those seeking to take the National Counselor Examination are able to make application for the examination at different stages in their professional development. The first groups are those individuals who have attained a master's degree or beyond in a helping field and meet the curriculum requirements set forth by the National Board for Certifying Counselors. The second group is composed of individuals from those states which legislate a license for counseling and who meet the specific requirements set forth by that state. Many states contract with NBCC to utilize the NCE as their cognitive evaluation instrument to establish a minimum competency assessment. Be sure to check with your state licensing board to determine if the NCE is the examination for your state. Some states

use an independent examination developer other than the NBCC. In most states you should call the secretary of state's office to inquire about an application and the state law specific to the title or practice of counseling. The 2002 spring issue of the Journal of Counseling and Development (Archival Features: 2001-2002, 2003) listed those states that have contacts for state license.

Both groups, at a particular site, are very likely to be taking the NCE at the same time, may even be using the same location, exact same examination questions (in the past), and scoring procedures. It is possible that results may be received at different times for the two groups. The NCE is frequently administered by an independent examiner as a computer examination.

Since 1994, some aspects of the test have been altered. The 200 items are no longer divided in the test by individual content sections such as 25 in research, followed by 25 in counseling theory, etc. The 200 questions are integrated with one another throughout the test with no divisions.

A second alteration has been the inclusion of questions relative to family foundations. There have always been family content questions in the examination; however, they were not identified as such. These questions are scored in one of the five counselor work behaviors. No doubt new and additional questions are constantly being added to the testing pool.

A third change has been in the score reporting. In the past, raw scores were recorded for the eight (8) content areas with respective group means and standard deviations. A final raw score with a sum is reported as pass or fail. This pass score has ranged from 87-107 of the 160 scored items and has varied for different times of testing. According to Loesch and Vacc (1994) the NBCC pass score (minimum criterion score) for some states issuing a license may be set higher than the NBCC national cutoff score.

Be sure you check with your state for specifics, as some states permit your pass score to be retrieved at the time of your application for state licensure, which may be three or four years after you have passed the NCE. The delay is often due to requirements for years of postgraduate clinical work and experience and supervision in the field.

The 200 questions are grouped into five counselor work behaviors, as well as the eight Council for Accrediting Counseling and Related Educational Programs (CACREP) content areas.

A fourth change has been in question formatting. Many questions are testing for the application of knowledge. These questions are presented in the form of a scenario and the examinee is to answer how the counselor is to respond. However, the question is still seeking applied knowledge.

A fifth change appearing in the 2002 testing has been a design change in the number of items within each unit of the objectives. Along with the changes in the number of items has been a name change for the Research and Evaluation chapter. Presently, it reads Research and Program Evaluation. Thus, appearing in the examinations are questions relative to program and therapist effectiveness.

A sixth change appeared when NBCC announced during 2012 a change in categories for the Work Behavior area as a result of a completed survey. The Work Behavior areas and number of items per work behavior are: Fundamental Counseling Issues (32), Counseling Process (45), Diagnostic and

Assessment Services (25), Professional Practice (38) and Professional Development, Supervision and Consultation (20).

A seventh change came about with the recent survey conducted in 2012. The major change has been to rename four units of the eight study areas. These unit changes are Assessment, Social and Cultural Diversity, Career Development and Professional Orientation and Ethical Practice (www.nbcc.org/nce).

# NCE Score Reporting

The National Board for Certifying Counselors did not grant permission to reproduce a sample of the standard format in reporting scores. From reports provided to a number of test participants, a few helpful suggestions can be provided. A word of caution is to be exercised. The number of questions for each of the eight content areas has recently been different than in the past few years. If you should desire the exact number, you should contact the National Board for Certifying Counselors for this release of information.

Based upon past examination reports, the following information should be considered but not taken as an exact figure. The number of test questions for each study does not appear to be equal. Human Growth, Social and Cultural Diversity, Helping Relationships, Group Work, Career Development, Assessment, Research and Program Evaluation, and Professional Orientation and Ethical Practice are the chapters for study. From recent score reports the percentage or number of questions for each content area often change with each survey NBCC undertakes. The number of questions per content appears to be as follows: 8.5% (17) Human Growth, 8% (16) Social and Cultural Diversity, 20.5% (41) Helping Relationships, 10.5% (21) Group Work, 13% (25) Career Development, 12.5% (25) Assessment, 10.5% (21) Research and Evaluation, and 17% (34) Professional Orientation and Ethical Practice. Therefore, in prioritizing study time, it is advisable to rank the percentages. In addition, one can multiply the percentage by 200 for an actual number as reflected in the parentheses. Included in the percentage and for each raw score will be five practice questions under review for future testing. Your scores will also be reported in counselor work behaviors. Those areas are Fundamental Counseling Issues, Counseling Process, Diagnostic and Assessment Services, Professional Practice and Professional Development, Supervision and Consultation (www.nbcc.org/nce).

In 2001 NBCC included work behaviors to the scoring format to represent counselor work areas and behaviors. Job analysis surveys are conducted periodically to determine if job tasks are different than past surveys. The same 200 questions designated for the eight content areas are grouped or sorted into the counselor work behaviors and yield percentages of 16%, 22.5%, 12.5%, 19%, and 10% respectively in the 2012 reported survey.

The National Board for Certifying Counselors releases for publication only past testing results in range scores. Although this is not very helpful for individual content area, means and study allotment goals, you will have to secure this information from those who have taken the examination. The Minimum Criterion Score (MCS) has been in the range of 87-107 with a mean range of 101.38-116.28, and a standard deviation range of 11.40-17.38.

The curriculum and degree requirements for NBCC approval in order to take the NCE are contained within the NBCC application packet that can be downloaded from NBCC's web site. The following address and telephone number will assist you in securing this information.

NBCC
3-D Terrace Way
Greensboro, NC 27403-3660
Telephone: 336-547-0607

# Information About the NCE Examination & Testing

NBCC schedules the NCE and it is administered in every state and in other locations upon approval. Be cautious about waiting to apply, as there are deadlines with a limited time span for approval. Some of the following suggestions may be helpful when studying for and/or taking the examination.

1. Data are being gathered regarding success from individuals who have purchased this manual. In addition, a questionnaire has been designed to request information from users of this manual. Information that would be helpful will focus on how many years exist between one's graduate degree and taking the examination, whether the individual used a study guide, studied alone or with someone, attended a seminar, used a study guide plus a seminar, and whether the study guide was helpful and in what way.
2. I have made the following suggestions based upon 43 years teaching counseling courses and 30 years teaching in a CACREP program and experiences in conducting in excess of 120 2-day preparation seminars and having interacted with many NCE participants throughout the United States. If you are a recent graduate of a CACREP program, an NCE preparation guide or seminar may be extremely helpful. If you graduated from a program that did not require some of the content courses, or you are two or more years away from your graduate study, a preparation guide and/or seminar are usually necessary. In all cases, many participants recommend a study partner.
3. The examination is composed of 200 multiple choice questions each with four options. The exact numbers of items for each of the eight content areas and five counselor work behavior areas are not equal. There is no penalty for guessing, so do not leave any questions unanswered. Remember, you do not have to pass each subtest area but must receive a total correct number to pass. The "pass" score number is established by the particular group under testing and the NBCC board. Reviewing past testing, this score has varied from 87 (1985) to as high as 107 of the 160 items scored.
4. NBCC indicates that some items on the test are being reviewed as future test items. This number is stated as 40 or possibly five from each of the eight areas, therefore your score will be based upon 160 rather than 200.
5. Your individual score (raw) may be returned with corresponding group scores for each content area and counselor work behavior along with a group mean and standard deviation. The score

will be highlighted as pass or fail. Some states do not return individual or summed content scores but do indicate pass or fail. If you took the NCE through NBCC, information will be provided along with your newly acquired credential, the National Certified Counselor (NCC).

6. Should you not be successful, it is recommended to continue your study and retake the examination as soon as possible. There is a tendency to delay retaking of the examination, but to do so is to run the risk of having to regenerate energy for relearning at a much later time. Be mindful of your test taking and test results and seek material for those areas in which you can gain the most points and use concentrated study and/or tutoring. Should you not be successful, revisit the standard error of measurement to help you determine your chances of success upon retaking the NCE. Remember, you do not have to pass each section.

7. Be sure you are aware of the location of the test site where the examination is to be administered. One can be unnerved upon arriving in the area the morning of the test and feel pressured by time and newness to surroundings. Give yourself adequate time to debrief and relax, and not feel pressed.

8. The examination rules allow for four hours, so an adequate amount of time is available. Be mindful that someone will get up and leave in a shorter amount of time than you think is possible. Do not allow that to affect your composure. There always seems to be someone who is a rapid test taker; the rest will be like you. Take your time but do not linger on difficult items too long. If you are nervous or tense use some of your own stress-coping strategies such as breath inhalation or muscle relaxation. Previous test takers comment that they did not use their test time wisely. The questions are longer than in earlier examinations, therefore it takes more time to read and reread questions. If you are unable to determine an answer in a couple of minutes and you find a need to reread, mark it as one of those questions to return. Make it easy to locate those items so mark the number on the piece of paper provided to you at the test site. The question may look different when you return, plus you may read a future question that will assist your memory and recall. For those program students taking the NCE at a university or a large group of examinees the paper form has been the procedure. Writing on the test booklet has been allowed but troublesome turning pages to find those left unanswered. So for those left undone, at the time, write the number down on the piece of paper so that it is easier to locate it upon return. For the computer application of the NCE use the piece of paper.

9. There will be an established procedure for taking leave of the examination for necessary breaks. You are not likely to have time for going over each question a second time. Before the examination, consider a method to return to those items you definitely want to review a second time. Your own special type of marking is recommended, as you will be able to write on the examination. Pressure mounts when you know there are five or six items you want to revisit but are unable to locate them.

10. It is advisable to know how you take examinations. Take a practice examination of four hours and determine your fatigue points. "The practice exams online are more like the actual test and the pre-assessment online is similar in format to the pre-1994 examination. The pre-assessment exam is designed to be a content and knowledge assessment test. It is

recommended that you first take the pre-assessment exams online so that you can assess your strengths and determine areas where study will be helpful. This assessment will also help prioritize your study along with an estimate of how many items are on the actual test for each unit of study. Past users of the manual indicate that this examination is more difficult than the actual test so do not be discouraged if you did not do well. An answer page accompanies each of the examinations along with brief reasons for the answers.

11. How should I prioritize my study? Remember each unit of the test has five questions under review that will not count. If you will add five questions to each number you can rank the test units of most questions. This would indicate that Helping Relationships with 36 +5 questions and Professional Orientation and Ethical Practice with 29 + 5 questions contains the most questions per section. The fewest questions are found in Social and Cultural Diversity with 11 + five and Human Growth with 12 + five. This type of sorting has been the situation since the change in test format in 1994 and most recently in 2012.

# Style and Format of Questions

This examination covers a broad area of study. It has not been steeped in psychoanalytic material or heavy in the specifics of the DSM-5™. That does not mean one should not know the structure of those theories or the framework for the diagnostic process. For the most part, training at this level and for this examination has not been testing for diagnostic work. This may change, as CACREP presently stipulates all CACREP programs to require at the master level programs a course in psychopathology (e.g., DSM-5™) and in addictions. New material for both areas will appear in this revision of the NCE Manual.

1. This examination covers material across the life span. It appears that the test writers and developers are interested in testing an awareness of the many concepts across the eight content areas of this examination. In addition, the application of these constructs in the form of scenarios will test a working knowledge of field experiences (counselor work behaviors). This is one area in which the number of test questions has increased. It is helpful to be mindful of changes that take place developmentally from child-adolescent-adult vocationally, intellectually, socially, physically, and culturally across the life span. A question may be posed where the examinee is to note changes in some theory or interaction.
2. You may come across questions to which you have not had content exposure in your program of study or in a study course guide. Do not allow that to affect you, as this is a broad examination. It is even possible that the question may be one under review and will not affect your score. It is only one question. The pre-assessment exam online has a few questions for which the content is not covered in the manual. When you take these questions, attend to your personal reactions and recognize how best not to allow this to affect your overall performance.
3. Study definitions, purposes, how to process through theories whether developmental or otherwise, how to apply knowledge, and how ethics will impact each section. Some names

(theory developers, etc.) may be found on the examination; however it seems to be very few. No dates have appeared on the examination.

4. Some questions will be such you may wonder what is being requested. Do the very best to break the question down into parts and re-link the meanings. If it becomes a struggle, do not spend too much time and become frustrated; leave it and return later during the examination. It may look different the second time you read it.
5. For ethical questions in the form of a scenario that requires a counselor action or decision, adhere to the basics. The overriding principle of do no harm should be foremost in your mind. In addition, do not act in isolation or take the dilemma to supervision are good choices. Keep in mind a decision should be based upon the greater good and basic fundamentals. It is difficult to write a question for intervention or midway into a dilemma as all of us could add or interject conditions such as "but also," "if it were this way I would," etc. Sometimes field experiences do not fit nicely into a multiple-choice format. Some practice examples will be provided in the next few pages.
6. Answer only the question posed. Do not read into the question or assume what is behind the question.
7. These are straightforward questions. When answering questions, first think of the basics, how one should begin counseling and proceed from there.
8. Questions may also reflect the cognitive domain, thus becoming increasingly more difficult. Some questions will require more than simple recall, and two or more chunks of facts or inferences will be necessary.
9. Questions 1-4 are intended to reflect spiraling questions and the different ways in which a question may be phrased. The difficulty level will begin with recall.

Recall:
Recall questions can be in the form of simple identification, such as who is the father of guidance (Frank Parsons), arranging certain theories and stages in order, such as the GAS syndrome (Hans Selye), and purposes of career, counseling, group, learning, and developmental theories. Recall can be names of authors, founders, matching author with theory, authors who share similar theoretical formulations, definitions, concepts, and constructs. Memorization is important because facts will be important to solve more difficult questions.

**Question I-1:**
Transference is:

a. the attributes of unwanted emotions.
b. returning to an earlier phase of development.
c. incorporating the qualities of another.
d. a client's projection of past feelings and attitudes onto the counselor.

Answer: d. a client's projection of past feelings and attitudes onto the counselor. Transference is when the client projects onto the therapist characteristics of another person such as a parent and then responds or reacts as though the counselor possesses those characteristics (Seligman & Reichenberg, 2010).

**Question I-2:**
The counselor's projected emotional reaction to or behavior toward the client is described as:

a. projection.
b. catharsis.
c. quoid and mavis.
d. countertransference.

Answer: d. countertransference. Countertransference is when the counselor projects onto the client's behavior or characteristics of individual's in the counselor's past. It might be the counselor's father was an angry person and certain behaviors or characteristics the client demonstrates may trigger a reaction the counselor had at that time.

a. projection is a psychoanalytical defense mechanism
b. catharsis is emotional release
c. (quiet, ugly, old, indigent, and dissimilar) (young, attractive, vivacious, intelligent, single)
d. countertransference is the counselor's emotional reaction toward the client

**Question I-3:**
The overriding client welfare term when resolving an ethical dilemma is:

a. nonmaleficence.
b. fidelity.
c. beneficence.
d. honesty.

Answer: a. nonmaleficence. Nonmaleficence refers to doing no harm. For definitions to letters b, c, and d, see Unit One in the manual.

# Information and Analysis

Resolving information and analysis questions requires the selection of one or more facts. Creating the confidence band in question four will require the selection of appropriate facts to establish the predicted score range for a client.

**Question I-4:**
A student requests assistance in understanding his SAT score that was 950. The data sheet indicated that the group mean was 1000, median of 1050, standard deviation of 100, standard error of

measurement equal to 25, and test-retest reliability equal to .94. The student wanted to know if it was feasible to retake the examination, as a score of 1000 was required to enter the school of his choice. The counselor could make one of the following statements:

a. two out of three times the score is likely to fall between 950-1000.
b. 19 out of 20 times the score is likely to fall between 900-1000.
c. 1 out of 100 times the score is likely to fall between 900-1000.
d. 2 out of 3 times the score is likely to fall between 850-1050.

Answer: b. 19 out of 20 times the score is likely to fall between 900-1000. The two pieces of information required to answer this question are the obtained score (950), which becomes the personalized mean, and the standard error of measurement (25), which becomes the individualized variance for the student. What the student is requesting is two confidence band(s) or limit(s) and what is the probability the score of 1000 can be attained. This score of 1000 is two standard units (25 + 25) or 50 points to the right and 50 points to the left of the obtained score (950). Thus, the range of scores for two confidence bands is 900-1000 and consumes a probability statement of 95 times out of 100 or can be reduced to 19 out of 20 times.

# Theory Questions

These questions range from how to process or progress from one stage or phase to the next, understanding the stages, arranging stages in order, and applying concepts of a theory (analysis). Theory questions can be in the form of contrasting two theories. Another format for theory questions might be to determine in what way are two theories similar or dissimilar. Theory questions may request the technique associated with that theory or what does the author consider a healthy person. Finally, the question may be formatted to appear as though the counselor is working in a field setting with a client (work behavior questions). Be mindful the question is still requesting content.

**Question I-5:**
Arrange in order Erikson's Stages:

1. industry vs. inferiority
2. initiative vs. guilt
3. generativity vs. stagnation
4. autonomy vs. shame

a. 1, 2, 3, 4
b. 4, 3, 2, 1
c. 3, 4, 1, 2
d. 4, 2, 1, 3

Answer: d. (4, 2, 1, 3)

**Question I-6:**

An adolescent counselor is counseling a 15-year-old youth who is experiencing difficulty in peer relationships, both male and female. In addition, this student vacillates between wanting to do well in school and not caring about grades. Using the Erikson psychosocial model, the counselor would expect this person to be experiencing conflict at which stage of development?

a. industry vs. inferiority
b. autonomy vs. shame
c. initiative vs. guilt
d. identity vs. role confusion

Answer: d. identity vs. role confusion. This stage usually encompasses those individuals in the age range of 12-18 who, in the process of finding out who one is, can experience the failure side of a false sense of self.

**Question I-7:**

Successful progression through Erikson's Stages requires:

a. resolution of the conflict at each stage.
b. meeting the tasks presented by society at each stage.
c. completing differentiation and integration of one's ego.
d. displaying age-appropriate cognitive learning per stage.

Answer: a. resolution of the conflict at each stage. Erikson's model is a conflict model and one is to resolve conflicts at each stage before successfully moving to the next. This entails the positive and negative affirmations.

**Question I-8:**

Donald Super, a vocational theorist, believes a maxicycle is completed during one's lifetime. A minicycle occurs at each stage in his theory and is essential for vocational maturity. At each stage what must happen in this minicycle for a person to be mature at that stage? The person will:

a. acquire and implement a skill.
b. integrate self-concept into an occupation.
c. complete tasks society presents at each stage.
d. continue the sequence of ego differentiation.

Answer: c. complete tasks society presents at each stage. Super is best known as a stage-and-task theorist. Super believed completion of age-appropriate tasks was essential for maturity at each age. Answer b. is a viable answer in that maturity also called for moving a person along the lines of maturity and integrating the many self-role concepts into one's self-concept role. The maxicycle is a step-by-step task and stage development.

# Synthesis-Inference

These appear to be difficult questions because it is assumed one knows the material thoroughly—terminology, component parts, and application. If you know what is requested and how to solve the question the question is not difficult. If not, attempt to break this type of question down and work from the answers to the terms.

**Question I-9:**
Criterion-related validity described as empirical validity and assumed to be separate will differ in:

a. size of a group of examinees.
b. distribution of scores.
c. statistics used to derive meaning.
d. time sequence.

Answer: d. time sequence. Criterion validity includes both concurrent and predictive. Concurrent is for the present and predictive is for the future, so time is the critical variable. The question is inferred from the "differ in." To develop this into a question, one has to recognize that criterion validity has two parts, concurrent and predictive.

# CACREP Objectives

The 200 questions will also reflect the CACREP 2009 standards. Since the NCE is a cognitive examination sponsored and developed by NBCC, it is reasonable to expect the NCE will represent the CACREP objectives. The curriculum objectives for one unit will be illustrated in the introduction chapter and the rest will be illustrated in the study units. For this example, unit seven-appraisal will serve as an example. Unit 7 assessment objectives will be abbreviated.

A. historical perspective and meaning of assessment;
B. standardized, nonstandardized, norm-referenced, criterion-referenced, environmental, performance, inventories, psychological testing, and behavioral observations.
C. scales of measurement, statistical concepts, central tendency, variability, shapes, correlations
D. reliability, measurement error, models and application
E. validity, types, relationship between validity and reliability
F. social and culture factors and specific populations
G. legal and ethical is issues

# Appraisal

**Question I-10: (Objective A.)**
Early forms of test development in Europe and the United States focused on which human behavior?

a. personality
b. interest
c. intelligence
d. achievement

Answer: c. intelligence. Between 1900-1909 the Binet and Simon Intelligence Scale was developed in an attempt to demonstrate that hereditary was the basis for intelligence. The scales of the Binet-Simon Intelligence Scale reflected language, memory, judgment, comprehension and reasoning (Binet & Simon, 1916).

**Question I-11: (Objective B.)**
When a counselor is considering how well a client performed in a particular test area, this concept is:

a. qualitative.
b. quantitative.
c. evaluation.
d. measurement.

Answer: a. qualitative.

**Question I-12: (Objective B.)**
When a score on a teacher-made math test is used to provide information to a client, it is often transformed into a standard score. All of the following are standard scores except?

a. T-score
b. z-score
c. stanine
d. raw score

Answer: d. raw score

**Question I-13: (Objective C.)**
A counselor is determining the relationship between grade point average and a graduate record examination score. A statistical technique to reflect this relationship is:

a. mean.
b. variability.
c. student t test.
d. correlation.

Answer: d. correlation.

**Question I-14: (Objective D.)**
Which reliability's correlation is derived when there are two administrations using two different but equal tests that measure the same construct?

a. test-retest
b. alternate forms
c. coefficient alpha
d. Kuder-Richardson 20

Answer: b. alternate forms. Alternate form may be called parallel.

**Question I-15: (Objective D.)**
The most frequent type of data gathering to form a case conceptualization is a(an):

a. interview.
b. test administration and interpretation.
c. sociometric.
d. computer program.

Answer: a. interview. A case conceptualization is a systematic collection and integration of clinical data. The conceptualization is utilized to gather data and to examine the client's presenting issue(s). Some examples of case conceptualizations are The Steven and Morris Model, Analytical Model, Inverted Pyramid Model and the Linchpin Model.

**Question I-16: (Objective E.)**
Standard error of measurement is to reliability as what is to validity?

a. standard equivalence
b. standard deviation
c. standard error of estimate
d. standard error of validity

Answer: c. standard error of estimate

**Question I-17: (Objective F.)**
When using a standard achievement test for elementary and middle school children and for the test to be fair, the sample when established should represent what type of sampling procedure?

a. random
b. cluster
c. systematic
d. stratified

Answer: d. stratified. Stratified sampling is using norm groups based on national norms such as the percentage of a certain age or race in the population (U.S. Census Bureau population figures).

**Question I-18: (Objective G.)**
When a counselor is using an instrument to diagnosis for a DSM-5™ disorder the counselor is to be mindful of the:

a. qualifications of the examiner.
b. level of licensure the counselor hold.
c. years of work experience the counselor has with the dysfunction area.
d. supervisory capacity of the counselor.

Answer: a. qualifications of the examiner. The user's qualifications include knowledge, skills, abilities, training and credentials. The Code of Ethics, Responsibilities of Users of Standardized Tests (RUST, 3rd ed.), the Code of Fair Testing Practices in Education (A1-9, B1-7, C1-8, D1-7), and the standards for Educational and Psychological Testing recommend that the counselor is to have acquired the necessary academic degree, specialized training and supervision. The RUST report stipulates four factors necessary for qualifications (purpose¸ characteristics, settings-conditions of use, and roles of test selectors, administrators, scorers, and interpreters).

**Question I-19: (Objective G.)**
When interpreting test results to a client, the Code of Ethics recommends that the counselor:

a. is of the same gender.
b. review the results with a supervisor.
c. rescores the test answers for accuracy.
d. has a manual present.

Answer: d. has a manual present. A manual is to be present for consultation during the testing, scoring and interpretation.

# The Profession: American Counseling Association (ACA)

The American Counseling Association (ACA) has undergone four or more name changes. Briefly, early (approximately 1913) formation centered around the interest group which formed the National Vocation Guidance Association (NVGA), only to grow into a membership with broader interests and form the American Personnel and Guidance Association (APGA) in 1952. The membership elected to convey a developmental and life span image, therefore changed the name to the American Association for Counseling and Development (AACD), and in 1989 to ACA. The intent of the name changes was to emphasize the type of work performed by counselors. A question regarding the history of the profession is likely to focus on the work performed by the members at the time. The following outline is to note some of the significant developments that have led up to the NCE.

# ACA Formation

## Standard Development

1. U.S. OFFICE OF EDUCATION: The U.S. Office of Education and programs such as NCATE administered early accreditation of counselor training. Accreditation focused on curriculum and instructor credentials.
2. ACES (Association for Counselor Education and Supervision) wanted more rigorous training criteria and broke away to eventually form CACREP, yet NCATE membership was retained.
3. CACREP was formed in 1981 (Sweeney, 1991). CACREP developed standards and a reviewing process for training programs calling for longer programs (curriculum), internships, supervision, and evaluation procedures.
4. CACREP sought membership in NCATE and COPA (Commission on Postsecondary Accreditation)
5. In 1987, CACREP applied for and received Category A membership on the National Commission for Health Certifying Agencies.

## NBCC: National Board for Certifying Counselors

NCE Examination: All counselors who meet the graduate degree and curriculum requirements are eligible to sit for the NCE. Those who successfully pass the NCE and graduates of CACREP programs are able to place after their name, NCC (Nationally Certified Counselor). Those graduating from non-CACREP programs are to acquire work experience of 2000 hours under supervision. For exact requirements and changes contact NBCC. Those who are able to take the examination but under different circumstances place after their name, Board Certified until additional criteria are completed.

Subspecialties: After becoming an NCC and having met specific criteria, one can apply for one of the special examinations now offered through NBCC (C.2.b., ACA, 2014). Very often an examination is required. A few are: The Masters Addiction Counselor (MCSC) —National Certified School Counselor NCSC—Certified Clinical Mental Health Counselor (CCMHC).

Continuing Education: To remain in good standing and to retain your NCC, each holder is required to update his/her expertise (C.2.f., ACA, 2014). Specific methods and required hours are provided to each NCC. Similar requirements are to be found for those holding state licenses to upgrade, remain current, and in some form continue to develop their professional expertise. These requirements are also reinforced within the ACA and NBCC Code of Ethics Two terms common to continuing education are "core" and "elective". Institutions that offer workshops, readings, supervision, and other experiences qualifying for continuing education credits are called Providers. NBCC will issue them a provider number. The provider reviews

programs before they are conducted ensuring the content falls within the curriculum requirements for credit and that the presenters are experts. The ACA Code of Ethics construct for this review is informed consent (prior approval and knowledge).

## Counselor Work Behaviors

Questions for the five areas labeled Counselor Work Behaviors, for the most part, are the same questions as those scored for the eight CACREP topic areas. The NCE questions are scored for content and practice. The eight (8) content areas, possibly, may not be tested equally, that is, twenty-five (25) questions per topic as noted earlier. One new content area in 1994 was included within one of the eight topic areas. This area is counseling with families and family foundations and is included in this preparation manual with Helping Relationships. In the NCE it is included under the theory unit. The family foundation questions are now requesting some specific family theory process and principles. The majority of the family questions appear to be name recognition, terms, and in a counseling scenario form which may require one to respond with an ethical response, some information, or in a "how to or what to do" format (practice). For many of these questions, common sense does apply. Following are examples for each of the five Counselor Work Behaviors.

## FUNDAMENTALS OF COUNSELING ISSUES

Counseling practice includes content questions as well as scenarios. This section will cover several of the content areas. It is likely these questions will be derived from the following chapters: Helping Relationships, Human Growth, Social and Cultural Diversity, Assessment, and Professional Orientation and Ethical Practice. There may be as many as 74 questions. Frequently, the name of the theory or theory founder may not be mentioned in the stem of the question. For practice these names will be included in the front of the manual and not toward the back, in the chapters, and in the last examination.

**Question I-20:**
CONTENT: The counselor is utilizing the Erikson Psychosocial Stages in order to understand what the client is experiencing. The client indicates he is an isolate among his friends, and often verbally assaults them for their lack of involving him. He further elaborates that he has no personal feel for himself and frequently is unsure of whom he is or what he wants to do. The counselor might surmise the person is conflicted at which stage?

a. industry vs. inferiority
b. identity vs. role confusion
c. intimacy vs. isolation
d. trust vs. mistrust

Answer: b. identity vs. role confusion. The process of finding out "Who am I?"

**Question I-21:**
PRACTICE: A client in therapy with a person-centered counselor makes the following statement, "I am a lousy parent." A person-centered counselor would respond:

a. I know what you mean when you say "lousy parent."
b. It must feel bad to think you are a bad parent.
c. In what ways do you see yourself as a lousy parent?
d. I am sure you are not a lousy parent but may have, at times, neglected to do the right thing.

Answer: c. In what ways do you see yourself as a lousy parent? This is an example of concreteness or specificity. This is also an example of an open-ended question or probe. The following example is the identical question, however calling for a content response rather than practice.

**Question I-22:**
CONTENT: A client working with a person-centered counselor makes the following statement, "I am a lousy parent." The person-centered counselor responds with, "In what ways do you see yourself as a lousy parent?" This response is an example of:

a. empathy.
b. immediacy.
c. concreteness.
d. confrontation.

Answer: c. concreteness

**Question I-23:**
CONTENT: A transactional therapist determines during therapy, and by examples given by the client of his/her interactions outside of therapy, that the client focuses on facts and not feelings. This therapist would recognize the client predominantly uses the ego state of:

a. parent.
b. adult.
c. child.
d. little professor.

Answer: b. adult

**Question I-24:**
PRACTICE: When a transactional therapist recognizes that the client is utilizing ulterior transactions, the counselor would point out the:

a. discrepancy, that is, what the client is conveying in words does not appear to be what the client is experiencing or feeling.
b. Karpman Triangle and begin to process the conflict.

c. therapist is giving the client a "stamp" and return to the discrepancy at a later time.

d. stance the client is taking such as "I'm not okay, you're okay," is a depressive stance.

Answer: a. discrepancy, that is, what the client is conveying in words does not appear to be what the client is experiencing or feeling. Overt interactions are different from the covert messages.

**Question I-25:**

CONTENT: A counselor is counseling a client who represents a culture different than the counselor. The client has recently moved to this region of the country from her home in another country. She expresses she has attempted to fit in with the people who live here but they seem to stand apart from her. She indicates this is unfair, this is a democracy but no one seems to recognize or stand up for her rights. She is confused and has thoughts that she should return to her country. The counselor using the Minority Identity Model surmises the client is at which stage of this model:

a. dissonance

b. resistance

c. immersion

d. introspection

Answer: a. dissonance. Dissonance, a questioning of one's oppressed identity, and she is about to enter the second stage, resistance.

**Question I-26:**

PRACTICE: Using the above example, the counselor is likely to:

a. process the Minority Identity Model with the client and determine if the client senses this may be true.

b. process the worldview with the client and assist the client in understanding the dominant culture.

c. refer the client to a counselor of the same culture.

d. read up on this culture and adapt a counselor style in accordance with the client.

Answer: a. process the Minority Identity Model with the client and determine if the client senses this may be true. The counselor would, with worldview knowledge of the culture, process the identity model and allow for interaction.

## COUNSELING PROCESS

Career Development questions are both content and practice. Some examples to complement those already written in the manual will be provided.

**Question I-27:**

CONTENT: A trait and factor career theorist would determine that a client who is expressing a desire to train and become a surgeon yet did not take courses such as biology, chemistry, and sciences in high school would be experiencing which type of choice?

a. uncertainty about his/her choice
b. no choice
c. discrepancy between interest and aptitudes
d. unwise choice

Answer: c. discrepancy between interest and aptitudes. Since the student avoided science subjects the counselor could surmise a discrepancy in interest and skill. Further counseling will determine if this is an unwise choice or uncertainty.

**Question I-28:**

PRACTICE: In the above example, the counselor would:

a. attempt to point out other occupations which agree more with the student's high school choices (subjects, activities, etc.).
b. explore with the student the requirements for training in the health sciences as well as his/her depth of interest in the field.
c. administer a battery of instruments and inventories to determine the validity of the student's reports.
d. encourage the student to bring his/her parents to the next session whereby the student and counselor will benefit.

Answer: b. explore with the student the requirements for training in the health sciences as well as his/her depth of interest in the field. Keep the options open for the student and counsel for exploratory measures.

**Question I-29:**

CONTENT: A career counselor representing the Segmental Theory and Cyclical Counseling would recognize that when a client expresses (dis)agreement between his/her abilities and preference(s), interests and preference(s), interests and fantasy preference(s), and the socioeconomic accessibility, the client is expressing:

a. congruence.
b. consistency.
c. transition.
d. realism.

Answer: d. realism. Donald Super's term for the degree of agreement is realism.

**Question I-30:**
PRACTICE: A cyclical counselor working with a client who is confused about his/her occupational direction and present level of satisfaction would conduct which step first?

a. assess vocational maturity
b. assess the person's self-concept
c. teach decision-making skills
d. appraise the life stage the individual is presently residing

Answer: d. appraise the life stage the individual is presently residing

**Question I-31:**
PRACTICE: A vocational counselor is counseling with a young person (31) who has had a series of jobs, none lasting over 3-4 months. He appears to be sincere about having a full-time job, however, and is confused about why the jobs end so abruptly. He has not, at any of the jobs, been delinquent regarding equipment, late to work, and/or disrespectful. During counseling the client expresses that he has no real feelings or reasons for these frequent dismissals, in fact he offers many reasons why the companies benefit. His initial request is for the counselor to help him find a job. The action of the counselor may be to:

a. administer a battery of tests to include an interest and personality.
b. refer him for a psychological evaluation to rule out any diagnoses.
c. indicate to him he should seek personal counseling with another counselor while this counselor works with him on a vocational plan.
d. assess whether his work history has a similar pattern to a parent's work history.

Answer: b. refer him for a psychological evaluation to rule out any diagnoses. All of the answers may be appropriate; however, before entering extensive counseling or vocational planning, rule out other complications. Letter c. might be an option, however this is an example whereby it may be best to start the counseling off with what is the nature of the concern before working on too many aspects at one time. If an examinee is indecisive about which of two choices is the best answer (unless a specific request is made in the stem of the question) it is usually wise to consider how to start some experience.

**Question I-32:**
CONTENT: A vocational counselor is counseling with a client who recently experienced, due to de-engineering, a permanent dismissal from work. The client has a broad range of industrial skills and experiences and realizes he will have to broaden his search to include new occupational settings. He does not desire to go on the unemployment rolls and wants permanent and immediate work. The counselor would:

a. recommend he begin with at least a few cold calls.
b. begin his search with Career InfoNet.
c. suggest he start with a temporary agency.

d. recommend the daily newspaper want ads.

Answer: b. begin his search with Career InfoNet. Career InfoNet is a key word search (Internet access) for more than a thousand occupations that includes descriptions, detailed data, employment outlook, salary range, state by state. It also includes the fastest growing occupations, largest employment, those occupations declining, and includes links to Web sites that provide assessment, occupational information, resume-writing instruction, job-seeking instruction, and general career planning support (Niles & Bowlsby2013)

## DIAGNOSTIC AND ASSESSMENT SERVICES

**Question I-33:**
All of the following are utilized when gathering client data to formulate a case conceptualization except?

a. clinical interview.
b. bio-social interview.
c. Kelly-Winship model.
d. Mental Status Interview.

Answer: c. Kelly-Winship model. Kelly Winship model is a communication technique to point out discrepancies in shared communication.

**Question I-34:**
PRACTICE: In a theme-oriented group for alcoholics, one member dominates the interaction. The leader of the group would best:

a. view it as a group role and his talking serves a purpose for the group.
b. request the group to talk about why it is comfortable with allowing one person to do the majority of the talking.
c. take the person aside and ask him to allow others to talk.
d. break into dyads and provide them a task, thus everyone gets to talk.

Answer: b. request the group to talk about why it is comfortable with allowing one person to do the majority of the talking. Most group leaders would suggest letting the membership deal with the concern. In addition, this behavior reinforces shifting the responsibility to the group and not the leader.

## PROFESSIONAL PRACTICE

Several professional practice questions are to be found throughout the manual. Additional examples will be provided in order that a differentiation can be made between content and practice as well as professional development.

**Question I-35:**
CONTENT: The counselor is counseling with a family that has been referred by the school counselor for suspected verbal abuse. The intake application indicates that there is a communication problem within the family, especially with the teenage daughter. During the first session this teenager refuses to speak or look at the father. Some therapies or parents might refer to the daughter as the:

a. scape goat.
b. identified patient.
c. client.
d. all of the above.

Answer: d. all of the above. Another way to ask that same question is: Which family therapist does not believe in the concept of "identified patient"?

**Question I-36:**
PRACTICE: In example 35 the counselor would best:

a. refer the daughter for individual counseling.
b. conduct a genogram.
c. conduct informed consent and begin to elicit trust.
d. teach communication skills to the family members.

Answer: c. conduct informed consent and begin to elicit trust. Informed consent is probably the first step. Until the seriousness of the problem is determined other alternatives become secondary.

## PROFESSIONAL DEVELOPMENT, SUPERVISION AND CONSULTATION

These questions very likely require knowledge of client issues, counselor behaviors in decision-making, consultation, supervision, up-dating of knowledge and skills, the Code of Ethics and C best client care.

**Question I-37:**
The ACA Code of Ethics regarding professional responsibility charge the counselor to do all of the following except?

a. monitor effectiveness.
b. maintain supervision with professionals and refrain from peer supervision.
c. practice in new specialty areas with training and supervised experience.
d. be alert for self impairment.

Answer: b. maintain supervision with professionals and refrain from peer supervision. Seeking supervision and peer supervision is good but skilled supervision is preferred. To seek peer supervision is to be encouraged not discouraged. Code of Ethics C.2.d. (effectiveness), F.1.a.(client welfare-monitor), C.2.b. (subspecialty), E.5.b. (impairment) ACA, 2014.

**Question I-38:**
The principle goal in consultation when utilizing a consultant is to:

a. produce change in client behavior
b. advance the skill of the counselor
c. maintain client adherence to the continued pursuit of the goal
d. alter the counselor's treatment plan

Answer: a. produce change in client behavior (Kratochwill & Bergan, 1990).

**Question I-39:**
A consultant in working with a consultee (counselor) attempts to provide all of the following except:

a. defining problems.
b. techniques for evaluating whether problem solutions have been attained.
c. formulate definitions of terms provided by the counselor or client.
d. strategies for solving problems.

Answer: c. formulate definitions of terms provided by the counselor or client. Most consultations would not formulate definitions of terms such as a bad attitude or lazy. Rather these definitions are to come from the client or observer.

**Question I-40:**
CONTENT: This is the first session with a 29-year-old male who has listed on his intake form he has had previous suicide attempts. His initial concern is a fear of an inability to sustain a relationship. He has recently met a woman with whom he has become serious. The counselor, during informed consent procedures, indicates that one of her duties is that in her professional judgment, if it would be likely the client would hurt himself or another she would act in his behalf. This statement is an example of:

a. an inappropriate act on the part of the counselor.
b. informed consent.
c. duty to warn.
d. malpractice.

Answer: c. duty to warn. Not only is this behavior a part of the informed consent procedures but is even more important since this client has a history of suicide attempts.

**Question I-41:**
A counselor takes public transportation to the therapy center on this particular day. During the last clinical hour the counselor's client does not show for the appointment and while waiting, the counselor begins talking with the receptionist at the front desk. While talking, another client whom the counselor had seen before in the reception area smiles at the two of them. The counselor is aware that this is a client of the therapist next door to his or her office. In fact, the three of them have previously passed in the hallway. Later, while waiting for the bus, this client appears also waiting for

the bus. The client initiates a conversation stating a recognition that the counselor works at the center to which the counselor acknowledges. Shortly, the client begins to share interactions she or he had with her or his therapist regarding a recommendation from therapy. The counselor should:

a. quietly listen but not comment upon the interaction between the client and his or her counselor.
b. indicate to the client a counselor is not allowed to interact or talk with another counselor's client.
c. indicate to the client she or he should discuss this matter with her/his counselor.
d. ignore the conversation by shifting the topic to the timing of the bus or some mundane material.

Answer: c. indicate to the client she or he should discuss this matter with her/his counselor. Maintain a line of positive regard and respect but politely indicate this material should be taken to therapy.

## Additional Practice Questions:

Questions in Unit One reflect history, profession and professional identity, ethics, and psychotherapy. Following are some examples. Note that much of the content for these questions may or may not appear in the manual.

**Question I-42:**
In a population of clinical clients and documented research findings all of the following are true except?

a. A small number of patients (15%) will show measurable improvement before attending the first session.
b. Three out of four patients are measurably improved at the end of six months (weekly) of psychotherapy.
c. There is a positive relationship between the amount of treatment and the amount of patient benefit.
d. Research evidence suggests that psychotherapies are not equal in effectiveness.

Answer: d. Research evidence suggests that psychotherapies are not equal in effectiveness. At the time of this writing, this information is documented in the literature. It is not likely the NCE questions will contain specific percentages such as found in letter a. and b. Another research report may list some other percentage therefore a response such as letter c. is the more likely presentation.

**Question I-43:**
The most common therapy response mode used by clients in the traditional therapies and by the majority culture is:

a. disclosure.
b. impulse response.

c. control.

d. silence.

Answer: a. disclosure. Disclosure wherein clients are encouraged to talk.

**Question I-44:**
All therapies have a common goal that is:

a. responsibility assumption.

b. hope.

c. emotional bonding.

d. self-efficacy.

Answer: d. self-efficacy. This refers to the total mental health direction for effectiveness.

**Question I-45:**
A counselor is a new intern in a community health agency. The clinical director assigns the intern the task of filing client folders in order to become familiar with the procedures and type of clientele at this center. The directions are to file all client folders with psychotic classifications in one file cabinet and the remaining ones in another file cabinet. Which one of the following would be filed separately from the rest?

a. paranoia

b. agoraphobia

c. panic disorder

d. obsessive-compulsive

Answer: a. paranoia

**Question I-46:**
A new employee in the secretarial pool who is typing psychiatric evaluations consults you because she or he became confused with the DSM-5™. She or he had overheard that the new DSM-5™ was different than the DSM-IV-TR. The psychiatrist has made the following notations regarding a client: the client has alcohol cirrhosis of the liver, has moved recently and divorced six months ago, has a dependent personality disorder, and is experiencing a major depression. This information is most likely referred to as a(an)

a. disorder

b. v-code

c. axis I and II

d. specifier

Answer: a. disorder. Dependent personality and major depression are disorders.

**Question I-47:**
The purpose of a developmental assessment is:

a. to identify the state of development clients are in and suggest tasks they have coped with successfully.
b. to suggest tasks they need to master to move to the next stage.
c. to determine the extent to which their career behavior is age-appropriate, delayed, or impaired.
d. all of the above.

Answer: d. all of the above. It is unlikely that NCE examinees will encounter any response calling for "all or none of the above." This is a teaching question.

**Question I-48:**
A counselor with knowledge of Marcia's Identity Status categories can expect a client is experiencing difficulties with identity formation when the client:

a. has had relationship difficulties.
b. complains that parental models are dysfunctional.
c. is caught in a work role unsuited to interests.
d. is bothered by his/her choice of friends and career preference because of parental differences.

Answer: d. is bothered by his/her choice of friends and career preference because of parental differences. Marcia's Identity Status categories suggest that clients who experience problems in identity formation reveal ambivalence about their choices, hold tightly to a rigid view of themselves, have constantly shifting interests, are immobilized by fear, or are besieged by questions about who they are and what they can do.

**Question I-49:**
Proponents of the Social Influence Model suggest that clients are influenced toward change by high counselor levels of all of the following except:

a. expertness.
b. resources.
c. attractiveness.
d. trustworthiness.

Answer: b. resources.

**Question I-50:**
The strongest predictor for client outcome as perceived by the clients is:

a. expertness.
b. attractiveness.
c. trustworthiness.

d. resources.

Answer: b. attractiveness. Strong (1968) suggested that the theoretical reasons for a counselor to be considered an expert, trustworthy and socially attractive was that the client was to be comfortable with the counselor's appearance otherwise any or all other variables will be affected.

**Question I-51:**
The therapeutic bond is composed of three variables. Which one is not considered to be one of those therapeutic variables?

a. client energy invested in the process
b. empathic resonance
c. mutual affirmation
d. experience level

Answer: d. experience level

**Question I-52:**
How genuine or self-congruent the client and the therapist perceive their respective role behavior is known as:

a. therapy socialization.
b. counseling attitude.
c. self-concept.
d. working alliance.

Answer: d. working alliance. The Working Alliance Theory dates back to the work of Sigmund Freud. Three factors were isolated by Edward Bordin to reflect a therapeutic alliance. The three factors are tasks (behavior and cognitions), goals (outcome) and bond (mutual trust, acceptance and confidence). Bordin's theory is a transtheoretical approach (Ardito & Rabellino, 2011; Bordin, 1979).

**Question I-53:**
To influence a client for change, research data suggests the counselor has all of the following power bases except:

a. coercive
b. referent
c. expert
d. legitimate

Answer: a. coercive. Strong, Welsh, Corcoran and Hoy (1992) believe that social influence modeling utilizes three power factors that are responsible for change. See the Group Chapter for definitions of these powers.

**Question I-54:**
Engagement in counseling refers to:

a. counseling delays, that is, length of wait for ongoing counseling beyond the intake session.

b. client returning for at least one session after intake.

c. premature termination.

d. formation of bonding and development of transference.

Answer: b. client returning for at least one session after intake. Bonding is an element in the Working Alliance theory for relationship development.

**Question I-55:**

Bordin developed a Working Alliance Theory. He believed this alliance is made up of three constituents. All of the following are constituents except?

a. tasks

b. communication

c. goals

d. bonds

Answer: b. communication. The Working Alliance Theory dates back to the work of Sigmund Freud. Later Edward Bordin isolated three factors to reflect a therapeutic alliance. The three factors are tasks (behavior and cognitions), goals (outcome) and bond (mutual trust, acceptance and confidence). Bordin's theory is a Transtheoretical approach (Ardito & Rabellino, 2011; Bordin, 1979).

**Question I-56:**

A constant error in measurement is also known as what type of error?

a. random

b. systematic

c. unsystematic

d. uncharacteristic

Answer: c. unsystematic. Systematic error causes measurements to deviate consistently from their true value. Random error causes measurement to deviate by varying amounts, either higher or lower than their true value. Constant errors cause the same amount of deviation in one direction only.

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# UNIT 1 - Professional Orientation and Ethical Practice

## Introduction

The units in this study manual are arranged according to the 2009 CACREP order (1-8, using numerical numbers) describing the curriculum objectives with the first unit Professional Orientation and Ethical Practice and the last unit Research and Program Evaluation. The same procedure exists within each unit study with material appearing first in line with the order of the objectives for that unit such as 1a, 1b, 1c, 2a, 2b throughout the eight units. An effort has been made to integrate the ACA Code of Ethics (ACA, 2014) into the CACREP curriculum objectives where possible. ACA released the 2014 Code of Ethics March, 25, 2014.

There is considerable overlap in several units of study such as life-span, consultation, multicultural society, diversity, wellness, crises, and family. Sometimes this may appear as though there is a certain amount of redundancy from unit to unit. An effort has been made to limit this as much as possible without detracting from the specifics for that objective in that unit. What may be important in the preparation for this examination is to examine each objective for the key word to study the specifics of the material. Key words appear in the objectives such as framework, effects, strategies, methods, importance, history, roles, responsibilities, advocating, trends, styles, basic concepts as well as specific

wording as self-care, reliability, validity, norm-referenced, central tendency, correlation. These words are direct evidence that questions are likely to focus on that specific information.

The professional orientation and ethical practices subtest covers material relevant to the historical development of the profession, professional preparation, role and functions of counselors, self-care, supervision models, professional organizations, advocating for the profession and client, and the ethical code. Concentrated study should be devoted to the professional organizations of the American Counseling Association (ACA), the National Board of Certified Counselors (NBCC), and respective ethical codes. The ACA 2014 Code of Ethics can be found in most introductory counseling textbooks and on-line (www.counseling.org). Examine your understanding of this code by developing an ethical dilemma pertinent to each section of this study guide. Also, if you have not had a recent course in ethics, it would be helpful to select a current textbook in ethics and become familiar with the legal and ethical practices in counseling. Since one chapter of a preparation guide cannot provide comprehensive coverage of such a broad area of counseling, be sure to understand the terms and concepts in the remaining chapters of the manual by interpreting the content in relation to the ethical code, best client care and implications of counselor behaviors. To aid in this endeavor, questions in this chapter span the broad area of the field to include integrating information from all eight units of study (chapters) and content areas for ethical decision-making. The most recent NCE examinations have included 34 content questions for the professional orientation and ethical practices section, of which 29 count toward your total score. These numbers are subject to change as NBCC conducts surveys and makes changes.

Each unit of study will be identified according to the numbering system for the CACREP 2009 objectives (1-8). Unit 1 is Professional Orientation and Ethical Practice.

# CACREP Objectives

Each unit of the eight NCE content areas and chapters of this manual will begin with the CACREP curriculum objectives. These objectives are outlined in the CACREP 2009 standards manual Section III, Professional Identity (pp. 9-14). The full text of the 2009 CACREP standards can be secured at www.cacrep.org. Each unit of study will include the identifying Section of the 2014 Code of Ethics that pertains to that CACREP objective. Throughout this study manual integration of the objectives will take place with the 2009 CACREP standards, 2014 ACA Code of Ethics, and the American Counseling Association standards of practice which are integrated into the ACA Code of Ethics. Example questions follow the listed objectives.

These objectives are abbreviated in this manual but are fully developed in the CACREP 2009 standards.

A. History and philosophy
B. Professional roles, functions, and relationships with other service providers, collaboration
C. Counselor roles, responsibilities, functions in an interdisciplinary emergency response team, crisis, disaster or trauma
D. Self-care strategies appropriate to the counselor role

E. Counseling supervision models, practices, and processes

F. Professional organizations

G. Professional credentialing, including certification, licensure, and accreditation standards and accreditation and the effects of public policy on these issues

H. Counselor advocacy for the profession

I. Advocacy for institutions and social barriers

J. Ethical standards of professional organizations and credentialing bodies

The following questions are to serve as an example for each of the CACREP objectives for the Professional Orientation and Ethical Practice unit.

**Question 1-1: (Objective A.)**
The professional counselor educator who was charged to create a code of ethics for the American Personnel and Guidance Association later named the American Counseling Association was:

a. Frank Parsons.

b. Victor Frankl.

c. Carl Rogers.

d. Donald Super.

Answer: d. Donald Super.

**Question 1-2: (Objective B.)**
A trainee begins to establish a professional identity by:

a. purchasing liability insurance.

b. joining ACA.

c. acquiring knowledge of human behavior.

d. reviewing professional and personal characteristics of a counselor.

Answer: d. reviewing professional and personal characteristics of a counselor.

**Question 1-3: (Objective C.)**
First responders such as safety officers (police, fire, volunteers) often encounter repeated stressful situations and are themselves affected. It is recommended that first responders are observed for coping skills of resiliency after responding to a crisis or trauma. All of the following actions or techniques are considered helpful to those responders affected by the disaster except for?

a. Mindfulness technique

b. Resiliency training

c. Stress reduction

d. Separate self from the crisis activities

Answer: d. Separate self from the crisis activities. Debriefing activities encourage the first responder to recognize their coping skills (resiliency) and honor their feelings regarding the impact a crisis has on the person.

**Question 1-4: (Objective D.)**
Self-care as defined by the Wheel of Wellness is based upon:

a. Disease and illness model
b. Adlerian model of leisure
c. Mental and physical disorders
d. Human growth and behavior

Answer: d. Human growth and behavior. Myers, Sweeney and Witmer (2000) model is a multidisciplinary focus grounded in theories of human growth and behavior.

**Question 1-5: (Objective E.)**
The model of supervision that does not rely on being didactic rather helps the supervisee draw on his or her own resources, learn to behave independently, and make changes and attend to the positive in both the counselor and the client is:

a. narrative.
b. solution-focused.
c. systemic.
d. reflective.

Answer: b. solution-focused.

**Question 1-6: (Objective E.)**
Solution-focused supervisors adhere to all of the following assumptions except:

a. Resistance resides outside the supervisory relationship
b. Focus on supervisee's strengths and successes
c. Work to achieve what is possible
d. Accept that there is no one correct way to intervene

Answer: a. Resistance resides outside the supervisory relationship. Resistance is considered to be in the supervisory relationship and a collaborative relationship is the means to avoid or circumvent. (Rita, 1998).

**Question 1-7: (Objective E.)**
Considered to be the supervisory role includes all of the following except:

a. Monitor client welfare
b. Encourage compliance to legal, ethical and professional standards
c. Monitor clinical performance

d. Hold a degree greater than the counselor being supervised

Answer: d. Hold a degree greater than the counselor being supervised. In addition to a, b, and c as roles for a supervisor the supervisor is to evaluate and certify current performance.

**Question 1-8: (Objective F.)**
The ACA sub-division that is responsible for spear heading the development of CACREP is:

a. ASGW.
b. ACES.
c. AMHCA.
d. AAC.

Answer: b. ACES (Association Counselor Education and Supervision)

**Question 1-9: (Objective G.)**
The designation that a professional has met certain predetermined qualifications and those qualifications are a non-statutory process by which an agency or association grants recognition is:

a. certification.
b. licensure.
c. accreditation.
d. standard of care.

Answer: a. certification. A non-statutory process by which an agency or association grants recognition to an individual for having met certain predetermined professional qualifications (Fretz & Mills, 1980). Hosie (1995) indicates that certification allows an individual to use a certain title but does not ensure quality of practice.

**Question 1-10: (Objective G.)**
Which of the following corresponds directly to clinical training and an ethical code?

a. Licensure
b. Business license
c. Standard of care
d. Certification

Answer: d. Certification. Licensure does as well but requires additional requirements such as an examination, required years of work experience and supervision.

**Question 1-11: (Objective H.)**
To advocate for the profession, philosophically, counselors share in the belief of helping others with their emotional and mental health. Typically four tenets make up this philosophy. Which one represents one of the tenets?

a. An intervention is the most successful approach to solving emotional and mental problems.

b. The best method to help resolve mental and emotional problems is the medical model.

c. Understanding the dynamics of human growth and development is not essential to solving emotional and mental problems.

d. The goal of counseling is to empower clients to resolve their own problems independently of mental health workers.

Answer: d. The goal of counseling is to empower clients to resolve their own problems independently of mental health workers. One way to advocate for the client is to empower.

**Question 1-12: (Objective H.)**
One way in which professionals can advocate for the profession is to:

a. write a paper on professionalism.

b. secure liability insurance.

c. join a local professional association.

d. include a lawyer on your counseling board.

Answer: c. join a local professional association.

**Question 1-13: (Objective H.)**
To ensure that counselors are able to hospitalize suicide ideation and attempter clients without securing the cooperation of other mental health providers, counselors need access to what commitment documents?

a. 1050.

b. 1032.

c. 1013.

d. 1000.

Answer: c. 1013. A 1013 is the document to admit a client to the hospital for mental health reasons such as suicide ideation or attempt.

**Question 1-14: (Objective I.)**
To advocate against a particular social barrier that limits clients or a service institution can be through all of the following except:

a. targeting policymakers.

b. media.

c. group activities serving a particular social barrier.

d. achieve advanced degree or license for greater recognition.

Answer: d. achieve advanced degree or license for greater recognition. Achieving an advanced degree or license is an individual accomplishment and may help but the outcome is for the client or institution and a, b, and c will have a more direct counselor benefit.

**Question 1-15: (Objective I.)**
When a counselor is deciding to accept a client for services, the counselor considers which of the following to be a primary consideration?

a. client's ability to pay
b. client welfare
c. years of clinical experience in counseling
d. other professionals who have more experience and may be the better provider for the client

Answer: b. client welfare (A.1. client-welfare, primary responsibility-respect for dignity)

**Question 1-16: (Objective J.)**
Most standards of care or practice in the mental health field recommend that counselors adhere to all of the following except:

a. following a professional code of ethics.
b. following all mental health disciplines standards of care.
c. seeking consultation and supervision with colleagues.
d. maintaining accurate documentation.

Answer: b. following all mental health disciplines standards of care. The profession dictates that the clinician adhere to the standard of care for the credentials of the individual. In addition to a, c, and d additional agreed upon behaviors include engaging in continuing education, practicing within the scope of training and expertise, following applicable standards of care, obtaining legal consultation and ensuring that professional malpractice policies are maintained (Corey, Corey, & Callahan, 2003; Patrick, 2007).

## Additional Questions:

**Question 1-17:**
Internet and technology counseling is on the increase. All of the following are considered advantages for technology except:

a. a greater freedom in scheduling.
b. a better choice of written words over oral.
c. anonymity decreases anxiety.
d. stronger client-counselor relationship.

Answer: b. a better choice of written words over oral. (H.4.d. effectiveness of services, ACA, 2014).

**Question 1-18:**
The double bind theory is:

a. a negative feeling that stems from the presence of conflicting ideas or cognition.

b. the fear of approaching a goal.

c. a series of anxious, repetitive thoughts.

d. when distress is experienced because of two contrary messages, one from another person(s).

Answer: d. when distress is experienced because of two contrary messages, one from another person(s).

At one time, it was a popular explanation for schizophrenia in which a confused relationship existed between the child and mother. Barlow and Durand (2002) indicate the double bind theory or double bind communication is an unsupported theory for the cause of schizophrenia.

# Terminology and Contributors

Terms and names of individuals who have made contributions in the field of counseling are listed. Descriptions are at the end of this chapter.

Abnormality
Beers, Clifford
Bulimia
Buros, Oscar
Catharsis
Certification
Confidentiality
Countertransference
Covered Entity
Davis, Jesse
Dependency (client)
Duty to Warn
Eclectic
Endogenous
Expert Witness
Exception to Privilege
Galton, Francis
Hypochondriasis
Informed Consent
Licensure
Malpractice
Mental Status Examination
Merrill, George
OARS
Parsons, Frank
Phrenology
Portability
Privilege
Public Law 94-192
Specifier (DSM-5™)
Super, Donald
Supervision
Synergy
Thanatology
Tiered Licensing
Transference
V-Code
Wounded Healer
Wellness
20/20 Vision

# ACA Guideline Sections

As you prepare for the NCE examination and ethical practice note the relationship between the core requirements in each unit of study and the ethical code sections.

| | |
|---|---|
| Section A: | The Counseling Relationship |
| Section B: | Confidentiality and Privacy |
| Section C: | Professional Responsibility |
| Section D: | Relationships With Other Professionals |
| Section E: | Evaluation, Assessment and Interpretation |
| Section F: | Supervision, Training and Teaching |
| Section G: | Research and Publication |
| Section H: | Distance Counseling, Technology, and Social Media |
| Section I: | Resolving Ethical Issues |

## OBJECTIVE A: History of the Profession

CACREP curriculum core objective 1.a. provides an understanding for the history and philosophy of the counseling profession.

The counseling profession originated and formed around the term guidance. Brown and Srebalus (2003) indicate that there is no particular point in time to recognize for the beginning of the counseling profession. This early development came about due to the contributions of several individuals. Guidance was most closely associated with the curriculum in the schools and occupational work with immigration during the early 1900's. Gibson and Mitchell (1995) identified Jesse Davis, Anna Reed, and Eli Weaver as early contributors to the guidance movement. Jesse Davis, an 11th grade counselor and later an administrator, developed a guidance curriculum (Aubrey, 1977). He preached moral guidance in the form of honesty and as a ministry to work. Anna Reed viewed the student as a product for the business world. Eli Weaver developed committees whereby teachers assisted in helping students discover their capabilities in locating employment. Frank Parsons, a social reformer, was credited as the father of vocational guidance. He was influential in promoting guidance with his work in the industrial world. He developed the first Vocational Bureau in the Civic Service House in Boston in 1908. This bureau development is cited as an important contribution because it was the first institutionalization of vocational guidance (Brown & Srebalus, 2003; Capuzzi & Gross, 2001). Frank Parson's belief and practice in listening to the desires and aspirations of clients regarding a vocation remains the mainstream of counseling today (Nugent, 2000).

The founding of the National Vocational Guidance Association (NVGA-1913) came about as a result of a vocational conference held in Boston (Aubrey, 1977). Several important individuals making

contributions emerged between 1900-1940. These contributions emphasized the importance of testing, a philosophy, education, and social work. The term counseling was first applied around 1930 with Trait and Factor Theory.

In 1952, the American Personnel and Guidance Association (APGA) was established. The major divisions at the time were the following: Association of Guidance Supervisors and Counselor Trainers (AGSCT), American College Personnel Association, and National Vocational Guidance Association (Aubrey, 1977). Membership continued to grow with expanding interests until 1981 when APGA changed its name to the American Association of Counseling and Development (AACD) and in 1990 to the American Counseling Association (ACA) (Sacks, 1992).

**Question 1-19:**
The individual given credit for the founding of psychology is:

a. Sir Francis Galton.
b. Wilhelm Wundt.
c. James McKeen Cattell.
d. Sigmund Freud.

Answer: b. Wilhelm Wundt.

# OBJECTIVE B: Profession-Professionalism

CACREP objective 1.b. core curriculum standard for Professional Orientation and Ethical Practices is direction for an understanding of counselor roles, functions, and relationships with other human service providers, including strategies for interagency/interorganization collaboration and communications (CACREP 2009 standards). Section C of the 2014 ACA Code of Ethics regarding knowledge of and compliance with standards: knowledge of standards (C.1.), professional competence (C.2.), professional qualifications (C.4.), public responsibility (C.6.), and responsibility to other professionals (C.8.) apply to this objective. The ACA Standards of Practice have been integrated into the Code of Ethics and represent the aspirational guidelines found at the beginning of each section (Introduction).

A profession gains status and maturity through professionalism, of accreditation, licensure, and certification. Professionals work individually and together and advocate for recognition for the profession. The development of educational standards assures quality in the practice of counseling and is essential for the recognition of a profession.

The history of professional development for ACA began during the reform movements. Standards development for counselors was conducted within the U.S. Office of Education. Later members of the Association of Counselor Education and Supervision (ACES) decided that additional standards were necessary for the training of counselors and thus began the development of professional standards for

ACA. In 1979, ACES published its first set of standards. This set of standards was the first effort to establish a separate identity and to create criteria for professional behavior. In 1981, the divisions of APGA united and agreed to form the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The major tasks of this council were to develop standards and begin the review of training institutions desiring accreditation and certification.

The National Council for the Accreditation of Teacher Education (NCATE) also conducts accreditation. CACREP sought and received membership in this organization and in 1987 received membership on the Council on Post-Secondary Accreditation (COPA) (Keese, 1990).

In 1987, NBCC received approval for Category A membership of the National Commission for Health Certifying Agencies register. This commission conducts national certification programs for health professions and occupations. The advantages of acquiring this membership are for the promotion of excellence in counselor behaviors in competency and research. In addition, there are greater chances of acceptance and opportunities within state and federal authorities, third-party payers, and the general public if the profession has an endorsed certification. According to CACREP, "accreditation is a process whereby an accrediting association through an evaluation indicates that a program meets certain established qualifications and conducts periodic self-evaluations. The process entails and includes a clear statement of educational objectives" (as cited in Sweeney, 1994, p. 99). The process entails and includes a clear statement of educational objectives, a directed self-study focused on the objectives, an on-site evaluation by a peer group, and a decision by an independent commission as to the worthiness of the requested program.

**Question 1-20:**
The council that reviews counseling programs for accreditation is the:

a. Council for Mental Health Programs.
b. American Psychological Association.
c. Council for Accrediting Counseling and Related Education Programs (CACREP).
d. American Association for Counseling and Development.

Answer: c. CACREP

Remley and Herlihy (2007) point out that the profession's underlying professional philosophy is that the counseling goal exists within the wellness concept. The goal is not to relieve the client of symptoms rather to pursue a direction for the client to have a healthy life. A second principle for the philosophy is to promote a developmental perspective or framework for the problems experienced by clients. A third principle is empowerment that is to encourage and foster independence (Erford, 2010).

Capuzzi and Gross (2001) cite Caplow and Glosoff's agreed-upon criteria for an occupation to become a profession. A profession has:

1. a specialized body of knowledge and is theory-driven research.
2. an established professional society or association.

3. control of training programs.
4. a code of ethics to guide professional behavior and
5. standards for admitting and policing practitioners.

VanZant (1990) describes professionalism as an attitude which reflects how a member of that profession develops and carries out the image and ideals subscribed to by the professional membership. It is his belief that professionalism rests within the individual as he/she exercises autonomy and personal responsibility in monitoring and promoting his/her profession. Professionalism is reflected through the professions willingness to enforce standards and monitor competencies with well-established ethics and certification programs.

A working definition of professionalism offered by VanZandt (1990) includes the following:

1. the manner in which a worker relies on a personal standard of excellence in competency
2. the manner in which the worker promotes the image of the profession
3. improvement of skills is observed through professional development
4. ongoing striving for quality and ideals
5. manner in which the worker exhibits pride in the profession (p. 244)

ACA accomplished the necessary steps toward professionalism through forming associations (1913-1958), changing names to reduce identification with a previous occupational status (from APGA to AACD), and developing a code of ethics (Remley & Herlihy, 2001). Political involvement is the action step in promoting, maintaining, and acquiring the elements of a profession.

# OBJECTIVE B AND C: Counselor Roles, Functions and Responsibilities

CACREP core curriculum objectives 1.b and 1.c recommend an understanding of the counselor's roles, functions, and relationships with other service providers. The ACA Code of Ethics identifies many of these roles in each of the eight sections: noncounseling roles (A.5.), role changes (A.6.d.), nonprofessional interactions (A.6.e.), roles and relationships (A.7.), public responsibility (C.6.), compliance with standards (C.1.), and responsibility to other professionals (C.8.). These elaborate on the roles counselors have with clients, individuals, and groups. Each introduction to sections A-I emphasizes adhering to the ACA Code of Ethics, advocacy, and to practice in a nondiscriminatory manner.

**Question 1-21:**
A counselor was interviewed by a newspaper reporter regarding a specialty technique and skill. When the article appeared in the newspaper the writer had included an additional area of expertise as a part of the therapist's credentials. The counselor was not trained in that additional skill. The counselor should:

a. do nothing as the counselor did not inform the writer of this skill area.

b. call the writer and inform him/her that you are not an expert in one of the areas the reporter had listed.

c. make an effort to acquire some expertise in the area since it was mentioned in the article and could provide additional clients.

d. write a statement to the paper addressed to the editor for a reprinting of the article with the stated corrections or a statement to that effect.

Answer: d. write a statement to the paper addressed to the editor for a reprinting of the article with the stated corrections or a statement to that effect. This misrepresentation is not of the counselor's doing; however, since it did occur the counselor is obligated to make the effort to insist on the correction. A written statement is a good record of your ethical response to rectify the concern. See C. 3.a (counselors identify their credentials in an accurate manner), C.3.c. (statement by others), C.4.a. (accurate representation), and C.8.a. (personal public statements).

**Question 1-22:**

When techniques or procedures are a part of the client treatment protocol the counselor is accountable for all of the following except:

a. that the treatment is grounded in theory.

b. there is empirical support.

c. document the treatment protocol in the chart.

d. the treatment is to have had at least two literature supported effectiveness studies.

Answer: d. the treatment is to have had at least two literature supported effectiveness studies. Although effectiveness studies frequently endorse a treatment of choice it is not required in the ACA Code of Ethics. Option a. and b. are highlighted in C.7.a. for the scientific bases for treatment modalities, if the treatment is not supported Section C.7.b. and C.7.c. provides guidance regarding risk. Documenting the applied treatment is expected as it relates to monitoring (C.2.d. Monitor Effectiveness).

Counselors serve many different roles and functions dependent upon the work setting and training. The elementary school counselors' roles include individual counseling, group guidance and counseling, working with parents, consultation with teachers and administration, classroom guidance instruction, assessment activity and coordination with community agencies (Gibson, 1989). In addition their roles have been identified as the three Cs, counseling, consulting, and coordinating, and are goal directed for prevention. The counselor forms relationships with other helping professionals and often is called upon to work in interdisciplinary roles with first responders. Some interagency relationships are shared with psychologists, social workers, medical specialists, family practitioners, health personnel, psychiatrists, neurologists, rehabilitation counselors and employee assistance counselors.

Counselors perform a multitude of roles and functions. They are to be trained to perform individual and group guidance and counseling interventions, techniques and skills, and to be vigilant in a gatekeeper role for the profession.

## Personal Characteristics

Gladding (2007) compiled a list of qualities of an effective counselor from several authors that include emotional insightfulness, curiosity, ability to listen, enjoyment of conversations, empathy and understanding, introspection, capacity for self-denial, tolerance of intimacy, comfort with power, and humor. Cormier and Cormier (1998) and Cormier, Cormier, Nurius, and Osborn (2009) summarized many of the specific qualities as intellectual competence, energy, flexibility, support, goodwill, and self-awareness.

## Guidance-Counseling-Psychotherapy

Counselors perform a variety of roles and perform different functions in many settings. The definitions of guidance, counseling, and psychotherapy are best understood in reviewing the evolution of the field of guidance and counseling. These terms are often used interchangeably. However, writers disagree as to their emphasis, and the definitions provided herein are not intended to be exhaustive. Guidance has been described as preventive; counseling as working with personal and social adjustment concerns; and psychotherapy as remedial. One might construe helping along a continuum of pro-growth (guidance) to the disease model (psychotherapy) with counseling somewhere between these extremes. For a more accurate definition one would have to consider the training, setting, goals, techniques, methodology, ethnicity, client cognitions, support systems, and countless other variables which affect the client. This is not an easy matter to discern, however for purposes of review, the following definitions might be useful. Counselors believe that the wellness model rather than the illness model (medical) is the preferred model to help clients resolve personal and emotional problems.

GUIDANCE from the early 1900s through the 1950s was often associated with occupations and vocations and frequently directive. The early definition emphasized assisting individuals in acquiring knowledge, attitudes, and skills necessary to develop behaviors for decision-making, identity development, and maturity (Herr & Cramer, 1992, 1996). Recently the focus has been a lifestyle concept combining vocational and career guidance redefining itself in light of sex role differentiation, sex bias, a holistic approach, decision-making, self-concept, lifestyle, free choice, individual differences, diversity, and coping skills (Herr & Cramer). Herr and Cramer (1992) define career guidance as "a systematic program emphasizing assisting clients to understand and to act on self-knowledge and knowledge of opportunities in work, education, and leisure and to develop the decision-making skills by which to create and manage his/her own career development" (p. 28).

COUNSELING, according to Gladding (1988, 1996), is "relatively a short (time-limited), interpersonal, theory-based, professional activity guided by ethical and legal standards that focuses on helping persons who are psychologically healthy in order to resolve developmental and situational problems" (p. 8). Counseling is for normal people. Counseling is typically shorter in duration for less severely disturbed clients but with a broader array of clients.

COUNSELING: Three additional definitions are provided in order to receive a clear idea of the different emphasis provided by different authors:

1. “stresses more rational planning, problem solving, decision making, and support development for situational pressures for normal persons” (Brammer & Shostrom, 1977, p. 8)
2. “a process involving a relationship between two people who are meeting so that one person can help the other to resolve a problem” (Thompson & Rudolph, 1983, p. 12)
3. “a learning process in which individuals learn about themselves and their interpersonal relationships, and enact behaviors that advance their personal development” (Shertzer & Stone, 1981, p. 168)

From these three definitions one can surmise that counseling is a process, helping another, problem-oriented, personal development, and involves at least two people. To be more complete in the understanding of counseling, it would be important to know and understand metaphysics, epistemology, anthropology, axiology, the process and counselors' role, counseling goals, and outcome effectiveness. The importance of values in counseling provides the direction. Therefore, the role of the counselor is to recognize, prevent, and remediate concerns as a client presents them. Professional standards provide a working definition of counseling by operationalizing the role of a counselor. The role outlines three basic areas of development for the counselor: knowledge, skills, and attitude.

1. Knowledge: The counselor is accountable, if working with a specific "concern or developmental issue of a client (gender, age, etc.), to be knowledgeable about the:
    a. definition of the concern (such as bulimia)
    b. prevalence of such a concern on the local, state, or national level
    c. theories about the concern (etiology, etc.) and developmental growth
    d. community resources available to treat the concern
2. Skills: If the counselor contracts to work with a client regarding a specific "concern," he/she must have the necessary skills to:
    a. explore and determine the concern
    b. assess and determine internal or external causes
3. Attitude: The counselor believes society needs to change as well as the counselor.
    a. examines own values, morals, biases, and belief system regarding the "concern"

PSYCHOTHERAPY: Psychotherapy is a re-educative process aimed at aiding the individual in perceptual reorganization, integration of insight, and to cope with feelings of hurtful events from the past (Brammer & Shostrom, 1960). Psychotherapy focuses on serious problems, emphasizing the past, insight more than change, and is long-term. Psychotherapy typically is long-term for chronic and severe problems.

**Question 1-23:**
Which one of the following was not one of the reasons vocational guidance evolved into a comprehensive career guidance definition?

a. Awareness of personality dynamics in vocational choice and work adjustment
b. The lack of a psychological approach to vocational guidance
c. Knowledge of individual differences
d. Developmental view of the individual

Answer: b. The lack of a psychological approach to vocational guidance

The trend was to take a psychological view of man. Another force was the emergence of a therapeutic treatment or psychotherapy.

## Life Span Stress and Problem Areas for Clients and Counselors

Historically as the profession's membership increased and service areas expanded to include counselor interest across the life span, the American Association of Counseling and Development (AACD) changed identity. Depending upon the level and specialty of training, a counselor will encounter and treat a variety of human difficulties and levels of functioning regarding personality, learning, emotions, social skills, moral development, moral dilemmas, and physical growth across the life span. Who comes to a counselor? Those who, with inadequately developed coping skills, seek the assistance of a counselor to cope with their life-stress-related symptoms of anxiety, depression, mood swings, isolation, and psychological incapacitation. Prospective clients may be suffering from the stress of a variety of events: major illness or impending death, divorce, job termination, finances; difficulties with emotions: anger, guilt, grief, shame; behavioral problems-stealing, lying, drug abuse; identity issues, spiritual alienation, work-related problems, or relationship conflicts.

A professional counselor must recognize dysfunctions and behaviors before applying treatment modalities and strategies for change. He or she should be knowledgeable about the normal manifestations of human psychological growth and development and be able to discern the difference between normal and abnormal functioning. By using keen observation, good interviewing skills, and asking the right questions, the counselor can conduct an assessment, make a diagnosis, develop a treatment plan, monitor progress, adjust goals, make a referral, and/or institute therapy.

In order to accomplish all of these tasks, it is important that the reader become acquainted with many of the psychological abnormalities found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5™), information that is essential for the diagnostic and treatment process. This will be covered more extensively in Human Growth and Development, Unit 3.

## Diagnosing and the DSM-5™

The amount of the DSM-5™ material may be more than required for the NCE. Caution may be good advice when devoting a considerable amount of time for the specifics of the new manual other than the basics. The ACA Code of Ethics Section E.5.a., b., c., d., proper diagnosis, cultural sensitivity, pathology, and to refrain from making a diagnosis and to be mindful of social prejudices (2014).

According to Rosenhan and Seligman (1995) a mental disorder is defined as "a behavioral or psychological pattern that either causes the individual distress or disables the individual in one or more significant areas of functioning" (p. 191). Each disorder is given a DSM-5™ diagnosis. Each diagnostic classification of a mental disorder in the DSM-5™ includes a time frame for each disorder, the number and types of symptoms necessary, removal of the NOS usage and replacement with specified and unspecified disorders, intensity levels, and deletion of the diagnostic multiaxial system. The DSM-5™ uses a dimensional approach to the measurement of distress, disability and severity (APA, 2013). In addition several other changes are noted in the DSM-5™ such as a developmental lifespan approach, severity measures, biological markers, an increased focus on culture and gender, inclusion of ICD-9CM and ICD-10CM codes, category changed for neurodevelopmental disorders (autism spectrum, ADHD, learning disorders, coordination disorder, movement disorder and tics), continuum changes for autism and substance use, separate disorders for panic disorder and agoraphobia, name changes such as persistent depressive disorder for dysthymia and somatic symptom disorder for somatic disorder.

To be ethical, professionals are to use the DSM-5™ with the full knowledge that the DSM-5™ was based on the medical model where problems were considered to reside within the individual. Coding systems now include the ICM-9 and ICM 10. The DSM-5™ does consider that the environment has involvement in the diagnosis whereas the DSM-IV-TR was minimal. Literature supports that the DSM-IV-TR has traditionally pathologized problems in the counseling of racial and ethnic minorities and women. The use of the DSM-IV-TR perpetuated a paternalistic approach to mental health care and reinforces societal oppression of women and minority clients (Remley & Herlihy, 2005). The multiaxial system for diagnosing and recording no longer is a component of the DSM-5™ (Axis I, II, III, IV, V). Information regarding the DSM-5™ is to be found in Unit 7, Assessment.

# OBJECTIVE D: Self-Care

Impairment (C.2.g.), self-growth (F.8.c.), and SP 19.

Professional orientation and ethical practices, CACREP core curriculum objective 1.d, lists self-care strategies appropriate to the counselor role (NBCC, 2005) and the 2014 Code of Ethics, Section C, Introduction. ACA standards indicate that counselors must refrain from offering professional services when their personal problems or conflicts may cause harm to a client or others. The ACA Code of Ethics Section C and F.7.b. encourage counselors to engage in self-care and self-growth activities. A counselor who exhibits qualities of self-care and wellness is in a better position to help clients and to model aspects of a healthy lifestyle. This type of modeling includes awareness to physical, cognitive,

emotional and spiritual self-care. The counselor who provides advocacy in the public arena or within the institution encounters factors that contribute to burnout, compassion fatigue, vicarious or secondary trauma and sometimes fails to have the coping skills to promote self-care, resiliency, and a multicultural adaptation (Roysircar, 2009).

## Leisure

In evaluating the physical self-care and the work style of the counselor leisure considerations are an integral part of a wholesome approach to a wellness-oriented lifestyle. Myers and Sweeney (2004) indicate that leisure is one of the wellness subtasks. Wozny (2012) quotes Stebbins' definition of leisure as un-coerced, contextually framed activity engaged in during free time, which people want to do and, using their abilities and resources, actually do in either a satisfying or a fulfilling way (p. 3). Munson and Widmer (1997) researching college students found a significant relationship between leisure behavior and occupational identity. Employed workers who experience higher levels of satisfaction in their jobs and leisure also experience increases in psychological health (Pearson, 1998).

Stebbins (2006) characterizes leisure as casual and serious. Casual leisure is an intrinsic, short-lived pleasure requiring little to no training for enjoyment. Stebbins' (1997, 2004) examples of casual leisure are play, relaxation, passive entertainment, active entertainment, sociable conversation and sensory stimulation. Leisure benefits include personal and social rewards.

Personal rewards may be enrichment, self-actualization, self-image, self-gratification, and recreation. Social rewards may be social attraction, group accomplishment, and contributions to others (Stebbins, 2006).

Serious leisure examples are those in which the individual displays a high degree of interest and is fulfilling usually a skill, specific knowledge and acquired experiences (Stebbins, 1992).

The serious leisure perspective (SLP) further delineates serious leisure from casual leisure according to six characteristics. These characteristics are; a) need to persevere at the activity, b) availability of a leisure career, c) need to put in effort to gain skill and knowledge, d) realization of various special benefits, e) unique ethos and social world, and f) an attractive personal and social identity (http://www.seriousleisure.net/concepts.html).

## Constraints

There are limitations that might make it difficult for involvement at the level that would provide a life-style of satisfaction. The hierarchical model of leisure constraints are of three types: interpersonal, intrapersonal and structural. The Crawford and Godbey (1987) model suggest that intrapersonal constraints tend to be personality factors and attitudes. Interpersonal constraints are interactions with family members, friends, coworkers and neighbors. Structural constraints tend to be lack of opportunity or affordability (Chick & Dong, 2003).

Chick and Dong (2003) include culture as a possible constraint because what may be available or not available in terms of leisure may or may not be accepted in different cultures (lin.ca/sites/default/files/attachments/CCLR11-30.pdf.)

# OBJECTIVE E: Supervision

ACA Code of Section F.1-F.7.i.

The CACREP 2009 standards for core curriculum objective E highlight knowledge of counseling supervision models, practice and current issues. Section F Supervision, Training and Teaching of the 2014 Code of Ethics (www.counseling .org) topic headings include: counselor supervision and client welfare (F.1.a.), counselor supervision competence (F.2.), supervisor relationship (F.3.), supervisor responsibility (F.4.), student and supervisee responsibility (F.5.), counseling supervision evaluation, remediation, and endorsement (F.6.), and responsibilities of counselor educators (F.7.).

Supervision in clinical settings is a triadic process involving a relationship about a relationship (Fiscalini, 1997). Supervision may be individual and/or group that includes evaluation, ethical and legal considerations, supervision models, relationships influenced by cultural influences and developmental differences, feedback, knowledge acquisition, client care, standards, triadic and dyadic processing, interventions and research.

Bernard and Goodyear's (2009, p. 7) definition for supervision is 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 and hierarchical, extends over time, has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitors the quality of professional services offered to the clients being evaluated and/or treated; and serves as a gatekeeper for those who are to enter the counseling profession. Gatekeeping is also a technique used by leaders to provide space and an opening for members to be included in the group participation (F.6.b., APA 2014). Supervision is a mentoring process that develops a relationship whereby the supervisee experiences support and guidance with a seasoned clinician, one who has knowledge and experience in the models, styles and practical experiences of supervision. Through this process the supervisee experiences wisdom and a personal style of a counselor-therapist. Mentoring teaches sound judgment for decision-making in ethical practice and assists in the clinical application of a treatment strategy as a discovery process to become an effective counselor.

A supervision course for practitioners has not been a required curriculum course in most master degree counseling programs although all trainees are recipients of supervision. Accredited doctoral programs, however, do require a didactic course regarding supervision as well as an experiential supervised supervision for the graduates. It would seem logical that the developers of the NCE do not place an examinee in the role of the supervisor rather the supervisee. As a result some information will be shared regarding the supervision theories or models and the role of the supervisor (F.2.a., ACA, 2014). It is recommended that each person preparing for the NCE review the 2014 Code of Ethics supervision standard (F.4.c.) to be found on-line for the American Counseling Education and Supervision (ACES), the American Mental Health Counseling Association (AMHCA) and the American

Counseling Code of Ethics (2014). In addition it is recommended that individuals preparing for the NCE also review supervision sections within the Code of Ethics for NBCC, ACA, and AMHCA in order to become aware of dilemmas often encountered in counseling and processed in supervision. In addition, if one has not been trained in supervision it would be helpful for that individual to think about possible questions that might be encountered during the process of a therapy case. Further preparation should include reviewing codes of ethics derived from the ethics and standards as well as ethical violations found in the Ethical Guidelines for Counseling Supervisors processed by ACA. [See online: ACA. ACES (Client Welfare and Rights, Supervisory Role, and Program Administration Role)].

Supervision is a process in which the supervisor assists the client through teaching, counseling and consultation while continuing to respect boundaries. Supervisory teaching may involve sharing information and assisting the supervisee to differentiate thoughts, feelings and behaviors apart from the client. The supervisor may share information or stimulate the supervisee to examine client-counselor interactions. Counseling is also drawing attention to supervisee variables that may be interfering with the client case. A major difference between therapy and supervision is the responsibility of evaluation. There is also a difference between supervision and consultation. Consultation is usually a one-time experience when the counselor requests a seasoned professional to help the client better understand how to process through a difficult case (skill level). Teaching, counseling and consultations are specific roles yet overlap in supervision.

Feiner (1994) specifies the roles of a supervisor as formative, normative and restorative while Bernard and Goodyear (2009) define the task of the supervisor as facilitating professional development and improving client care.

Although the supervisor has an unequal relationship (power deferential) with the trainee due to the administrative nature of the role, his or her clinical acumen is of utmost importance since it includes being aware of and processing the supervisee's defensiveness and 'counter-transference' toward the supervisor as well as the trainee's personal 'issues' that could be projected into the counseling process.

Supervision contracts with supervisees should include learning goals, length and frequency of supervision, and summative evaluations. Haynes, Corey and Moulton (2003) suggest that a supervisor-supervisee contract is to include purposes and goals for supervision, frequency, duration and structure of meetings, roles and responsibilities for supervisor and supervisee, description of supervisor background, experience, and areas of expertise, model and method of supervision, documentation responsibilities, evaluations methods, feedback, commitments to follow all applicable agencies policies, professional licensing statutes, and ethical standards, agreement to follow healthy boundaries with clients, function within the boundaries of competence, provide informed consent to clients, reporting procedures for legal, ethical and emergency situations, confidentiality policy and statement of responsibility regarding multicultural issues (p. 198). The contract is essential when a counselor begins the search for an on-going supervisor. A supervision contract is a written document describing the supervisor's expectations and supervisee conditions set forth to counsel with clients. The supervisor routinely evaluates at least once a year to include the supervisee's personal as well as clinical functioning. If inadequacies are noted, supervisees are advised, a remediation plan with a time

line is developed and the supervisee is made aware of consequences of not addressing and improving the inadequacies (F.5.b.).

Ethical considerations and issues for supervision may include due process, informed consent with clients, supervision, supervisees, multiple relationships and multiple relationships between supervisees and clients, preventing supervisee transgressions, preventing supervisor transgressions, competence, monitoring supervisee competence, and confidentiality. Legal issues include malpractice, duty to warn, direct liability and vicarious liability, and preventing claims of malpractice. Direct liability is the direct negligence of supervisory practices and is likely to include allowing supervisee to practice outside scope of practice, not providing sufficient time for supervision, lack of emergency coverage and procedures, not providing a supervisory contract, lack of appropriate assessment of supervisee, lack of sufficient monitoring of practice and documentation, lack of consistent feedback, and violation of professional boundaries in the supervisory relationship (Haynes, Corey & Mouton, 2003, p. 190).

The 2014 Code of Ethics Section F.6. relates to supervision evaluation, remediation, and endorsement. F.5.b. addresses limitations and impairments regarding the supervisee's preparation and fit for the counseling tasks. The supervisor is responsible for this evaluation of strengths and limitations. Limitations may, at times, be impairment. Impairment according to Overholser and Fine (1990) include five areas, that of factual knowledge, generic clinical skills, orientation to specific technical skills, clinical judgment, and interpersonal attributes. Lamb, Presser, Pfost, Baum, Jackson, and Jarvis (1987) deem serious deficit to be in the areas of knowledge and application of standards to include ethics, mental health laws, and professional behavior, competency in areas of conceptualization, diagnosis and assessment, and appropriate interventions, and personal functioning, to include awareness of self, the use of supervision and management of personal stress.

The supervisor is to point out strengths of the supervisee in the same areas as limitations are noted. In addition Frame and Stevens-Smith (1995) suggest personal characteristics of strength include being open, flexible, positive and cooperative, willing to accept and use feedback, aware of impact on others, ability to deal with conflict, accept personal responsibility, and express feelings effectively and appropriately.

## Models

Hart (1982) described the skill development model, personal growth model and the integration model. Most clinicians are recipients of supervisors adhering to a supervision model of choice. Bernard (1997) developed the discrimination model where the focus for the supervisor is process, personalization and conceptualization skills as a teacher, therapist and/or consultant.

Theories, models, and styles represent different approaches such as psychodynamic, developmental, and social models. Psychodynamic models include styles characteristic of psychodynamic, person-centered, cognitive-behavioral, systemic and constructivist (narrative and solution-focused) theories. Developmental models include the integrated developmental model (IDM), process developmental (reflective practice; Loganbill, Hardy, and Delworth (1982) events-based and life span model. Social

role models include discrimination, Hawkins and Shohets' approach (2000), and the Holloway systems approach to supervision (SAS) (1995).

During supervision the supervisor and supervisee may be discussing parallel processes and isomorphism, triangles, working alliances, goals and expectations and specific counselor behaviors (expert and referent powers), self-disclosure, attachment style, effective practice (supervisor evaluations), supervisee's resistance, shame, anxiety, performance, transference, countertransference, and ethnicity.

Evaluation performance by a supervisor of a supervisee can include the use of process notes and case notes, audiotapes, written critiques, transcripts, interpersonal process recall, and live observation (bug in the ear, monitoring, walk-in, phone-ins, interactive television).

The ethical experience didactically and experientially for a supervisor is to address Competency 5: Ethical, Legal, and Professional Regulatory Issues whereby the supervisor makes it known to the supervisee the purpose of supervision, information about the supervisor-credentials/qualifications, structure and practical aspects of the process, specifics of evaluation, and permission to record sessions (SP-14 ACA Standards of Practice; Getz, 2009). Much of this work is toward teaching and reinforcing the structural work of counseling such as case presentations, case conceptualizations (clear goals), interaction regarding the counseling process, involving the supervisee in feedback regarding the supervision style or approach, goal processing, viewing video or taped session work, supervisor feedback and summarization (Getz).

PSYCHODYNAMIC MODEL: The trainee is taught how to be open to experience using a process that often mirrors therapy. Moldawskhy states that anxiety in the client produces anxiety in the therapist, and unless the therapist is open to the experience he or she will defend against the anxiety by characterological or symptomatic defenses and will unconsciously encourage repression in the client, rather than exposure. The therapist is to learn the analytic attitude. This attitude is patience, trust in the analytic process, interest in the client, and respect for the power and tenacity of client resistance (Bermard & Goodyear, 2009).

DEVELOPMENTAL MODEL: The focus is on supervisee change as they gain training and supervised experiences. Developmental models are based on two assumptions; a) in the process of moving toward competence supervisees move through a series of stages that are qualitatively different from one another, b) each supervisee stage requires a qualitatively different supervisory environment if optimal supervisee satisfaction and growth are to occur.

SOCIAL ROLE MODEL: The focus is the supervisor's role as teacher, counselor, and consultant based on supervisee's learning needs. The Holloway model has seven dimensions and focuses on five tasks by five functions or two task-function combinations (Holloway, 1997). Tasks consist of monitoring, evaluating, instructing, advising, modeling, and consulting. Functions include counseling skills, case conceptualization, professional role, emotional awareness and evaluation.

SOLUTION-ORIENTED MODEL: The supervisee is the expert based on personal integrity and respect. The supervisor attempts to coax and author expertise from the supervisee's experiences, education,

and training rather than provide direct teaching expertise from a superior position. There are two steps in the process conceptual and implementation. Conceptual is the process of examining what the supervisee wants from supervision and the supervisor. Implementation of solution is oriented supervision, socializing, saliency, setting goals, and future orientation (Thomas, 1996).

## Standards (ACES, AMHCA, AAMFT)

The ACA Code of Ethics standards are listed in Section F within Teaching, Training, and Supervision. The original standards of practice were developed by ACES and referred to as ethical guidelines for counseling supervisors and association for counselor education and supervision in 1993 (Bernard & Goodyear, 2009). Presently the standards of practice are integrated into the 2014 Code of Ethics in the introduction to each section.

The AMHCA standard of practice for supervisors' requirements is knowledge and skill based. Knowledge standards criteria include (brief) evidenced-based clinical theory and interventions, understanding client population and working knowledge of supervision models; understanding roles, functions and responsibilities of supervisors including liability, communicating expectations and nature of relationships; understanding appropriate professional development activities, supervisory relationships related to issues, cultural issues; understanding and defining legal and ethical issues (laws, licensure, rules and 2014 Code of Ethics); understanding evaluation processes; and understanding knowledge of industry recognized financial management processes, record keeping, and transmission of records.

Skills standards for the AMHCA emphasize understanding client populations and demonstrating clinical interventions with cultural and clinical contexts; developing, maintaining and explaining supervision contracts; demonstrating and modeling clear boundaries and appropriate balance between consultation and training; and demonstrating the ability to analyze and evaluate skills and performance.

## Possible Questions:

The NBCC website identified work behavior for consultation and supervision. The work behaviors may include:

1. Maintain case notes, records and/or files
2. Determine if services meet client's needs
3. Correspond orally with others to maintain professional communications
4. Assist clients with obtaining social services

Work behaviors suggest a counselor is considering through supervision or consultation ethical decision-making, acquiring clinical knowledge-direction, consultation and dilemma processing. Following are some possible questions one might anticipate. It would be expected that questions will involve ethics.

**Question 1-24:**

A supervisee has agreed to receive supervision with a particular supervisor. The supervisor would state that the supervisee is to commit and agree to which of the following: (select as many as you consider important)

a. Share the treatment plan with the client
b. Adhere to all policies of the counseling agency
c. 3,000 hours of clinical experience
d. 30 continuing updating hours each year
e. Reveal all personal information about yourself
f. Meet over dinner to discuss particulars about the situation

Answers: a., b. NCE questions have not requested two answers to check and if there were two they would be combined. F.4.a. (consent) and F.4.c. (standards) informed consent for supervision describes expectations for supervision.

**Question 1-25:**

The client is a 46 year-old African American female ready for discharge after 19 sessions for major depression. She is the owner of a small jewelry store in the city. Her presenting complaint was a loss of interest in her jewelry business and considered selling until her 23 year old son discouraged her from selling until she was feeling better. The client has regained her energy level, sleep restoration, spirited laughter, and re-engaged in her social life. In compliance with the initial contract Lucy agreed to inform the counselor at least one session before closure that she would be discontinuing counseling. During that session she told the counselor she intended to bring her a gift she knew that the counselor would appreciate. Prior to the last session the counselor was in supervision and was concerned about Lucy's statement about a gift. What type of concerns would the supervisor likely bring up for Lucy to process? Select as many as you consider ethical and legal. This question is likely to be longer than found on the NCE.

a. The cost (value) of the gift
b. Reciprocity of a return gift
c. Ethnicity of the client
d. Countertransference
e. Family members
f. Counselors motivation for wanting or declining the gift

Answer: a., c., f. The Code of Ethics (A.10.f.) recommends a consulting process for the supervisor-supervisee to consider when receiving or accepting gifts. The counselor is to process with the supervisor the cost of the gift, the race and culture of the client, and the counselor's reasons for accepting the gift.

## Group Supervision

Group supervision has many of the same purposes as individual supervision. Group composition is 4-8 supervisees coming together to present and receive assistance with cases. The supervisor is to monitor the quality of the supervisee work and personal understanding as a counselor. Some advantages of group supervision are economics of time, cost, and expertise, vicarious learning, breath of client exposure, feedback with greater quantity and diversity, greater quality, comprehensive picture of the client and supervisee, learning supervision skills, normalizing experiences and mirroring interventions (Bernard & Goodyear, 2009).

During the early years of group supervision the focus was on the interpersonal process or therapy-based approach regarding self-awareness and emotional growth (Prieto, 1996). The more recent approaches have focused on models of supervision, ethical issues in group supervision, and styles of leader supervision.

Group supervisors need to be accomplished counselors as well as have a working knowledge of group process and dynamics. It is important the supervisor is aware of the advantages and disadvantages of homogeneity versus heterogeneity of supervisee's levels of experience.

**Question 1-26:**
A counselor has recently come from a counseling agency where individual supervision was the agency policy. This agency utilizes group supervision. The supervisee asked the supervisor what might be limitations of group supervision compared to individual supervision?

a. Cost to the agency
b. Confidentiality
c. Focus is not mirror
d. Quantity of supervision time
e. Quality of supervision
f. Lack of client exposure

Answers: b., c., d.

**Question 1-27:**
A supervisor is describing a supervision contract to a supervisee. According to counseling protocol what should be included in the contract?

a. Frequency, location, length and duration of supervision meetings
b. Type of notes
c. Supervision models and expectations
d. Fee structure
e. Liability and fiduciary responsibility of the supervisor
f. The evaluation process, instruments used and frequency of evaluation

g. Therapy techniques required for treatment

h. Emergency and critical incident procedures

Answers: a., c., e., f., h. -- preparation (F.2.a.), informed consent (F.4.a.), standards (F.4.c.), and professional disclosure (F.5.c.).

**Question 1-28:**

The counselor during individual supervision told the supervisor s/he was stuck in counseling a client. The supervisor might make what suggestions?

a. Develop a descriptive metaphor

b. Develop a theoretical orientation

c. Develop homework for the client

d. Request the client to consider a different perspective

e. Consider a referral to another counselor

f. This is a situation that calls for case consultation

Answer: Any one of the above might be an answer if one answer is requested.

**Question 1-29:**

During individual supervision and prior to the client's termination the counselor was charged by the supervisor as how s/he evaluated effectiveness. The supervisee requested the supervisor to provide direction to derive this type of information. What methods might the supervisor utilize to provide the most reliable feedback?

a. Bug in the ear (BITE)

b. Ask the client

c. In Vivo

d. Phone Ins

e. Client relapse

f. An empirical study

Answer: d. Phone Ins - evaluation (F.6.a.), and gatekeeping and remediation (F.6.b.) relate to feedback and evaluation roles of the supervisor.

**Question 1-30:**

For eight weeks the counselor provided Mr. Albert with psychoeducation and supportive therapy for early onset of Alzheimer's disease. During the eighth week the client told the counselor that he thought whatever the counselor was doing was not helpful. The counselor asked the supervisor what alternative approaches might be recommended in addition to the standardized therapies? (Select as many as you consider helpful)

a. Provide Mr. Albert the truth that there is no therapy for Alzheimer's

b. Seek consultation from a hypnotherapist

c. Trauma focused therapy
d. Physical exercise
e. Use of music
f. Continue psychoeducation and supportive therapy
g. Short-term memory training

Answer: d., e., f., g.

a. Research continues to advance the study of the brain, medication and therapy for this disorder.

b. There is little to no support for hypnotherapy as a treatment.

c. Not indicated

d. Flow of oxygen to the brain spurts growth of new brain cells. It is recommended a client might commit 15 minutes a day of exercise to delay or reduce the risk of Alzheimer.

e. Music therapy is associated with right brain activation

f. Yes, supportive therapy during the early stages of Alzheimer's disease would be helpful.

g. Right brain training provides gains using games, and memory games.

**Question 1-31:**
A counselor decided to seek supervision for a client's treatment. In selecting a supervisor the counselor would want to consider which of the following?

a. Supervisor experience
b. Supervisor is listed on the approved supervisor registry
c. Supervisor is within 5-15 minute travel time
d. Supervisor theoretical orientation
e. Supervisor's training

Answer: a., d., e.

# OBJECTIVE F: Professional Organizations

Membership status (C.4.f.)

Professional Orientation and Ethical Practice CACREP core curriculum objective 1.f includes professional organizations, including membership benefits, activities, services to members and current issues. Members differentiate between current, active memberships and former memberships in associations (C.4.f., APA, 2014).

The American Counseling Association (ACA) was formerly called the American Association for Counseling and Development (AACD). Prior to that, it was the American Personnel and Guidance Association (APGA). The first organized body of guidance professionals was called the National Vocational Guidance Association and was formed after 1910. The major association, ACA, has 20

divisions. These 20 divisions are represented by a body of professionals who regard their specific expertise and identity to be within one or more of the divisions. Some of those divisions represent college personnel, counselor education and supervision, career development, school counseling, rehabilitation, assessment, employment, cultures, religion and values, gay and lesbian issues, group work, public offenders, mental health, military, adult and aging, and marriage and family. American Counseling Association (ACA) and divisions are (ACA, org).

AARC – Association for Assessment and Research in Counseling

AADA – Association for Adult Development and Aging

ACAC – Association for Child and Adolescent Counseling

ACC – Association for Creativity in Counseling

ACCA – American College Counseling Association

ACEG – Association for Counselors and Educators in Government

ACES – Association for Counselor Education and Supervision

AHC – The Association for Humanistic Counseling

ALGBTIC – Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling

AMCD – Association for Multicultural Counseling and Development

AMHCA – American Mental Health Counselors Association

ARCA – American Rehabilitation Counseling Association

ASCA – American School Counselor Association

ASERVIC – Association for Spiritual, Ethical, and Religious Values in Counseling

ASGW – Association for Specialists in Group Work

CSJ – Counselors for Social Justice

IAAOC – International Association of Addiction and Offender Counselors

IAMFC – International Association of Marriage and Family Counselors

NCDA – National Career Development Association

NECA – National Employment Counseling Association

ACA and all divisions subscribe to the ACA Code of Ethics. Several divisions, such as ASGW, have developed specific codes relative to the specialty of that division. Familiarity and understanding of various codes will be necessary to apply the ethical principles. This preparation manual is based upon the ethical code for ACA, which contains constructs, which may or may not be specifically mentioned

in the code for the National Board for Certified Counselors (NBCC). The NBCC Code of Ethics can be secured on-line at NBCC.org. For those applying for a state license, the ACA 2014 Code of Ethics will need to be secured. The Code of Ethics for ASGW has specific counselor behaviors, which are unique to that area of counselor skills for group work.

**Question 1-32:**
The most recent sub-division to the American Counseling Association is the:

a. Counselors for Social Justice
b. Association for Creativity in Counseling
c. Association for Child and Adolescent Counseling
d. Association for Adult Development and Aging

Answer: c. Association for Child and Adolescent Counseling. ACAC became an affiliate in the fall of 2011 with 450 signatures and needed 500 members to become a sub-division of ACA (ACA.Org)

# OBJECTIVE G. Professional Credentials and Public Policy

ACA Code of Ethics: accurate representation (C.4.a.), credentials (C.4.b.), implying doctoral competence (C.4.d.), accreditation (C.4.e.), professional membership (C.4.f.) describes responsibilities in developing and maintaining accurate identification for a professional. Public responsibility involves reports to third party parties (C.6.b.), media presentations (C.6.c.), contributions to the public good pro bono public (C.6.e.), and responsibility to other professionals (C.8.a.).

CACREP was established in 1981. The Association for Counselor Education and Supervision (ACES) was credited with creating the first set of standards for CACREP. CACREP used ACES standards for the first set of standards and CACREP's first set of standards was in 1988. This set of standards created structure for all entry level programs for three specialty groups with separate standards; Mental Health Counseling, School Counseling, and Student Affairs Practice in High Education. A split took place between Community Counseling and Mental Health Counseling regarding standards and the number of credit hours. In 2001 CACREP and ACPA disaffiliated from ACA and became the American College Counseling Association (ACCA). CACREP 2009 specialty standards include Addiction Counseling, Career Counseling, Clinical Mental Health, Marriage, Couple, and Family Counseling, School Counseling, and Student Affairs and College Counseling (Bobby, 2013). A major infusion into the 2009 standards was the disaster preparedness and crisis response criteria, Clinical Mental Health Counseling required 60 semester-hours for entry level graduate degree and 600-clock hour internship, Gerontology Counseling standards were eliminated, therapy was dropped from Marital, Couple and Family Counseling, and a new set of standards for Addiction Counseling (Bobby, 2013, Kaplan & Gladding, 2011, Newsome & Gladding, 2014). In summary CACREP through all revisions of the standards has maintained a direction for a strong counselor identity. The emphasis in a unified profession has been troubled when standards were approved for the specialty areas. Counselors who have specialty training were expressing that identity first and secondly as a professional counselor.

The CACREP standards suggest that every student is to develop a professional counselor identity (Professional Orientation and Ethical Practice, 1).

**Question 1-33:**
CACREP has approved specialty for all of the following except:

a. Gerontology Counseling
b. Addiction Counseling
c. Career Counseling
d. School Counseling

Answer: a. Gerontology Counseling. Only two institutions applied for accreditation using these standards.

**Question 1-34:**
CACREP board and standard development has consistently maintained that specialty areas:

a. are encouraged to broaden the professional counseling service areas.
b. will be a political force for the professional counselor.
c. counselors are counselors first and specialty counselors second.
d. should unite and form one organization of counselors.

Answer: c. counselors are counselor's first and specialty counselors second. [See Bobby (2013)] New specialty areas of practice (C.2.b.) specifies that counselor are to acquire education, training, and supervised experience and ensure competence in protecting others from harm.

## Licensing

Virginia was the first state to establish a license for counselors in 1976 and California the last. Since that time all 50 states have passed licensing laws for counselors. Each state has specific requirements for degree (hours), curriculum requirements, internship hours, post-master's clinical work experience, years and hours of supervision and passing either the NCE or NCMHCE. Added to the confusion regarding professional unity and counselor identity is the fact that there are nine different licensure titles among the 50 states (Bergman, 2013). Some states have a provisional license which allows for counselors to be working toward a full license. Professionally, from the professions position for licensing counselors the standards for Counseling Supervisors (AASCB), CACREP, NBCC, and the National Credentials Registry (ASSCB) have united to work toward a unified identity for counselors, degree requirements, supervisory experience and portability (Mascari & Webber, 2013). A form of protection is how the state specifies the license, title or practice. There have been two or more identifications of the licensure for states, title or practice. A title license indicates the individuals who are licensed with that title and if there are several different titles in different states, confusion exists. A practice title specifies what duties and/or skills the licensed individual may practice.

In 1994 NBCC announced a board of individuals (33), The American Association of State Counseling Boards (AASCB), from 28 states met to discuss and form direction and portability for the licensing of professional counselors. There have been 13 yearly meetings and one purpose is to advocate for equity in providing paid services for counselors and for portability (National Certified Counselor, 2013). The most recent meeting was in 2013 with 37 states represented with a focus on licensing examination and emerging issues for counselors.

## Portability

Portability is the process in which counselors may transfer their license without repeating the application procedure. Reciprocity and endorsement are terms used to recognize credentials from different states and identify this process of portability. The effort to establish portability calls for common licensing standards. The National Credential Registry was created by AASCB to assist in gaining portability. The American Association of State Counseling Boards (AASCB), ACA, NBCC and CACREP in supporting a unification of the profession are lobbying for license portability.

## Federal and State Government

The Council on Licensure, Enforcement and Regulation (CLEAR) adheres to the sunshine law as the procedures for legislation toward a licensing law. Only 14 states have the sunshine law and is a first step in state regulation and legal recognition (Bergman, 2013). The scope of practice is defined as what a professional is permitted to perform within that profession. The qualifications stipulate education, training, and experience. The critical terms for practice for professional counselors are diagnosis, psychotherapy, assessment, treatment, and counseling (Hartley, Ziller, Lambert, Loux, & Bird, 2002). At this time only 36 states include diagnosis in the licensing law (ACA, 2010).

The federal government's Medicare and Medicaid programs do not recognize professional counselors as Medicare providers. The U.S. Department of Veterans Affairs (VA) has recently added licensed professional mental health counselors as providers (U.S. Department of Veterans Affairs, 2010). TRICARE is the civilian health care provider which opened benefits to licensed counselors although required to meet specific standards such as master's or higher in mental health or clinical mental health credited by CACREP, state license in a state with tiered licensing, passing the NCMHCE, and a well-defined scope of practice (IOM, 2010, p. 10).

# OBJECTIVE 1.H: Advocacy-Roles and Process

Advocacy (A.7.a), confidentiality and advocacy (A.7.b.), public responsibility (C.6.), testimonials (C.3.b.), statements by others (C.3.c.), accurate representations (C.4.a.), media presentations (C.6.c.), and personal public statements (C.8.a.) pertain to advocacy, roles and process. CACREP core curriculum objective 1.g states the counselor is to become cognizant of the role and process to advocate on behalf of the profession. Advocating requires competencies in six domains extending from the micro

level to macro level and acting with and acting on behalf of the client (Toporek, Lewis, & Crethar, 2009, p. 267).

Historically social justice and advocacy can be traced back to the time of Frank Parsons' and Clifford Beers' writings regarding mental illnesses and mental hygiene. Smith, Reynolds and Rovnak (2009) see as the "major focus of advocacy is related to power, privilege, allocations of resources, and various forms of prejudicial discrimination and violence toward the underrepresented individuals or groups" (p. 483).

The Governing Council of the American Counseling Association in 2003 developed a set of competency domain guidelines for student-client advocacy. One of the first advocacy documents was created by Derald Wing Sue, Patricia Arrendondo and Roderick McDavis for multicultural competencies in 1991 (Toporek, Lewis, & Crethar, 2009). The concept for systematic change came about as a result of the school counselor's role. The school counselor's role included a developing and expanded relationship and interaction between the student and school environment to reduce the effect of environmental and institutional barriers that would prevent or limit academic success. Political involvement propelled many counselors to advocate for services to utilize their license to serve clients. The need to secure these benefits with the political forces highlighted the need for advocacy competencies. The ACA division Counselors for Social Justice (CSJ) was instrumental and poised to disseminate information to capture a network of members involved in advocacy. A taskforce was assembled by Jane Goodman (ACA president) to develop a set of advocacy competencies for social justice which was completed in 2002 (Toporek).

### Competencies: competence (A.11.a.), competence (C.2.), limits (E.2.a.), supervision (F.2.)

In addition to developing knowledge and skills for advocacy it is important to effectively implement those competencies with client issues and barriers. Lewis and Lewis (1983) described two types of advocacies, those that involve clients (case advocacy) and those that involve policies and institutions. Advocacy was framed on a continuum of empowerment to social action. Empowerment was defined as actions taken by the counselor regarding the environment for a client or group and recognizing sociopolitical barriers. Social action takes place when the counselor's actions advocate for change in the public arena (Lewis, Lewis, Daniels, & D'Andrea, 1998). The three different levels acting with or on behalf for an intervention are client/student, school and community, and public arena (ACA Governing Council, March, 2003). See the article by Toporek for the six domains (2009).

The client/student intervention is addressed through empowerment and direct intervention within the system for clients. School and community intervention is addressed by a systems advocacy, a systemic approach with information and insight. The public arena intervention approach is a social/political advocacy (large scale). Roysircar's (2009) emphasis is from a social justice perspective. This framework suggests a macro level to a micro level involves recruitment, sociopolitical education, diversity management, and self-care of the counselor-advocate.

A systems advocacy according to Lewis et al. (2002) consists of eight competencies to address barriers. The intervention steps are (a) identify environmental factors impinging on students' or clients' development; (b) provide and interpret data to show urgency for change; (c) in collaboration with

other stakeholders, develop a vision to guide change; (d) analyze the sources of political power and social influence within the system; (e) develop a step-by-step plan for implementing the change process; (f) develop a plan to deal with probable responses to change; (g) recognize and deal with resistance; and (h) assess the effect of counselor's advocacy efforts on the system and constituents (p. 1).

The Congressional management foundation in 2011 surveyed influencing factors that have a positive impact with senators. The following factors in order had the most influence:

| | | |
|---|---|---|
| 1. | In-person issue visit from constituents | 46% |
| 2. | Contact from a constituent who represents other constituents | 36% |
| 3. | Individualized postal letters | 20% |
| 4. | Individualized e-mails | 19% |
| 5. | Comments during a telephone town hall | 17% |
| 6. | Phone calls | 14% |
| 7. | News editorial endorsement of an Issue | 10% |
| 8. | Visit from a lobbyist | 8% |
| 9. | Individualized faxes | 8% |
| 10. | Form postal letters | 1% |
| 11. | Form email messages | 1% |
| 12. | Comments on social media sites | 1% |
| 13. | Form faxes | 1% |

**Question 1-35:**
A counselor desires to advocate for the passage of a bill that will allow counselors to admit clients to a hospital for treatment. The influence of most importance regarding the counselor's action is:

a. through a lobbyist.
b. an in-person issue visit.
c. an individualized e-mail.
d. a phone call.

Answer: b. an in-person issue visit (from the counselor).

Volunteer with advocacy groups and organizations, build a social movement, for peace, justice, equity, access, racial equality, internationalism and disaster recovery (Roysircar. 2009)

# OBJECTIVE I: Advocating for Removing Social Barriers

Counselors are encouraged to advocate and to promote change at the individual, group, institutional, and society levels (Introduction C, ACA, 2014). Ethical responsibilities for advocacy are further defined in advocacy (A.7.a.) and confidentiality (A.7.b.). Success in becoming a change agent and to take action

and address oppression that impedes access, equity, and opportunities for client success is through training and individual and societal commitment at the institutional level within the educational and political world. Oppression refers to the "systematic disadvantage of one group by other groups who hold more power in society" (Lopez-Baez & Paylo, 2009, p. 277). Neighborhoods, schools, media, culture and religious, political and social institutions are fertile grounds for social justice advocacy efforts by mental health organizations and mental health individuals. Processes to do advocacy are identified in the ACA advocacy competencies appendix (Lewis, Arnold, House & Toporeka, 2002). This document elaborates advocacy competencies at the community, systems, public, and social/political levels.

Roysircar (2009) quotes Lerner's use of the term "surplus powerlessness". Lerner (1998) attempted to broaden the horizons held by counselors and to realize the narrow scope of understanding is not just with the client making changes to alleviate personal conditions, rather, these understandings take place at a macro level and the problems encountered by clients are often more the social forces that shape the individual experience (Prilletensky, 1994; Ratts & Hutchins, 2009; Roysircar).

Specifically community level advocacy is a collaboration to:

1. identify environmental facts that impinge upon students' and clients' development
2. alert community or school groups with common concerns related to the issue
3. develop alliances with groups working for change
4. use effective listening skills to gain understanding of the group's goals
5. identify strengths and resources that the group members bring to the process of systemic change
6. communicate recognition of and respect for these strengths and resources
7. identify and offer the skills that the counselor can bring to the collaboration, and
8. assess the effect of counselor's interaction with the community (Lewis, et al. 2003, p.2).

Systems advocacy is when there is recognition of barriers which are:

1. identify environmental factors impinging on students' or clients' development
2. provide and interpret data to show the urgency for change
3. in collaboration with other stakeholders, develop a vision to guide change
4. analyze the sources of political power and social influence within the system
5. develop a step-by-step plan for implementing the change process
6. develop a plan for dealing with probable responses to change
7. recognize and deal with resistance
8. assess the effect of counselor's advocacy on the system and constituents (p. 2)

Those practitioner's using managed care organizations (MCO) to treat clients must be vocal advocates for continuing care beyond the prescribed limitations. Even though MCOs have an appeal system it is

difficult to navigate the lengthy amount of time to pursue this pathway and maintain at the time continued therapy.

ACA Office of Public Policy and Legislation (2011) identified and published statistical data for professional counseling service needs and issues that pose barriers and impede client success or access. A few of those will be identified from that list for adults (1-8), children (9-13), seniors (14-19), and veterans (20-23):

1. Adult mental illness and substance use disorder
2. Suicide, 3rd leading cause of death 15-24 and 2nd for 25-34
3. Receiving mental health services
4. Major depression leading cause of disability
5. Disabled workers desiring work and have lower educational attainment
6. Young adults drinking increase, increase in illicit drug use
7. Adults with major depression only 64% received treatment
8. Rural area residents less likely to receive treatment with populations of 2,500 or less
9. In 2006, 5% of children ages 4-17 have serious difficulties with emotions, concentration, behavior or get along with others, 49% prescribed medication.
10. 5%-9% of children have a serious emotional disturbance
11. 80% of children in juvenile centers have mental disorders
12. In 2009 8.1% of the population ages 2 to 17 had major depressive episode that year. Of that number 35.7% used illicit drugs
13. In 2009 34.7% of youths age 12 to 17 received treatment for depression
14. For 65 and older seniors 20% have mental illness and expected to double in next 30 years
15. Less than 3% report seeing a mental health professional
16. Depression affects more than 6.4 million seniors
17. Account for 20% of suicides, 75% of those who committed suicide saw a physician within the month before
18. Medicare spending represented 3% of the budget for all mental health services
19. Inadequate training in working with the seniors
20. 20% of all suicides occur among veterans
21. In 2010 veterans from Iraq 295,000 were diagnosed with one mental health disorder and 171,000 with PTSD.
22. 25-30% of veterans of the wars in Iraq and Afghanistan reported symptoms of a mental disorder or cognitive condition
23. From 2004-2007 99.2% of veterans aged 21 to 39 reported major depressive episodes and impairment.

This list is incomplete and certain selections were made to glean areas where social justice can be identified for counselor, client, community, and legislative actions.

Social barriers may be economic needs, educational limitations, lack of familial support, gender and ethnic discrimination, prejudice, socioeconomic issues, belief systems, power, authority, and oppression.

**Question 1-36:**
In using an intervention with a client of diversity the counselor may hold a biased view or perception that limits or denies a client access, equity and success through counseling. One possible reason this barrier might exist is that the counselor gives excessive weight to which one of the following?

a. family and personal life issues or economic conditions.
b. individual factors such as genetics or psychological constitution in explaining individual or social behavior.
c. it is a lack of support from the mental health field.
d. a personal view that these changes and client rights are to begin at the federal level.

Answer: b. individual factors such as genetics or psychological constitution in explaining individual or social behavior. Prilletensky (1994, 1997) attributes that there is excessive weight given to individual factors such as genetics or psychological constitution in explaining individual or social behavior. Lerner (1998) believed that the lack of a sense of social causality by counselor views and that frustrations of the family and the personal life of clients are failings of the family and the individual client. In using culturally appropriate intervention strategies counselors are to be aware of institutional barriers that prevent minorities from using mental health services and to have knowledge of biases in assessment procedures. The introduction to Section A stipulates that counselors are to be active in attempts to understand the diverse cultural background of clients as well as their own and how the counselor's values and beliefs may affect the care of a client. This observation is further expanded in Section A.4.b. personal values whereby the counselor is to be aware of and avoid imposing their own values, attitudes, beliefs, and behaviors. The counselor is to explore in those training and clinical areas where imposing values are inconsistent with the client's goals and are discriminatory (APA, 2014).

Master-level graduates are entering into private practice once they attained the proper legal qualifications such as a state license. Some general questions are likely to begin to appear in the NCE regarding effective practice. Although few, if any, programs of study have prepared graduates for the scope of a private practice many graduates are learning from those having experienced setting up a business. Section A.10. (fees and business practices), A.10.b. (unacceptable business practices), A.10.c. (establishing fees), A.10.d.(nonpayment of fees), A.10.e. (bartering), and 10.f. (receiving fees) all pertain to private business practices (ACA, 2014). The following material does not pertain solely to private practice but also with hospitals, group practices, and agencies providing mental health services. A few suggested areas to begin your preparation are the 2014 Code of Ethics, standard of care, standard of practice, opening and setting up a business, budget concerns and accounting, defining your practice, collecting fees, record keeping, managed care, office personnel, determining organizational and therapist effectiveness, and legal parameters (Remley & Herlihy, 2005).

## Private Practice

Success in private practice may be evaluated according to whether or not one:

1. is financially solvent to start a business
2. can manage others and effectively implement and evaluate all aspects of a business
3. can satisfactorily provide services and maintain professional standards

What are some characteristics needed to run a successful business?

a. self-initiative
b. business sense
c. organizational and management abilities
d. ability and willingness to network

Considerations:

1. where to locate office space: home, office complex, separate building, mobile unit, telephone, Internet: does it match the type of service you will provide? Can the office space take into account disability requirements, safety, and visibility?
2. partnership, alone (pros/cons), need for consultation, part-time, full-time (e.g., consult on cases/safety issues), part-time or full-time
3. privacy issues: soundproofing, security of records, computer access
4. safety issues: parking lots, moveable items in the office, lighting, pictures, safety concerns regarding physical/psychological assaults
5. office appearance/ambiance
6. professional image/professional dress
7. consultation issues and costs: psychiatrist, lawyer, collection agency (develop a policy regarding overdue debts and fees, bad checks, pro-bono, sliding scale)
8. policies (pro bono, bad checks, missed appointments)
9. HIPAA and FERPA forms-contracts: informed consent, client rights, release forms, etc.
10. handicap accessibility (Americans with Disabilities Act)
11. advertising: cards, fliers, telephone directories
12. hospital privileges, medication, insurance panels
13. counselors as employers
14. managed care/health care panels
15. computer technology associated with record keeping and electronic transmission of client information

Managed Care: Definition: "a system created to slow down or control rising health-care costs by means of some 'external review', 'watchdog', or 'gatekeeper' organization or group overseeing and scrutinizing

the work of a professional provider or facility" (Browning & Browning, 1996, p. 4). Browning and Browning (1996, p. 4) list five components to a managed-care system:

1. screening and restricting appropriate and necessary services provided to clients
2. reducing or limiting fees charged for professional services and procedures
3. eliminating unnecessary, wasteful, or inappropriate care
4. ensuring quality of cost-effective services rendered
5. providing a source of patient referrals and timely payment to providers who work cooperatively with the system

The benefits to providers who join managed care are an ongoing referral process and receiving payments in a timely manner. The therapist has to be willing to limit the duration of care, use low-cost yet effective levels of care (quality), and cooperate with external screening and review by case managers. Managed care is a system that controls the cost as well as the treatment (U.S. Agency for Healthcare Research and Quality, 2004). Some therapists avoid managed care because they have difficulty with some ethical considerations such as confidentiality; managed care only reinforces certain therapies or techniques, and attaining membership on panels. There are many managed-care systems, however. Browning and Browning (1996) refer to four evolving systems: a) health maintenance organizations (HMOs); b) preferred provider organizations (PPOs); employee assistance programs (EAPs); and utilization review (UR) and Patrick (2007) added a fifth; individualized practice associations (IPAs). Many counselors claim it is difficult to access and receive panel approval for these programs. Counselors who decide upon private practice and do not want to participate in a managed care environment have been creative in setting up a practice. The early decision may be to conduct a small, part-time practice and be skilled at aggressively marketing to upper-middle-class clients.

Managed care places requirements and restrictions on those on the approved panel. Some of these are to (a) how "efficacy" is measured that may vary across managed care plans; (b) how care is managed and accessed over time; (c) limits on length of treatment, diagnosis, and method of treatment; (d) data is compared between the managed care companies and fee-for-service outcomes. (Patrick, 2007, p. 29).

In summary the most frequently encountered ethical issues in working with MCOs are confidentiality of client records, treatment needs, and competence to practice. MCOs require that a counselor must provide written or oral information about a client to a managed care person. One of two issues may be the person receiving the report may not be credentialed and a second may be the client prefers that information is not provided (autonomy does not exist). For treatment purposes this inability to contain the confidentiality of reporting affects disclosing during the treatment process.

Effectiveness studies: Private practices as well as agency programs are evaluating therapist effectiveness (C.2.d. monitor effectiveness). This can be conducted in a number of ways. Surveys and empirical studies (pre-post, and control studies designs) have been the usual methods for conducting effectiveness studies. There are a number of studies that provide client satisfaction as feedback for effectiveness, however more and more direction is being focused on controlled studies utilizing specific treatment variables, that is, curative variables. Another method to secure data for these

evaluations has been through the use of two-way mirrors, video and audiotaping, live supervision, and co-therapy as a means to derive client raw data and counselor interventions or theory applications.

Brief and Solution Therapy: Emphasis is mounting for therapies to achieve symptom reduction and solutions that bring about early discharge. The limited number of sessions managed-care companies make reimbursements for creates an early decision for therapists. A therapist may either consider shorter-term therapies such as brief or solution therapies, to not receive clients who use managed-care insurance companies, or continue therapy with the client after the managed-care sessions are depleted, usually at a much-reduced rate of compensation.

Pros and Cons of a Private Practice

1. Pros of a Private Practice
    a. autonomy
    b. determine own fees
    c. develop own schedule
    d. flexibility of time
    e. your own boss
    f. remain in direct service
    g. economic improvement
    h. avoid bureaucratic conflicts
    i. motivated clients
    j. more incentives to improve
    k. skills and abilities challenged
    l. higher status and recognition
    m. possibly more attentive services
    n. ego involvement
2. Cons of a Private Practice
    a. loneliness, less colleague access
    b. dealing with insurance company
    c. pay for own health insurance
    d. overhead responsibilities
    e. upkeep and repair
    f. advertisement costs
    g. must establish own referral base
    h. less backup in emergencies
    i. accounting, bookkeeping duties/ costs

j. liability insurance

k. quarterly taxes must be paid

l. pay for continuing education

Topics for Private Practice: The ACA Code of Ethics (2014) specifies that counselors respect other professionals that have a different license or respond to a different Code of Ethics as described in different approaches (D.1.a.), forming relationships (D.1.b.), and interdisciplinary teamwork (D.1.c.). The 2014 ACA Code of Ethics cautions against making claims in personal statements that might be considered libel or slander as in personal statements (C.8.a.) and statements made by others (C.3.c.).

**NOTE: Answers to questions 1-37 through 1-42:** Recognize in this study guide that the recommended answers are subject to change as managed-care providers alter specific requirements for paneling, reimbursement, and qualifications.

**Question 1-37:**

A counselor has become aware of negative statements regarding this counselor's practice and ethical behavior made by another counselor that was stated in a public forum. This counselor believes them to be unfounded and untrue. These statements made in public may be considered:

a. slander.

b. libel.

c. vicarious liability.

d. interrogatories.

Answer: a. slander. Slander is oral and libel is written dishonesty. An interrogative is a type of subpoena in which you are provided a list of questions, and you are required to provide answers. This subpoena, as well as your answers, should be reviewed by your attorney (Remley & Herlihy, 2005).

**Question 1-38:**

All of the following except one might suggest why therapists are critical of the managed-care practices:

a. infringement on patient confidentiality

b. loss of freedom of ethical treatment choice

c. loss of right to set competitive fees for services

d. easy and willing to justify their professional conduct to the gatekeepers

e. amount of paperwork and lower fees for doing more work

Answer: d. easy and willing to justify their professional conduct to the gatekeepers. Justifying to a gatekeeper has been a criticism because therapists believe their therapy of choice is capable of achieving desired results and some find it difficult to alter their treatment of choice and to reduce the time schedule to eight or less sessions.

**Question 1-39:**
Which one of the following identified problems is likely to not receive reimbursement under managed care?

a. obsessive-compulsive
b. supportive marital therapy
c. eating disorder
d. tic disorder

Answer: b. supportive marital therapy. Supportive marital therapy is not a DSM- 5 diagnosis nor a problem area in which managed care providers reimburse.

**Question 1-40:**
Managed-care indicates that a diagnosis is to be made by:

a. the end of the first session.
b. at least by the third session.
c. no later than the fifth session.
d. no more than what the defined amount of time is for the tentative diagnosis.

Answer: d. no more than what the defined amount of time is for the tentative diagnosis. Although there might not be an exact number as few as possible is the choice.

**Question 1-41:**
Managed-care gatekeepers recognize when a therapist is not current with the up-to-date treatment procedures and or protocol when the therapist recommends which one of the following and not the other three with the diagnoses sexual addiction, obsessive-compulsive, gambling addiction, abuse and incest survival, eating disorders, and CD:

a. recommend cognitive-behavioral therapy as the therapy of choice
b. recommend supportive therapy
c. recommend a recovery group involvement
d. recommend medication through an appropriate source (MD)

Answer: a. recommend cognitive-behavioral therapy as the therapy of choice. Alternatives b, c, and d are normally required to accompany treatment conditions. It is recognized that follow-up is especially necessary for difficult to treat conditions.

**Question 1-42:**
A clinical director is interested in researching therapist effectiveness data as practiced in this private practice. The clinical director might do this by:

a. requesting each therapist to indicate how many clients he/she has seen over a specified time period and of that number how many of those clients are better as a result of their therapy.

b. conduct a random sample of clients over a specified time period and with a mail survey. Ask each client who has terminated therapy if he/she is better because of the therapy received at this clinical center.

c. conduct a telephone survey for client satisfaction and dissatisfaction.

d. conduct a survey on a pre-post session for the 1st, 3rd, 5th, and exit interview regarding improvement.

Answer: d. conduct a survey on a pre-post session for the 1st, 3rd, 5th, and exit interview regarding improvement. Although there may be better-designed studies, alternative d. would be the choice. A better choice would be for the agency to utilize an intake instrument that assesses for a level of mental health and to conduct it again at termination and at some specified time period after discharge.

# OBJECTIVE J: Ethical Standards of Practice

CACREP Objective 1.J. of the core curriculum requirements for the Professional Orientation and Ethical Practice calls for the application of ethical and legal considerations in counseling: knowledge of and compliance with standards (C.1.) and professional competence (C.2.) involve the education, training, supervised experience, state, and national professional credentials, and professional experience regarding standards (ACA, 2014).

Ethics is the study of the nature of morals and values and how they apply to the standards that govern relationships between people. Professions usually have a code of ethics that governs the conduct of the members of the profession. Professional codes of ethics provide general guidelines for resolving ethical dilemmas rather than offering specific instructions for various situations. The Knapp (2001) chapter that is contained within Cullari's text is a good source for review.

Ethical behavior and decisions will reflect choices made by counselors. Choices are made on the basis of the philosophical foundation held by that counselor and how those choices affect client care. Ethical behaviors may be mandatory or aspirational. Mandatory ethics is a forced choice, an all or nothing behavior. There is no gray area. Aspirational ethics are those in which many variables are considered and less of a definitive outcome. A licensing board and an ethical committee would likely perceive a dilemma from a mandatory perspective. Aspirational ethics would be a broader perspective and would examine the client variables, present and past, coping strategies and likely be considered in a gray zone. This is not to assume that the counselor exercising aspirational ethics does not consider the principles of the profession's code of ethics (autonomy, beneficence, nonmaleficence and justice).

The primary function of a code of ethics is to serve as a framework for professional behavior and responsibility. In addition, the code fulfills the need for professional identity and reflects the maturity of the profession. A code of ethics is a limited document usually set in the broader social ethical tradition. For a profession to be recognized, it must provide the means to enforce its code. The 2014 Code of Ethics serves six main purposes. The first is to clarify the nature of the ethical responsibilities held by the members. The second identifies ethical considerations relevant to professional counselors and counselors-in-training. Third is to establish principles that define ethical behavior and to clarify for

clients the nature of the ethical responsibilities that are held in common with ACA members. Fourth is for the Code to serve as an ethical guide to assist members in developing a course of action that will best serve those who utilize counseling services. Fifth, the Code helps to support the mission of ACA. Finally, sixth, the Code serves as a basis for processing inquires and ethical complaints concerning ACA members (ACA, 2014, p.3.).

Donald Super (working in conjunction with the APA) pioneered the first proposed code of ethics for APGA. The ACA Code of Ethics is comprised of a preamble and nine sections. The first code of ethics was released in 1961, five pages in length. Since that time there have been five revisions and updates to include the 2014 Code. It is recommended that the examinee thoroughly read each section of the code and then utilize the outline below to test knowledge and understanding of the scope of each section.

Professional conduct is defined through guidelines such as principles, codes, and standards and goes from general to specific. A code of ethics is an explanation and description of appropriate behavior that applies to all situations and conditions for professional practice (Herlihy & Corey, 1997). Herlihy and Corey and the 2014 Code of Ethics cite the underlying principles of a code of ethics as:

1. autonomy
2. beneficence
3. nonmaleficence
4. fidelity
5. justice
6. veracity

The overall intent of these principles respectively is to allow for choice, promote good and avoid harm, being truthful, and being fair. A standard of practice based upon a code of ethics is a description of minimal behavioral statements. A standard of practice is more specific and will state what is mandatory behavior for minimal care. A standard of practice established the preferred methods or techniques used in diagnosing and treating clinical conditions (Granello & Witner, 1998). Anderson (1992) indicates that a standard of care is based upon theoretical concepts of counseling theory, on accumulated clinical experience, and on empirical research. Care should be exercised in the use of any labeling, especially those of the DSM-5™ labels. The validity of the data to make an assessment remains scant. An ethical approach to this dilemma is to conduct the assessment at a later time and see if the assessment matches.

## Outline of the ACA Code of Ethics

The 2014 Code of Ethics was used for this outline. The ACA Code of Ethics serves five purposes and values contain nine main sections. Major changes are noted throughout the code. For a complete set of standards for the ACA Code of Ethics consult the ACA website, www.counseling.org. Brief stimulus

statements are listed for each topic to facilitate your study. If you have difficulty recalling the specifics of each section, retrieve the code and reread the entire section.

Changes in the 2014 Code of Ethics include a major change with the addition of Section H: Distance Counseling, Technology, and Social Media with six subsections. The only reference to technology applications counseling in the previous 2005 code was A.12. that included 12 subsections and included the World Wide Web. The counseling field is no longer a face-to-face interaction rather has expanded to include technology, social media, and internet counseling and supervision. The subsections to Section H emphasize acquiring knowledge and legal competencies, informed consent and security, confidentiality, limitations, client verification, relationship, boundaries, technology-assisted services, effectiveness, access, communication differences in electronic media, records and web maintenance, client's rights, electronic links, multicultural and disability consideration, social media, and use of public social media.

Each of the following point out brief changes or new concepts introduced in the ACA 2014 Code of Ethics. It is recommended to review the complete writing for a fuller understanding of the change or additions to the code.

Throughout the nine Introductions (A-I) there is a consistent repetition of core values and attitudes representing counselor traits or behaviors such as trust, boundaries, diversity, counselor cultural consideration, devoting a portion of professional activities includes pro bono public, privacy and confidentiality, and advocating,

Section A.2.e. Mandated clients: counselors discuss limitations to confidentiality, explain types of information shared with others, and client refusal rights or to refuse services and consequences of a refusal.

Section A.4.b. Personal values: avoid imposing their own values, attitudes, and beliefs-respect diversity of clients, and seek training in areas where the counselor is at risk of imposing values.

Section A. 5.e. Personal virtual relationship with current clients: prohibited from engaging in personal virtual relationships.

Section A.6.b. Extending Counseling Boundaries: risks and benefits in extending current counseling relationships beyond conventional parameters (such as cross walking; examples: weddings, visiting different locations, parties, etc. ).

Section A.6.c. Documenting boundary extensions - counselors are to officially document extensions prior to the interaction (rational, benefits, consequences, etc.).

Section A.10. Fees and Business practices and self-referral to A.10.f.: receiving fees that pertain to working in private practice or organizations.

Section B.2.b. A change from the previous code - counselors now have an option of confidentiality depending on applicable laws and after seeking consultation or supervision.

Section C.3.b. Testimonials: counselors discuss with clients implications of and obtain permission for use of any testimonial.

Section C.6.e. Contributing to the Public Good: pro bono public and the counselor makes an effort to make a return to the public.

Section D.1.a. Different approaches: respect different approaches grounded in theory and supported by empirical scientific foundations that differ from the counselors.

Section E.9.b. Instruments With Insufficient Empirical Data: caution is exercised in using instruments with insufficient data and to qualify conclusions, diagnoses, or recommendations based on instruments with questionable validity or reliability.

Section F.2.c. Online supervision: Competent in technologies and take precautions to protect confidentiality of transmitted information through electronic means or forms.

Section F.4.a. Informed consent for supervision: informed consent, policies and procedures, due process, all related to distance supervision.

Section F.5.b. Impairment: Student and supervisor monitor signs for impairment.

Section F.5.c. Professional Disclosure: status, limits of confidentiality, qualifications, client permission.

Section F.7a., F.7.b. and F.7.d. Responsibilities of Counselor Educators: new to the code. These subsections involve traditional, hybrid, and online formats conducting counselor education and training programs in an ethical manner. Counselor educators provide instruction based on knowledge in the profession and to integrate academic study and supervised practice.

Section F.8.d. Addressing Personal Concerns: Counselor educators may require students to address personal concerns that have potential competency.

Section G.2.i. Research records custodian: A plan for transfer of records with a custodian

Section G.3.a. Extending researcher-participation boundaries: Risks and benefits of extending research beyond conventional parameters.

**Question 1-43:**
A client who has been in counseling for three sessions shares that he is seeing another counselor but for a different reason. The appropriate action of the counselor is to:

a. respect the client's right to see whomever he desires.
b. continue counseling with the client once it is determined that this counseling is for different purposes.
c. request that the client tell the other counselor that he is also seeing a second counselor.
d. secure a written release to contact this counselor to discuss the counseling.

Answer: d. secure a written release to contact this counselor to discuss the counseling. This is the preferred behavior. Once you have secured the release the counselor can contact the counselor and determine the nature of the other relationship. Acquiring this information allows the counselor to determine if by accepting this client the counselor would or would not be working at cross purposes to the other counselor. See ACA Code A.3. (clients served by others).

In Sections A-I of the 2014 Code of Ethics at least one construct will be illustrated for each section.

## Section A1: Client Welfare - Informed Consent (A.2. Informed Consent in the Counseling Relationship)

Informed consent is a set guideline that is a written document that is presented orally to ensure that a client competently understands the procedures of care. This guideline is detailed and is specific regarding all aspects of the client-counselor relationship during the course of treatment. Informed consent for covered entities will add requirements but most oral forms of informed consent procedures includes the intervention, fees, client/ research participant, educational and clinical training of the counselor or researcher, theoretical orientation of the counselor, level of licensure, policies and agency procedures for "no show", scheduled vacations, and relationship with a minor and communication with parent or guardian. The client holds the right of refusal.

**Question 1-44:**
Jerry and Lyn self-referred to the counseling stating Lyn's concern regarding Jerry's inability to make reasonable decisions. Lyn indicated that Jerry could benefit from counseling because he has made some poor decisions. Lyn said she would be in each session to provide clarification and support and she wanted to be sure he worked on that issue. It was her hope that he would learn how to make positive decisions. Before initiating counseling the counselor would want to:

a. clarify who is the client
b. seek a release of information from Jerry so the counselor can seek supervision
c. provide informed consent guidelines
d. indicate to Lyn that she could only remain if she was willing to receive counseling regarding the marriage and decision-making

Answer: c. provide informed consent guidelines (to Jerry and Lynn). If Jerry is the client and Lynn is to sit in the counseling sessions Jerry should sign a release as they did not commit to counseling as a couple. ACA (2014) references multiple clients (A.8.) of two or more and that the counselor clarifies at the outset who is the client and the nature of the relationship so that the counselor is capable of avoiding conflicting roles. The counselor is to clarify, adjust, or even withdraw from roles that are inappropriate.

## Section A.11. Termination and Referral

**Question 1-45:**
A counselor may terminate a client for all of the following reasons except when the client is:

a. no longer producing material for work
b. no longer needs assistance
c. likely to benefit
d. no longer paying fees as agreed

Answer: a. no longer producing material for work. The counselor before terminating is to communicate to the client the non-productive work in order to determine why the client is no longer working.

## Section B: Confidentiality (B.1.c., B.2.b.), Privileged Communication, and Privacy

**Question 1-46:**
A client who terminated three months ago has verbally requested the counselor for a copy of all materials contained within his permanent record. The counselor should:

a. provide the materials to the client upon a written request.
b. tell the client that all materials are incomplete and the materials would be of little value to her.
c. tell the client that the counselor would be willing to let her read the notes but only in the presence of this counselor.
d. review the policy of your agency about any release of information.

Answer: d. review the policy of your agency about any release of information. Reviewing agency policy is a primary step followed by whatever appropriate action is stated in the policy and the Code of Ethics. Letter c. is an ethically appropriate action; however, it does not involve your obligations to the agency and your employer. See client access (B.6.e.), assistance (B.6.f.), and precautions (B.6.i.).

## Section C: Professional Responsibility (C.1. standards, C.2. competence)

**Question 1-47:**
A counselor is interviewing for a therapist position at a local therapy center. The counselor is aware of a particular technique which seems to be an accepted practice at the center, however, it is against the counselor's moral and ethical belief. There are very few jobs and the counselor desires to work to attain his state license. The counselor should:

a. apply for the job and plan to avoid the practice of this particular behavior.

b. apply for the job and plan to change the particular behavior once employed.

c. apply for the job and tell the clinical director your moral and ethical code is at odds with the behavior.

d. do not apply for the position.

Answer: d. do not apply for the position. Ethical code D.1.g. specifies that to accept employment implies there is agreement with its general policies and principles. The answer to this question is a bit sticky; however, letter d. is the preferred answer. The counselor is not to become entangled or associated with a known practice that he/she might or might not be able to change. The power of change is frequently with management. Letter c. is an honest answer in that you are up front with your values and the interviewer is in a position to reply yes or no. However, if the technique remains at the agency the counselor will be faced with the same dilemma, a behavior that goes against his values and ethical standards. See ACA Codes: competence/boundaries (C.2.a.), consultation with other counselors (C.2.e.), qualified employment (C.2.c.), employer policies (D.1.g.), personal values (A.4.b.), potential risks, benefits, and ethical consideration (C.7.b.), harmful practice (C.7.c.), and grounded in theory/scientific foundation-explain risks (C.7.a.).

## Section D: Relationship with Other Professionals (C.8., D.1.)

**Question 1-48:**

A professional counselor is working in a team oriented clinical therapy center where there are several different professional disciplines. The professional counselor is concerned because the team of nine has decided upon a course of treatment that borders on an ethical practice he considers unethical. According to this counselor's code of ethics he is to:

a. seek a meeting with the clinical director in order to resolve the issue.

b. approach the team of nine and specify why there are ethical issues.

c. refuse to participate in the prescribed treatment.

d. contact the client to point out why participation is not in the best interest of the client.

Answer: b. approach the team of nine and specify why there are ethical issues. The counselor is to be respectful of approaches that are grounded in theory and/or have empirical or scientific foundations but may differ from their own (D.1.a.). D.1.c. teamwork with different disciplines (other professionals) counselors are to be respectful for those practices that are founded in perspectives, values, and experiences of the counseling profession. D.1.c. indicates the counselor works with the disciplinary teams to clarify ethical responses and obligations. The counselor first attempts to resolve a possible ethical issue with the treatment or client treatment by approaching the team members and state reasons for the ethical issue concern. If resolution is not reached the counselor is to pursue other avenues.

## Section E: Evaluation, Assessment, and Interpretation

**Question 1-49:**
The counselor is using a computerized report for a test interpretation with a client. The ACA Code of Ethics and the manual indicate that the interpreter is to:

a. have a manual present during the interpretation.
b. hand score the answer sheet as a double check of the scan procedure.
c. give a second test to confirm the results of the one being interpreted.
d. review the Buros Mental Measurement Yearbook before the interpretation.

Answer: a. have a manual present during the interpretation. A manual is to be present in order to answer any questions that come about as a result of the interaction. Although the exact wording is not found in the ACA Code of Ethics, Section E.2.b. refers to the appropriate use of administering, scoring and interpretation and E.3.a., E.3.b., and E.3.d. indicate that pertinent data is to be shared.

## Section F: Supervision, Training, and Teaching

**Question 1-50:**
When students apply for admission to a counselor training program they should be advised that they:

a. may find some of their friends in the program and as a result their friendship may be altered.
b. should read the standard of care and the role of a counselor before enrolling.
c. may change as a result of going through different didactic and experiential components of the program and training and that self-growth is an expectation.
d. will have to compete with social workers, family therapists, and psychologists for work positions.

Answer: c. may change as a result of going through different didactic and experiential components of the program and training and that self-growth is an expectation. Letter c. is an informed consent decision in that many individuals are subject to and do undergo change as a result of their experiences in a counseling or mental health program. Letter d. is also a correct answer and no doubt one for discussion. See ACA Codes: program information and orientation (F.8.a.1,6, ) and self-growth experiences (F.8.c.).

## Section G: Research and Publication

**Question 1-51:**
During a research project in which all participants signed a release and within the informed consent procedures all of the following are to be shared except:

a. identify procedures that are experimental
b. describe benefits

c. describe limitations

d. caution the participants that once they have agreed to the format it is imperative they finish the program.

Answer: d. caution the participants that once they have agreed to the format it is imperative they finish the program. Section G.2.a. (9) specifies that the participant has the right to decline a research request and is free to withdraw consent to participate in the research and can withdraw without penalty.

## Section H.1. Knowledge and Legal Considerations.

**Question 1- 52:**

Technology can be utilized to empower marginalized, disenfranchised and diverse populations. Although there are many advantages to using technology and internet counseling there are barriers. All of the following are considered barriers for this population except:

a. lack of Internet access

b. expensive

c. feelings of disempowerment

d. create limits to connections through distance

Answer: d. create limits to connections through distance. Reljic, Harper, and Crethar (2013) suggest that options a., b., and c. lack of computers at home are all barriers for different members of the marginalized and disenfranchised groups. Limitations (ACA H.2.c.), benefits and limitations (H.4.), and communication differences in electronic media (H.4.f.).

## Section I: Resolving Ethical Issues

**Question 1-53:**

Counselor A becomes aware that counselor B is unethically taking advantage of certain clients. A few of counselor B's clients are stockbrokers and conversations early during each session interactions are frequently over "hot" stock tips. Counselor B has made it known he acted upon a few of these tips and has done well. Counselor A should:

a. make an informed resolution by approaching counselor B and informing him this behavior is inappropriate.

b. consider that this behavior could affect a relationship issue between counselor A and B, therefore inform the clinical director.

c. view this as an illegal act and report this behavior to the state ethics committee.

d. consider it is the client's choice to share this information and that this material is covered by the confidential rule or privilege and the client is not harmed.

Answer: a. make an informed resolution by approaching counselor B and informing him this behavior is inappropriate per Informal resolution (I.2.a.). Since counselor B has made it known that he has encouraged this sort of talk during each session and has acted on some of the tips, counselor A is certainly free to interact with counselor B regarding the unethical nature of his behavior.

# Why A Code of Ethics

It is understood that the code is a limited document and as a result issues arise which have to be determined in a broader context. Some of these issues are between and among autonomy, welfare, enforcement, forums (state, federal, courts, etc.), conflicting codes, and issues that are not covered within the code. Being knowledgeable about the content of the code means recognizing its provisions as well as its limitations. Corey, Corey, and Callanan (2003) point out that mental health professionals become involved in principle ethics and virtue ethics in their personal and professional development. According to Meara, Schmidt, and Day (1996) the difference between the two types of ethics is that principle refers more to the situation of the ethical concern while virtue ethics reflects the character traits of the counselor. Virtue ethics is an integral aspect of the intrinsic set of morals represented by the professional's philosophy while principle ethics relate to situational practice in the best interest of the client. Principle and virtue ethics are intertwined when processing a dilemma. Below are some plausible reasons why a code is helpful.

Herlihy and Corey (1996) cite three objectives of a code of ethics. These objectives are to educate professionals in responsible ethical conduct, accountability, and the impetus for improving practice. In summary, the outcome of the three objectives and effective outcome of a code is the welfare of clients to:

1. increase the chances that practitioners will be more competent and that their services will be better distributed.
2. upgrade the profession.
3. allow the profession to define for itself what it will and will not do.
4. protect the public from ignorance about mental health services.
5. protect the public by setting minimum standards of service.

Ethical dilemmas surface as a result of the difficulty in separating our personal and professional identities. The very nature of who we are personally becomes a part of the tools we utilize to provide our counseling services. Our personal traits and human responses are heavily involved in relationship building. Ethical dilemmas arise due to unavoidable, inadequately anticipated, and/or unforeseen events. Ambiguities in consequences, guidelines that are nonexistent, and conflict between client welfare and established legal obligations often result in ethical dilemmas (Sieber, 1982).

There are five principles related to client welfare that are used in evaluating dilemmas (Beachamp & Childress, 1979, 1994; Cottone & Tarvydas, 2003; Huber & Baruth, 1987). Meara et al. (1996) adds veracity to the other five.

Autonomy: All human beings have the right to make decisions and act on them in an independent fashion as long as they do not infringe on the rights of others (Beachamp & Childress, 1994).

Beneficence: One must actively attempt to benefit another in a positive manner (Beachamp & Childers, 1994).

Nonmaleficence: One must avoid causing harm to another (Beachamp & Childress, 1994).

Justice: All individuals should be treated fairly must be treated in a way most beneficial to their specific circumstances (Cottone & Tarvydas, 2003).

Fidelity: One should keep promises, be truthful, loyal, and follow through with commitments (Bersoff & Koeppl, 1993).

Veracity: Truthfulness. A counselor is to be honest with his/her clients. Veracity is evident in sharing test results, diagnosis, and informed consent (Meara et al., 1996).

**Question 1-54:**
A counselor when sharing informed consent procedures with a client is involving more than one of the principles that underlie the 2014 ACA Code of Ethics. The one principle, which may be central to informed consent, is:

a. nonmaleficence.
b. justice.
c. veracity.
d. autonomy.

Answer: c. veracity. Veracity is one of the foundations for ethical behavior and decision making. Veracity represents being truthful to the client revealing such things as the fee structure, diagnosis, etc.

It might be helpful to be aware that ethical theory has the components of value and morality. The most common ethical dilemmas with clients are inappropriate interactions. A study conducted by Stadler and Paul (1986) listed 15 dilemmas cited by counselors of which the following six occurred most frequently:

1. confidentiality
2. client-counselor relationships
3. supervisor-supervisee relationships
4. faculty/faculty relationships
5. faculty/student relationships
6. research

This research was conducted in 248 university counseling centers. The results of this survey are supported by the findings of Pope and Vetter (1992) who compiled data from 679 psychologists. The

returned reports of troubling incidents ranked confidentiality and dual relationships first and second on a list of 23 categories.

The general public expects the counselor to be trustworthy, competent, and to cause no harm. In conclusion, when principles are in conflict one should make decisions that are consistent with how one would want to be treated, in a way that would produce the least amount of harm, and in the best interest of the clients.

## Examples of Major Complaints

(Keith-Spiegel & Koocher, 1985) Complaints can arise in any area of the code (A-H); however, the majority appears to center around the themes of:

Exploitation: sexual, excessive fees, deceiving clients or research participants, failure to credit colleagues.

Incompetence: inadequate training, using poor professional judgment, personal problems interfering, attitude bias toward special populations.

Irresponsibility: blaming others, minimal professional work, being unreliable or undependable.

Abandonment: failure to follow through, lack of termination, premature or abrupt termination MacBeth, Wheeler, Sither, and Onek (1994) suggest that abandonment can be avoided by:

1. discussing with the client reasons for terminating
2. providing the client opportunities to make changes whereby the counseling may continue
3. providing a written notice of termination
4. including one to three sessions for termination
5. providing a number of referrals
6. providing places to contact in case of an emergency
7. providing a summary of the termination that is placed in the file but not transferred to another therapist
8. providing sufficient time for the client to locate another counselor

During the years 1989-1991, 1991-1992, 1992-1993, 1993-1994, 1994-1995, 2003-2004, 2004-2005 ACA received a total of 7, 6, 30, 32, 7, 9, and 13 formal ethical complaints, respectively (ACA Ethics Committee, 1991; Garcia, Glosoff, & Smith, 1994; Garcia, Salo, & Hamilton, 1995; Smith, 1993, Anderson & Freeman, 2006). Each set of complaints cited from 1-34 standards violated. Garcia, et al. (1994) stated that standard H was cited as many as 53 times during one year (1993-94) while standards A, B, and F 38, 19, and 9 times respectively. The standards most frequently cited were failure to maintain high standards, recognizing boundaries of competence, counselor meeting personal needs, sexual harassment, maintaining confidentiality, and dual relationships. For the 1989-1991 complaints 2 of the 7 reports were for misrepresentation, 2 for client sexual intimacy, 2 for unethical research and 1 for

dual relationships with clients (ACA Ethics Committee, 1991). For the results of the 1992-1993 survey counseling relationships and Section A (general) were cited 46 times of the 66 violated standards (Smith, 1993). In 2003-2004 and 2004-2005 confidentiality accounted for 47% and 52% respectively of the formal complaints (Anderson & Freeman, 2006; Kocet & Freeman, 2005). Counseling relationships represented 27% of the formal complaints.

ACA has established a three tier categorizing and processing method for ethical issues such as inquires, complaints (filing a complaint), and sanctions (actions taken). During the year June 2012 to June 2013, 2011-2012, and 2010-2011, ACA received respectively 6,231, 6,558, and 4,943 inquires, 4, 6, and 9 complaints, and 0, 0, and 1 sanction. The nature of the inquires respectively contained confidentiality (37%, 42%, and 32%), responsibility (41%, 21%, and 19%), Supervision (7%, 4% and 5%), licensure (11%, 22%, and 27%), and other (4%, 11%, and 17%). Retrieved www.counseling.org/knowledge-center/ethics, 3-21-2014.

A professional group such as ACA does have in place an ethical sanctioning system, that is, a set of enforcement procedures to govern the action of its members. This system for ACA includes different levels for an appropriate response to the violation along a continuum from no violation, request to voluntarily cease behavior, to being unethical with sanctions. These sanctions can include a reprimand for corrections, suspension from ACA, probation for a period of time, and expulsion from ACA. In the event that a member is suspended or expelled with no appeal the notification process begins. For ACA, this entails notifying the members through Counseling Today, divisions of membership within ACA, state branches, NBCC and existing state license boards in the state of residence (ACA Ethics Committee, 1991).

Dryden (1987) found that ethical dilemmas could be grouped according to six themes: compromise dilemmas, boundary dilemmas, and dilemmas of allegiance, role dilemmas, dilemmas of responsibility, and impasse dilemmas (p. 2-4). Each type can be summarized as follows:

1. Compromise dilemmas:
    a. ideal vs. practical
    b. preferred role vs. successful outcome
    c. conservative goals vs. radical goals
2. Boundary dilemmas:
    a. therapists self-disclosure vs. risks involved
    b. professional vs. personal life
    c. appropriate vs. inappropriate therapist behavior
3. Allegiance dilemmas:
    a. school of thought vs. client welfare
    b. professional community vs. new reference groups
4. Role dilemmas:
    a. educator vs. healer

b. scientist-practitioner vs. psychotherapist
c. clinician vs. researcher

5. Responsibility dilemmas:
    a. client welfare vs. client autonomy
6. Impasse dilemmas:
    a. dealing with vs. risking harm
    b. therapist vulnerability vs. resolution

# Decision-Making

When a decision arises concerning a dilemma, the counselor must make a judgment in deciding what course of action to take. This necessitates a decision-making strategy that will systematically take into account the various aspects of the situation so that the counselor's chances of reaching the best ethical decision are maximized. Also, it is crucial that the decision-making process be taken to supervision. Do not make ethical decisions in isolation!! In consultation or supervision, flaws in reasoning may surface, other perspectives may be generated, and most importantly, responsibility may be shared. It is important that the decision and its rationale be thoroughly documented as a way to protect the counselor and provide information for similar situations in the future (Keith-Spiegel & Koocher, 1985). Three models for ethical reasoning and decision-making are described below.

1. Interpret: Determine if one's actions are bringing about consequences that affect client welfare.
    a. Formulate: Course of action Intuitive level: development perspective and prior learning

        Critical-evaluation level: 3 tiers

        1) Ethical rules composed of autonomy, nonmaleficence, beneficence, justice truthful, confidentiality, informed consent, faithful
        2) Integrating competency: decide how client will act
        3) Implement: perseverance, resoluteness, and character
2. A developmentally experienced-based model for decision-making was proposed by Pelsma and Borgers (1986). These authors suggest that the decision maker needs four kinds of abilities: concrete, reflective observation, abstract conceptualization, and active experimentation. This is a four-stage learning model prepared by Kolb (1976) and utilized in conjunction with Kirby's growth dimensions (affective, perceptual, symbolic, and behavioral).
3. A third developmental process was presented by Van Hoose and Kottler (1985) that was developed using stages from the work of Piaget and Kholberg. Van Hoose's five stage model is as follows:
    a. Punishment Orientation
    b. Institutional Orientation

c. Societal Orientation
d. Individual Orientation
e. Conscience Orientation

# Enforcement

## Suspected Violations: ACA Ethical Code Section I.2

In order to be a profession, the professional group has to be able to process and take educative/ punitive action for those violating ethical/legal behaviors. Enforcement procedures are usually suggested depending on severity and ramifications, and whether the observing professional attempts to resolve the complaint. If this is not possible a local ethics committee should be consulted. If this committee does not exist, a written complaint should be filed with the existing state ethics committee. This complaint should contain the stated observations, where in the code the violation is addressed, dates of the observations, and the document is to be signed by the observer. The professional group will determine whether the behavior warrants an investigation. Action by the professional group is in the form of educational advice, warning, reprimand, censure, resignation, or expulsion. Individually the ACA Code of Ethics and standards of practice indicate that the counselor must take action when he has reasonable cause of self or others acting in an unethical manner (SP 49) or in filing unwarranted complaints (SP-50). Counselors are to cooperate with investigations, proceedings and requirements of ACA Ethical Code of Ethics and (SP 51).

# Legal Issues

## Standards and the Law: ACA Code of Ethics Section C.1. and I.1.

Ethical standards are not the only guidelines that govern our profession. There are legal guidelines that we must adhere to as well. Ethical and legal issues are not the same, though there is some overlap. What is legal may not necessarily be ethical. The law does allow the profession's ethical guidelines to rule professional behavior, but it can override the ethical guidelines when the public's welfare is at stake. Ignorance of ethical and legal guidelines is not an excuse for failing to follow them. It is imperative that a counselor reviews the specific legal codes of the state in which he or she practices. Counselors have a duty to thoughtfully use their best judgment in the care of clients. If a counselor does not do this, the counselor is being negligent.

Negligence is any conduct that falls below the acceptable professional standard of care. This may be due to the result of carelessness on the counselor's part. The counselor who is negligent is not trying to hurt anyone, but the negligence could cause a client to be harmed. When this happens, malpractice has occurred.

Malpractice is determined when harm to the client occurs because of negligence on the part of the counselor.

The terms negligence and malpractice are often used interchangeably in courts. Malpractice refers to a deviation from a professional standard and negligence refers to deviation from what a competent professional would have done in similar circumstances (Beis, 1984). When a client asserts that a counselor has harmed him or her in some way, the client can file a complaint. Grievances should be covered under informed consent as to how to handle such complaints.

Tort: A tort is a legal action where one party asserts that the negligent behavior is a civil liability. When a complaint is filed, the plaintiff must prove four things:

1. A therapist-patient relationship existed (duty to the plaintiff).
2. The treatment fell below the standard of care (breach of duty).
3. There was an actual loss of injury.
4. A causal relationship existed between the breach of duty and the injury (proximate cause).

In malpractice cases, the plaintiff usually has to prove the case by a preponderance of the evidence, which means that the evidence provided against the therapist is more convincing than the evidence offered in support of the therapy.

Liability: Liability is the legal obligation or responsibility one person has toward another person.

Libel: Libel is a false written statement that causes harm to a living person. The intent is malice (a disregard for the rights of others).

Slander: Slander is a defamatory spoken statement that causes harm to a person. The intent is malice. The following are some safeguards for avoiding malpractice.

1. Be able to articulate that the client is making progress.
2. Have ongoing supervision with other professionals either through staffing or individual sessions.

Have a lawyer available for consultation.

# Legal Information

## Freedom of Information Act

Anyone has the right to have access to and may receive copies of any document, file, or other record in possession of the federal government subject to certain specific exemptions, especially N.I.M.H. access to grant applications—denied new research grants-financial information/medical nature, etc.

## Revised Family Educational Rights and Privacy Act 1974 (FERPA, Buckley Amendment)

FERPA gives students 18 and older and their parents the right to inspect relevant school records. Freedom of Information Act refers to the ability of third parties to obtain information from federal files, where the Privacy Act refers to the ability of a person (or a relative) to obtain information about himself or herself. It provides the parent the right to be informed and give consent when their student undergoes assessment. Parents and students have the right to gain access to their records upon request, and must provide written permission for anyone else who is not directly related to the student's education to gain access. This act became known as PL93-380.

## Protection of Human Subjects

Article 7 of the U.N. draft covenant on Civil and Political Rights says no one shall be subjected to torture or cruel, inhumane, or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

## Public Law 94-142

Education of all handicapped children part B. Confidentiality of information and funding to state is guaranteed. Public Law 94-142 ensures an Individualized Education Plan (IEP) for each handicapped person. This includes:

1. statement of child's present levels of educational performance
2. annual goals and short-term instructional objectives
3. statement of specific education services provided in which child can participate in regular programs
4. projected date for initiation and anticipated duration
5. appropriate objective criteria for determining on an annual basis whether instructional objectives are being met

# Ethical Issues for Specific Constructs

## Privacy/Confidentiality/ Privilege

ACA Code of Ethics:  privacy (B.1.b.) and confidentiality (B.1.c., D.1.e., F.1.c.)

Privacy, confidentiality, and privilege are three similar and yet distinct terms that are relevant to professional ethics. Privacy is an evolving legal term that recognizes the client's right to decide when, where, and what he or she wants to share or withhold in terms of personal information.

Confidentiality is an ethical standard that protects a client from having information disclosed without his or her consent. The counselor informs the client that under certain conditions she or he will not be able to maintain confidentiality. Some examples are child abuse, harm to self and others, a court subpoena signed by a judge, and malpractice claims.

Finally, privilege is protected by a law in which the privacy of the client and the confidentiality of the client/therapist (or other professional) relationship is guaranteed (Herlihy & Sheeley, 1987).

Privileged Communication

Legal right: exists by statute and protects the client from having his/her confidences revealed publicly from the witness stand during legal proceedings.

Legal concept: privilege belongs to the client so if he/she waives this right you cannot withhold (e.g., attorney, marital partners, physicians, psychiatrist, clergy).

Privileged communication protects the client from unauthorized disclosures of any sort by a professional without the consent of the client. It refers to ethics rather and legalism and indicates an explicit promise or contract to reveal nothing except under conditions agreed to by the source or subject. Privilege communication is now incorporated in legislation and court rulings, so civil or criminal liability is possible (Knapp & VandeCreek, 1983, 1987, 1997; Shah, 1969). The client owns privileged communication and this privilege is only waived by the client except in extreme circumstances (Reaves, 1999).

Two Types of Privileged Communication:

1. Absolute: no legal action can be taken even if it is untruthful
2. Qualified:
    a. exceptions are possible danger
    b. duty to warn relationship
    c. may not know until after communication

**Question 1-55:**
For the past six months the counselor has been counseling regularly with a 17-year-old male. During this session the client reveals some material that when combined with previous work with him causes the counselor to consider a breach of confidence. Of the following, which two choices are ethically sound reasons to break confidence?

a. the counselor believes the client was a victim of crime such as incest.
b. the counselor thinks his needs have become entangled in the therapeutic relationship.
c. the client initiates a lawsuit against the counselor for malpractice.
d. a misdemeanor is committed.

Answer: a. the counselor believes the client was a victim of crime such as incest and c. the client initiates a lawsuit against the counselor for malpractice. Alternatives a. and c. permit the counselor to

break confidence. So far there have not been questions where there are two correct answers requested for the NCE. The first is to protect the client and the second is to be able to defend oneself. Attorney/ client, husband/wife, physician/patient, and priest/ penitent have privilege. Some states now extend privilege to psychologist/client or psychotherapist/ client relationship. Actual laws vary widely. Informed consent in formal consultation (D.2.b.)…limits of confidentiality.

Almost all states granting privilege require some form of licensing, certification, or registration. Keith-Spiegel and Koocher (1985) cite several states that provide for the application of privilege when the client is under the impression supposedly that a counselor is licensed as a psychologist. Some states permit the judge discretion to overrule privilege when he or she determines the interest of justice outweighs the interest of confidentiality's (Keith-Spiegel & Koocher, 1985). Some states grant privilege to counselors (Herlihy & Sheeley, 1987).

**Question 1-56:**
A counselor educator who trains counselors from time to time has a consultative relationship with private businesses conducting team-building exercises with the Myers-Briggs Inventory. In doing so, the counselor has acquired many mid-to-top-level management acquaintances. Two evenings per week the counselor is employed by a mental health agency as a therapist. On a particular visit to the post office, the counselor encounters Mr. Rank, a manager, with whom he has conducted some managerial training. Mr. Rank is familiar with the counselor's many duties and affiliations. Briefly, in conversation, the counselor makes the comment that he had heard that Mark Brice was going to work for Mr. Rank's company as a manager in the same division as he. The counselor had first heard this in a session with Mark Brice although it is not public knowledge that Mr. Brice is employed with this company. The issue at stake is:

a. a breach of confidentiality.
b. no breach of confidentiality.
c. a dual role relationship.
d. no issue because Mark Brice's employment is common knowledge.

Answer: a. a breach of confidentiality. Information obtained in session should remain in session. With the manager's awareness of your profession, he may assume your contact with Mark Brice was in a counseling environment. This may be placing your client in a position where he/she might need to explain your exception to privilege.

Exceptions to privilege: When law and ethics diverge, exceptions to privilege arise. If ordered by the court to break confidence, it would be difficult to fault the counselor. To violate the law becomes an individual decision and an act of civil disobedience. Statutory obligations to break confidence include the following:

1. child abuse
2. child custody
3. criminal activity and future crimes yet non-existent

However, in some states three elements must be reported: perpetrator, victim, and third party.

1. When client requests it.
2. When client is bringing a lawsuit against the counselor, as in a malpractice suit, the counselor has a right to defend him/herself.
3. When there is a clear and imminent danger that disclosure may help to divert or avoid the outcome. This is Duty to Warn. The key is whether the counselor knows or should know of the potential seriousness (Knapp & VandeCreek, 1982, 83, 97).

MINORS: Confidentiality with minors is a special issue and the issue may be voluntary or involuntary right to give consent. This is covered in A.2.d. inability to give consent. The counselor's role is to attempt to balance the rights of minors to communicate and their parent or guardian rights to be informed and to perform parental duties regarding an awareness of issues. Generally, minors are not granted involuntary informed consent. There are some exceptions, however, where the counselor makes every effort to protect and develop trust in the relationship and maintain the best interest of the client. Wilson (as cited in Gustafson & McNamara, 1987) notes four exceptions in which minors are capable of seeking treatment without parental consent. These exceptions are: "mature minor," "emancipated minor," "emergency treatment," and "court ordered." Each resultantly ensures some degree of confidentiality.

## Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability (HIPAA; Public Law 104-191) was enacted in 1996 and fully implemented in 2005 to safeguard and ensure health care providers and patients (physical and mental health care) uniform standards to protect information privacy. Any third party transmission of patient information must meet the statutes for HIPAA. Entity refers to treatment, payment and health care operations. In cases of emergency, providers may sometimes disclose information to exercise a clinical judgment (Retrieved 9-14, 2011 http://www.omh.ny.gov/omhweb/hipaa/phi_protection.html).

The Privacy Rule was finalized in 2003 and applies to 'covered entities' such as organizations and individuals that transmit patient information electronically, in paper form or provided orally. The covered entity includes health and mental health plans and written client signed releases of information. The Privacy Rule covers all records that are held or information disclosed to a covered entity. The interpretation for this rule is that counselors are to provide to the client a written explanation of how the counselor will use, keep and disclose his/her health information. A procedure is to exist so that the client may make amendments or execute changes in the record as well as gain access to his/her records. In addition, the counselor is to have an established privacy procedure as to who has access to the client records. Client consent is to be obtained for the release of information regarding treatment, payment and health care operations purposes as well as transmission of client information to financial institutions. Exceptions are noted in the document whereby information may be released during times of an emergency. Even when clients provide permission to release information, the minimum amount is covered under the "Minimum Necessary" rule. The "Minimum Necessary" rule allows the health provider to use, to request, or to disclose to others only necessary

patient information to fulfill the intended purpose. Each provider is to consult other privacy federal laws when a disclosure is under consideration. The Privacy Rule may be secured at Web site: http://www.hhs.gov/ocr/hipaa.

The typical information a 'covered entity' protects or uses is:

1. treatment, payment, or health care operations
2. upon the individual's agreement in certain limited circumstances (after an opportunity to agree or object)
3. disclosure to the individual
4. pursuant to an authorization from an individual
5. as permitted or required by HIPAA for government or other purposes (45 C.F.R. & 164.502[b])

A privacy officer is to be established in a counseling office. This officer is to train employees how to handle confidential information, ensure procedures are in place to protect, and ensure that proper forms are used by health personnel. The HITECH officer is to inform all employees the specific information regarding breach notifications. According to HIPAA the definition of breach is the "acquisition, access, use, or disclosure of protected health information…which compromises the security or privacy of the protected health information ". If a breach is considered, the entity is to perform a risk assessment, mitigate the breach, and report the breach to affected clients, the federal government, and possibly the media (Wheeler, 2013). In addition, the Omnibus Rule indicates that the counselor, if requested by the client, is not to disclose information to others if the client pays out of pocket expenses except if required by law.

Psychotherapy notes are covered under 45 C.F.R. & 164.508(a) (2) and stipulates that an authorization is to be obtained for use or disclosure of psychotherapy notes. The psychotherapy notes should be located in a separate file from the rest of the patient's record. HIPAA's rationale is that psychotherapy notes are not a part of the health record and not intended to be shared with anyone (Remley & Hurley, 2010). The client is to provide a release before any notes are transmitted elsewhere. There are exceptions for psychotherapy notes that include:

1. use by the counselor of psychotherapy notes for providing treatment, payment, or health care operations
2. training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling
3. use or disclosure by the covered entity to defend a legal action or to other proceedings brought by the individual
4. use with respect to the oversight of the originator of the psychotherapy notes, such as peer review and
5. disclosures required by law (445.CFR & 164.512(j), certain disclosures about decedents (45 CFR & 512(g), and disclosures to avert a serious threat to health or safety (45 CFR & 164.512(j); Remar, Bounds, Rogers & Hardin, 2011, pp 12-13).

A modification to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules were released January 5, 2013. Briefly some of these changes had to do with covered entities. A covered entity is a health provider who uses electronic transmission of client information. HITECH breach notification charges that providers are to update their privacy and security policies and procedures. Providers may not transmit or disclose client information to a client's health insurer if the client paid out-of pocket unless the disclosure is required by law. Second, a client may request a copy of her electronic health record in electronic form. Another addition regarding use of e-mail is that information may be sent through unencrypted format if the risk is explained to the client and the client agrees (Wheeler, 2013).

Practitioners who are exempt from the HIPAA requirement for adherence to an electronic transmission in sharing private health information are those who do not use office staff to process client payment information, and those who do not use electronic or technical devices to transmit client information (Patrick, 2007). HIPAA requirements are a part of all intake interviews.

In summary complying with HIPAA procedures health providers are to adopt written policies and procedures, train employees, designate a privacy officer, designate a contact person, and maintain documentation (Leslie, 2002).

## Family Educational Rights and Privacy Act (FERPA)

This act, created in 1974, was previously referred to as the Buckley Amendment. The act and specifications affect all public and private parochial educational institutions that receive federal funds. If a school system has a health based center, it may be subject to HIPAA requirements regarding student health records. FERPA indicates that parents of minor students (18 or older or in college) have the right to inspect the records and to challenge information contained within the file and to have written authorization obtained before any education records are transferred to any third party (US Department of Education, 2008). Parents or guardians may receive copies of the student records without the permission of the student (Remley & Herlihy, 2010). This does not include case notes if retained as separate from the student file and not made available to anyone else.

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1972.

This act specifies how records are to be conducted, regulated, and are directly or indirectly affected by the federal government's confidentiality definition. There are a variety of records which meet the guidelines for prior approval by a client; risk of death, audits or evaluations, and medical emergencies.

# Competence ACA Code: Termination (A.11.a., C.2.a., and E.2.a.)

Section C of the ACA Code of Ethics responds to the ethical area of competence. Competence is assessed by the quality of provided service and the boundaries or scope of competence (Cottone & Tarvydas, 2003). Competence requires the ongoing need to remain current in the practice of counseling and this can be accomplished though continuing education according to the standards of

practice (SP-18) as a must. The standards of practice indicates the counselor must practice only within the boundary of their competence (SP-17). Pipes and Davenport (1990) describe competence as accurately representing your training, recognizing limits of competence, seeking and utilizing supervision, recognizing differences among people, and the limits imposed by your personal problems. Welfel (1998) defines competence as made of three elements: knowledge, skill, and diligence. According to Welfel knowledge is "being schooled in the history, theory, and research in one's field and cognizant of the limits of current understanding" (p. 63). Skill is an acquired understanding of the therapeutic procedures and making appropriate applications of an intervention with a client. Overholser and Fine (1990) divide skills into clinical skills and technical skills. Clinical skills are interviewing skills while technical skills are interventions. Diligence is the steadfast attention and consistency by the counselor in working in the best interest of the client by maintaining the client's needs as a priority.

Several behaviors can be grounds for questioning the competence of a counselor. Some of the following serve as examples.

1. Boundaries of formal training—practicing within one's training and qualifications
2. Maintaining competence—the half-life of a doctoral degree is 10-12 years. That is, one half of the acquired knowledge is considered obsolete.
3. Burnout transfers to
    a. client's prognosis
    b. degree of personal relevance the client problems have for the counselor and
    c. client's reaction to the counselor

A client who does not improve may be fostering dependence.

Malpractice in the area of competence may be in question when the counselor's competence areas of skills, abilities, and diligence come into question. Three factors must be established and proven:

1. relationship must have existed
2. negligence or dereliction of duty
3. some harm as result of negligence

The role of the counselor is to recognize, prevent, and remediate in problem areas. The therapeutic contract has three major functions. These functions imply a healing, educational, and technological function. In all cases, the client has the right to know what service he/she is receiving and the therapist has a responsibility to be exact and state these conditions under the terms of the contract. Informed consent will usually contain a discussion of goals, expectations, procedures, and potential side effects. The area of competence means that the helper has boundaries of formal training, recognizes when his/her knowledge is obsolete, and recognizes the stages of burnout, client dependency, and malpractice. The ACA code is explicit in the area of updating ones knowledge and practice.

**Question 1-57:**
At a local mental health facility the admissions clerk introduces a beginning master level counselor intern to his/her first client. In so doing the clerk identifies the intern as Dr. Larson. On the way to the office the client thanked the intern using her name, Dr. Larson, for offering her a Kleenex. The intern continues on with brief comments about the weather until the two of them reach the office where the interview begins. If an ethical issue is to be resolved, it would be in the area of:

a. competence
b. dual role
c. preparation
d. boundaries

Answer: a. competence. Accurate representation (C.4.a.), credentials (C.4.b.), and degree (C.4.c.) - If the intern allowed for the miscommunication to remain, misrepresentation would exist.

**Question 1-58:**
In question 85, what should be the prerequisite behavior for the counselor?

a. immediately correct the client informing him/her of the academic degree the intern is presently working towards
b. correct the admissions officer by stating that the counselor is an intern working under the guidance of Dr. Supervisor
c. at least for this client allow the introduction to stand as the client may have attributed the expectations of an advanced degree with the ability to effect change.
d. attempt to state the intern's title and responsibilities to the client during the interview introduction. Seek out the admissions clerk on an individual basis and conduct the necessary informed procedures.

Answer: d. attempt to state the intern's title and responsibilities to the client during the interview introduction. Seek out the admissions clerk on an individual basis and conduct the necessary informed procedures. The most professional and ethical answer is to immediately correct the misinformation.

**Question 1-59:**
Counseling positions have been difficult to locate, especially those that allow for individual counseling. A counselor has taken this job for that reason plus the fringe benefits of retirement and insurance. During the interview the counselor learns that all drug-related behaviors reported to any counselor during counseling must be reported to the director. This is contrary to the counselor's belief. What is the ethical dilemma?

a. boundary of competence
b. unethical behavior by the director
c. agreement with policies and principles
d. philosophy

Answer: c. agreement with policies and principles. Qualified for employment (A.2.a. and C.2.c.)

# Research and Publication: ACA 2014 Code of Ethics Section G.

The 2014 Code of Ethics is essentially the same as the 2005 Code of Ethics. The issue of autonomy and nonmaleficence are important in the selection and utilization of human subjects. Research with human participants is to be conducted utilizing informed consent procedures. Subjects are to be informed (G.2.a.) of the procedures (G.2.a.1.), techniques, duration, dissemination of results, and the freedom to withdraw at any time (G.2.a.9.). A researcher must be careful to disguise subject results as the utilization and retrieval of computer storage poses a problem of confidentiality. In addition, the principal researcher must be careful to give due reward to those who contribute to the research and writing. In the writing of research findings the authors must be cognizant of the validity, reliability, and norms utilized for reporting such research.

## Values for Human Research

Sieber (1982) cites beneficence, respect, and justice as the primary values in guiding ethical research. In addition, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1987) provides six norms in which the three values are transmitted. They are the following:

1. Validity of research design includes relevant theory, prior findings, and ethical methods.
2. Competence for investigators is to be adequately trained and have sufficient knowledge to conduct the research.
3. Identification of consequences is to anticipate risks and benefits of conducting the research. Caution is to be exercised in order to retain confidentiality and minimize harm.
4. Selection of subjects for samples should be such that generalization can take place.
5. Voluntary informed consent is when subjects willfully agree to participate in the research and are informed of risks and benefits of this involvement.
6. Compensation for injury provides for compensation where risks are involved.

**Question 1-60:**
Two researchers are convinced that paradoxical techniques are useful and more effective than more acceptable, conventional techniques. To prove their point, they set up a model research design to test the effectiveness of a paradoxical technique compared to a literature-supported effective technique similar to stress inoculation. In order to test this paradoxical technique, the researchers feel it is necessary to not use informed consent procedures. To do so would invalidate the results. If this is ethical, what is to take place?

a. informed consent is a must, regardless of the type of research—the researchers need to redesign the project

b. deception is a necessary fact for some types of research

c. "debriefing" of the subjects should be conducted soon after the study

d. this type of research should be set up with the training groups to secure baseline data in order to justify the use of this technique on real participants

Answer: c. "debriefing" of the subjects should be conducted soon after the study. Although controversy surrounds this issue the most correct answer would be c. This would allow for follow-up if harm should occur and that compensatory action can be taken if warranted. Deviation from standard practice (G. 1.d.), risks (G.2.a.3.), and explanation after data collection-full clarification of research (G.2.g.).

**Question 1-61:**

A principal investigator has conducted a drug research survey in the public schools for four years. Graduate students who were employed in those schools have assisted him. Each year he has published the results of the different surveys and after the fourth year he wrote a summary article entitled "Longitudinal survey of drug use in public schools." The local newspaper became aware of this research and called the principal author to ask for permission to run the article in the city paper. The ethical issue in this request is what?

a. none, as it has already been printed, and therefore public domain

b. the writer needs to be referred to the school officials, since the contents of this report belong to the school

c. the graduate students need to give their permission to print, as they assisted in the work

d. permission must be secured from the students who took part in the research

Answer: b. the writer needs to be referred to the school officials, since the contents of this report belong to the school. The information omitted from this question is whether prior approval had been secured from the school district for data gathering and publication. This action places the school personnel in a position to respond to information about which they may have little to no awareness. This will cause an embarrassing situation for the researcher, however it is the researcher's obligation to correct and inform. Therefore, the correct answer for counselor action is letter b.

**Question 1-62:**

The statistical strategies of contamination, randomization, micro aggregation, and balanced incomplete blocks are utilized in research to assure the researcher and participants' protection for which of the following regarding ethics?

a. privacy

b. informed consent

c. volunteerism

d. research design

Answer: a. privacy  The counselor is to protect the counseling relationship and to safeguard the privacy of the client (Section A Introduction; ACA, 2014).

**Question 1-63:**
The Milgram study of obedience and the Tuskegee syphilis study raised an ethical dilemma. This dilemma had to do with:

a. informed consent
b. design error
c. sampling strategies
d. dual role

Answer: a. informed consent. Informed consent entails all participant information before participation thus allowing participant autonomy (the right to participate or not to participate).

# Technology (Administration-Scoring)

## ACA Code of Ethics Section E.

Ethical issues surface in knowledge, skill, and attitudes regarding testing and evaluation. The most recent revisions have pointed out ethical issues in computer technology and the application of computerized scoring and printouts. Users of instruments are required to have a manual present during interpretations and to be knowledgeable regarding the constructs of validity, reliability, and norming. Bias and unfairness (definitions in Unit 2 and Unit 7) are two terms frequently applied to tests and test items. Psychoeducational assessments of racial and ethnic minority groups have received discriminatory practice in the form of test bias and unfairness. Frequently, minority groups have been over-represented in all special education programs, and biases in intelligence tests have been the instruments for those placements (Gregory & Lee, 1986).

**Question 1-64:**
A counselor has become convinced of the usefulness of the Myers-Briggs Type Indicator and has begun to use the results in marriage counseling. The counselor's belief is a best marriage match is opposite stereotypes such as Es and Is or even TPs and FJs. To avoid errors and to retrieve a professional looking profile, the counselor sends the results off for scoring. The ethical issue for a counselor in this scenario is:

a. counselor should avoid counseling couples based on his/her belief system.
b. counselor needs to verify the scoring of the computed assisted source as mistakes are made.
c. counselor should not use instrument results as the basis for marriage counseling.
d. validity and reliability of the Myers-Briggs Type Indicator are not acceptable for marriage counseling.

Answer: a. counselor should avoid counseling couples based on his/her belief system. Personal values (A.4.b.). Counselor personal beliefs or values that are not researched in the literature and imposed on the client is a possible bias.

**Question 1-65:**
You are a therapist in a private practice in a small community. A local reporter calls to request you write an article in a three-part series on test scores and how parents should guide their children. The first is to comment on standardized testing, the meaning of scores, and how parents can decide whether to homebound teach or continue to mainstream their children. The second is to comment upon SAT/ACT scores for those who are college-bound and what to do if scores are not sufficiently high to be accepted into the local university. The third article in the series is to comment upon how effective these types of scores are for the purpose they were intended. The therapist who has been trained in psychometrics should:

a. decline the request even though this information is helpful to.
b. explain to the reporter that you have been trained in testing, however you would be willing to write only the content part in which you feel competent.
c. recognize this as an opportunity to make counseling services known as a competent and knowledgeable service. Accept the assignment with the stipulation you need sufficient time to acquaint yourself to the most recent data in these three areas.
d. consult your lawyer to determine if there could be any liability in writing the articles.

Answer: a. decline the request as much as this information can be helpful to the community psychometric training is limited when it comes to providing guiding information, or what is needed for the college bound. In accepting the request to write the article are risks for misinterpretations or omissions because often the writer does not have the last review before printing. Frequently space is the issue in preparing print for publication.

# Multiple Relationships (Dual Relationships)

## ACA Code of Ethics Section A., D., and F.

The ACA Code of Ethics lists several different types of relationships that possibly could be described as multiple or dual relationships such as virtual (A.5.e.), sexual or romantic (A.5.a.), previous relationships (A.6.a.), nonprofessional (A.6.e.), individual, group or societal (A.7.), multiple clients (A.8.), former students (F.10.c.), nonacademic (F.10.d.), colleagues, employers, and employees (D.1.), supervisory (F. 3.a.), and other professionals.

Cottone and Tarvydas (2003) and Corey, Corey, and Callanan (2003) draw attention to the fact that several ethical codes have replaced or modified the term dual role with multiple relationships. Multiple relationships imply two or more therapist-client relationships. These authors go on to indicate that a therapist in a private practice is involved with his/her clients as a record keeper, helper, and service provider. As a result the therapist may have multiple roles with his/her client, not all of which are considered bad or unethical (Herlihy & Corey, 1997). Historically, dual role has implied a misuse of therapist power or authority. Some authors contend that dual role relationships will impair judgment, increase chances for conflicts of interest, client exploitation, and a blurring of boundaries (Pope &

Vasquez, 1998). For the time being the term dual role will be used for this test preparation but do recognize that multiple relationships may be the preferred term. O'Conner-Slimp and Burian (1994) cite the American Psychological Association definition of a dual relationship existing when a professional develops a "social or other nonprofessional contact with persons such as patients, clients, students, supervisees, or research participants" (p. 39). It is their contention that a dual role exists when a professional is "engaging in one or more types of relationships in addition to a professional relationship with an individual at a given time" (as cited in Bowman, et al., 1995, p. 232). The general principle regarding dual relationships is that once a professional counselor/ client relationship has been established, that relationship is paramount. Entering into a secondary level of relationship may compromise the therapy by adversely affecting professional judgment and/or client trust and safety. Pope (as cited in Corey, Corey, & Callanan, 1988) and Blanshan (as cited in Bowman, et al., 1995) state that in addition to impairing professional judgment, dual relationships pose the danger of exploiting the client, due to the more powerful position of the counselor. Furthermore, the client is in a vulnerable position due to the strong transference relationship that develops.

There are many types of dual relationships. They include counseling close friends, relatives, students, or employees; exchanging therapy for goods or services; accepting gifts or favors; and entering into social or sexual relationships with clients, students, or supervisees (Keith-Spiegel & Koocher, 1985). Pipes and Davenport (1990) list four areas in which client/counselor and instructor/student are susceptible to violating relationship rights of the other and become boundary issues. Other types of role conflicts occur when the counselor is "caught between loyalties" to two parties such as a conflict between agencies' needs and client needs, legal requirements and client welfare. It should be foremost in the mind of the counselor that dual role relationships are evident not only during a relationship but after termination of a client. Lamb, Strand, Woodburn, Buchko, Lewis, and Kang (1994) surveyed 1,000 psychologists (348 returned) and found that 29% of practicing therapists engaged in business relationships with their clients. Borys and Pope (1989) in a study of 4,800 (49% return rate) psychologists, psychiatrists and social workers that a majority of responders to the survey found five dual roles to never be ethical; sexual activity with a client before termination, selling a product to a client, sexual activity with a client after termination of therapy, inviting clients to a personal party or social event, and providing therapy to an employee.

## Boundary Issues (Section A.6.)

Corey, Corey and Callanan, (2003) define boundary violations in the context of multiple relationships. Boundary violations are frequently found in a business and social relationship and are non-therapeutic. When a therapist places his/her business or social needs above that of the client's welfare, such as sexual contact, a boundary issue has taken place. Although sexual contact is an obvious violation some violations may not be that evident, such as extending session time when therapist gratification is taking place, talking to clients between sessions, and even reducing fees in order to see a certain client. Boundary issues or violations are often on a gradient of involvement and need to be processed in supervision. The following section addresses specifically the dual relationship that involves sexual contact between client and counselor. This type of dual role is, unfortunately, overly represented in ethics complaints and under-represented in graduate training programs. Lamb, et al.

(1994) determined that 6.5% of practicing therapists engaged in sexual relationships with former clients within three months of termination. From available research reports these authors found an incidence in the range of 3.98% - 11%. The 2014 Code of Ethics specifies five years and includes a supervisory review before a relationship with a former client is possibly renewed (ACA, 2014 ).

Despite the fact the principle prohibiting sexual contact between therapist and client is the clearest and most concrete of the ethical codes, it remains the most commonly violated (Vasquez, 1988). Keith-Spiegel and Koocher (1985) state that sexualizing the client/therapist relationship is "dangerous, unprofessional, and grossly unethical" and results in harm to both the client and the therapist.

The principle supporting do no harm to clients is nonmaleficence as well as A.4.a. (avoiding harm). Harm to clients ranges from mistrust of opposite-sex relationships to hospitalization and even suicide. Even minor sexual advances adversely affect clients and can lead to depression and exacerbated emotional problems (Vasquez, 1988). In general, sexual intimacy between a client and counselor is an abuse of the power that counselors have by virtue of their professional role. Such relationships also foster dependency in the client and ruin the objectivity of the therapist (Corey, et al., 1988).

In terms of therapist harm, sexual contact is grounds for a malpractice suit, and courts have not considered client consent to be a viable defense (Hotelling, 1988). Legally and ethically, the responsibility for setting, communicating, and maintaining appropriate sexual and intimacy boundaries rests squarely on the licensed professional (Coleman & Schaefer, 1986; Schoener, 1984). Failure to do so has resulted in professional loss of career and primary relationship. Although erotic touching is unethical, some forms of nonerotic touching may contribute to a positive therapeutic experience. The ACA Code of Ethics (2014) prohibits sexual or romantic relationships with current clients (A.5.a.) and with former clients (A5.b.).

Gelb (as cited in Goodman & Teicher, 1988) found that clients experienced nonerotic touch as positive with fewer than five of the following conditions:

1. The client and therapist discussed the "touch event," the boundaries of the relationship, and the actual or potential sexual feelings.
2. The client felt in control of initiating and sustaining contact.
3. Contact was not experienced as a demand or need satisfying for the therapist.
4. The overall expectations of the treatment were congruent with the client's experience of the treatment.
5. The emotional and physical intimacy were congruent.

Holroyd and Brodsky (1977) and Holroyd and Bouhoutsos (1985) observe that it is sometimes difficult to determine where nonerotic touching, hugging, etc., ends and erotic touching begins. Therefore, some clinicians are categorically opposed to any form of touching between client and counselor because it can promote dependency, interfere with transference, be misinterpreted by the client, or become sexualized. In any case, counselors need to honestly assess their own motivations concerning physical contact and cultivate their sensitivity as to how touching might be either therapeutic or counterproductive for a particular client in a particular context of the therapeutic relationship (Corey,

et al., 1988). Schoener (1995) made reference to detrimental relationships by the predictive traits of certain professionals. Individuals who exhibit these traits have:

1. psychotic and severe borderline disorders
2. manic disorders
3. impulse control disorders
4. chronic neurosis and isolation
5. situational offenders
6. deficits due to naiveté.

Borys and Pope (1989) in researching dual relationships between therapist and client in a national study found that burnout and professional isolation are major risk factors in many boundary violations.

One last area of boundary issues is boundary crossing and boundary violation. Although there is not full agreement as to the dual issues involved in both, it is commonly agreed that if one allows for boundary crossing that the counselor must remain alert to motivation, client issues, and the counselor's issues.

Boundary crossing is defined as shifting to meet the needs of the client. An example of a boundary crossing might be when a counselor attends the wedding of a client or receives a gift from a client. Not all counselors agree as to advisability of taking such actions or even what the intent is of the client. Sexual contact or touching is clear violation.

**Question 1-66:**
A male counselor has been in a counselor-client relationship for the past nine months with a female client. Over the duration of therapy the counselor has treated this client for restricted emotional development. The client indicates that this was a difficulty in her past two marriages. Her husband(s) accused her of not having any feelings and not being able to get close to anybody. She has worked diligently on this problem and is making progress in revealing and understanding her identity. The client has begun to sense her growth and has shared her appreciation with the counselor. As a result of this positive feedback and also being attracted to the client, the counselor recognizes that transference and countertransference have developed. The counselor interpreted the transference to the client. She acknowledges these dynamics but continues to express her good feelings toward the counselor. The counselor struggles with sharing his true feelings with her. What should the counselor do?

a. reveal his own feelings and suggest terminating the counseling relationship so that they can have a personal relationship
b. transfer her to another colleague, giving her the true reasons for the referral
c. deny any feelings and discuss the client's attraction as a natural part of transference that occurs in therapy

d. acknowledge the professional boundaries of the counseling relationship and seek supervision to deal with the transference/ countertransference.

Answer: b. transfer her to another colleague, giving her the true reasons for the referral. Perhaps none of the alternatives provide an ideal solution. Both dual role relationships and sexual intimacy issues could develop. This may have been an ethical issue to begin with but could end up as a legal issue. In some cases where the counselor terminated the relationship and reinstituted a personal relationship, legal cases evolved. The safest procedure would be to transfer this client to a colleague or outside resource and provide the true reason for referral. Letter d. may be a preferred action. At this time the therapist has not been able to resolve this issue in an ethical and timely manner. Therefore, refer and through supervision, the counselor is to learn about his own behaviors and how to therapeutically explain the similar dynamics. If the counselor boundaries are, in fact, entangled in the client and therapy, referral is recommended. The least harmful and in the best interest of the client would be advised. Review boundary violations (A.5.) through documenting boundary violations (A.6.c.) for full understanding of romantic or therapeutic issues related to possible relationship and boundary violations.

**Question 1-67:**

During practicum supervision a supervisor makes statements that could be interpreted by the counselor-intern as counseling them in their marital relationship. This is an example of:

a. a dual relationship.
b. client dependency.
c. malpractice.
d. countertransference.

Answer: a. a dual relationship. The supervisor has crossed the line of supervising and is involved in psychotherapy or boundary violation. Section F.3.a. indicates the supervisor consider risks and benefits of extending current supervisory relationships in any form beyond the conventional.

**Question 1-68:**

A counselor in a local mental health clinic enjoys playing competitive tennis. The counselor has entered a local tournament and upon arriving for the match reviews the list of players. It is discovered one of the participants is a client of the counselor. The client is not matched to play against the counselor but through the elimination process could conceivably become a match. What is the response of the counselor?

a. this is outside the realm of the counselor's responsibility and situations such as this are bound to occur. Continue on with the match.
b. if one or the other is not eliminated, and in the event this does become a match, the counselor should disqualify self.
c. the counselor should disqualify himself before the tournament begins.
d. continue as planned and if, by chance, the counselor and client do become a match, process this in your next session.

Answer: c. the counselor should disqualify himself before the tournament begins. Prohibited noncounseling roles and relationships (A.5.) and virtual relationships (A.5.e.). If the counselor would consider playing in the tournament, extending supervisory relationship (F.3.a.) and extending counseling boundaries (A.6.b.) emphasize the counselor is to consider the risk and benefits, again a possible boundary crossing. As unfair as it may seem, the possibility of a match elicits behaviors that may never get processed in session. Topics such as competition, power, and assertiveness may be examples of client issues. The principle is to do no harm.

**Question 1-69:**
The second portion of the above problem is encountered when the counselor realizes this is a matched doubles tournament. The entry deadline has passed, thus eliminating the possibility of a replacement for the partner. What should the therapist do?

a. inform the partner that the counselor will have to disqualify himself without an explanation.
b. inform the partner there is an ethical dilemma in the counselor participating, not with the partner, but with someone else and the counselor will have to disqualify himself.
c. participate in the tournament and if a set becomes matched with the client, at that time, withdraw.
d. locate the client and process the dilemma and determine how the client feels about the counselor participating.

Answer: a. inform the partner that the counselor will have to disqualify himself without an explanation. Once again this may appear to be unfair to the partner; however, the therapist has a professional relationship contract with the client. The same ACA Code of Ethics standards exist for this situation.

# Unit 1 - Terms

ABNORMALITY:
Any mental, emotional, or behavioral activity that deviates from culturally or scientifically accepted norms (world view) (Edgerton & Campbell, 1994). The causes of abnormality are explained through three perspectives: animistic (evil spirits), physical, and psychogenic.

BEERS, CLIFFORD:
Wrote A Mind That Found Itself, which was his account of his own mental illness as he attempted to submerge himself into the depths of abnormality and emerge learning the process of curing.

BIOMEDICAL:
An illness of the body model. A physical malfunction in the body where the emphasis of the problem is a focus upon the neurotransmitters.

BULIMIA:
Bulimia is an eating disorder in which an individual overeats (binges) and then uses self-induced methods such as laxatives or will vomit to purge him/herself of the food.

BUROS, OSCAR:
Developed the Mental Measurement Yearbook as a source book for test information. This source book provides expert opinions regarding the technical nature (validity, reliability, construction, norms, etc.) as well as the strengths and weaknesses of each instrument.

CATHARSIS:
An expression of repressed or suppressed feelings releases energy that has been tied up in withholding those threatening feelings. Catharsis can be a healthy release of ideas through talking accompanied by an emotional reaction.

CERTIFICATION (limited license):
Certification is a nonstatutory process by which agency or association grants recognition to an individual for having met certain predetermined professional qualifications (Fretz & Mills, 1980).

CONFIDENTIALITY:
Protects client from unauthorized disclosures of any sort by professional without consent of the client. Refers to ethics rather than any legalism and indicates an explicit promise or contract to reveal nothing except under conditions agreed to by source or subject. Is now incorporated in legislation and court rulings. Civil or criminal liability is possible.

COUNTERTRANSFERENCE:
When the therapist's own needs become entangled in the therapeutic relationship obstructing or destroying the therapist's objectivity. Countertransference can come about due to:

1. a need for constant reinforcement
2. seeing yourself in your client
3. the development of sexual or romantic feelings
4. compulsive advice giving
5. the desire to develop a relationship with a client

COVERED ENTITY:
Covered entities was developed by Civil Rights at the U.S. Department of Health and Human Services in 2003. The Health Information Technology for Economic and Clinical Health (HITECH) promotes the adoption and meaningfulness of health information. According to HITECH a covered entity refers to three groups including health plans, health care clearing houses, and health care providers that transmit health information electronically. Examples of health care providers are doctors, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies.

DAVIS, JESSE:
Davis stimulated the guidance movement from within the schools. He brought church and the golden rule to guidance. Preaching the social gospel philosophy he felt students should be lectured to regarding the values and morals of hard work and honesty. A self-analysis, occupational study, and an examination of self in relation to an occupation were the ministry for each person.

DEPENDENCY (client):
Therapists can encourage client dependence in several ways such as failing to challenge a paying client though no progress is being made, keeping the therapeutic process mysterious (powerless), keeping clients immature and dependent, and readily giving clients advice. This could also be done in a very subtle way out of the therapist's need to feel important.

DUTY TO WARN:
Duty to warn is an obligation to inform another of a potential harm. Three conditions are noted for duty to warn. These are:

1. a foreseeable victim
2. a reasonable prediction of conduct that constitutes a threat
3. a special relationship (Tarasoff case)

The counselor is aware of a duty toward a third party, a protective action, and a decision as to which action best meets the demand. Foreseeable harm is when the counselor has knowledge or practice experience in which he/she can predict a harmful action on the part of the client.

ECLECTIC:
Eclecticism is a flexible application of a variety of theories and techniques to fit each unique client and client relationship. Robinson (1965) defines the eclectic counselor as one who selects concepts and techniques from different counseling theories using research findings and at the same time integrates personal ideas and adaptations into a consistent whole.

ENDOGENOUS:
Originating within the organism.

EXCEPTION TO PRIVILEGE:
When a client is potentially violent and dangerous to others the rule of silence can be broken. Since the psychotherapist-client privilege is a legal concept, there are certain circumstances under which information must be provided by the therapist. The following nine exceptions to privilege are noted by Corey, et al. (1988, p. 178-179) and by Herlihy and Corey (1996).

1. Therapist is acting in a court-appointed capacity.
2. Therapist makes an assessment of a foreseeable risk of suicide.
3. Client lawsuit against the therapist.
4. Client introduces mental condition as a claim for defense.
5. Client is under the age of 16 and the therapist believes that the child is the victim of a crime.
6. Hospitalization for a mental or psychological disorder.
7. Criminal action is involved.
8. Information is an issue in a court action.
9. Clients share their intention to commit a crime or they can be accurately assessed as "dangerous to society" or dangerous to themselves.

EXPERT WITNESS:
A person who is "professionally acquainted with, skilled, or trained in some science, art, trade and thereby has knowledge or experience in matters not generally familiar to the public" (Schwitzgebel & Schwitzgebel, 1980, p. 238). The testimony provided by an expert witness can be his/her direct work and a judge will allow indirect observations.

GALTON, FRANCIS:
Set up anthropometric laboratory and developed tools to measure differences in people through the sense modalities. He emphasized reaction time and movement in his testing. He was responsible for the beginning of the normal curve.

HYPOCHONDRIASIS:
A somatoform disorder in which the person constantly worries about his/her health as though he/she has a disease without any physical findings to support that fear.

INFORMED CONSENT:
A concept that guarantees the client his/her rights and the opportunity to be informed before any behaviors or decisions take place. Informed consent is central to all aspects of the therapy world and is often stated during the initial client session, however it is ongoing throughout treatment. Informed consent ensures the client of full and active involvement in all decisions regarding treatment (Cullari, 2001). Welfel (1998) indicates that disclosure and free consent are the essential elements of informed consent. She makes a case that informed consent should minimally contain the following six parts:

1. credentials (qualifications and practices of therapist)
2. logistics of counseling such as fees, location, emergencies, etc. (procedures/goals of therapy)
3. insurance reimbursement (procedures)
4. indirect effects of therapy (consequences secondary to the change/side effects)
5. use of untested or experimental techniques (available sources of help beside traditional therapy)
6. grievances (how to handle)

LICENSURE:
Statutory process by which an agency of government (usually a state), grants permission to a person meeting predetermined qualifications to engage in a given occupation and/or particular title and to perform specified functions. Licensure is a protection of title, practice, or both. Licensure is important because it will:

1. increase chances the practitioner will be competent and services will be better
2. upgrade the profession
3. allow the profession to define for itself what it will do and will not do

MALPRACTICE:
When a professional does not practice up to the standard of care harm to a client is likely. Three elements accompany the definition of malpractice and these are:

1. The defendant must have had a duty to the plaintiff.
2. Damages resulted through negligence or improper action.
3. Causal relationship is established between damage/negligence.

MENTAL STATUS EXAMINATION:
A mental status is an evaluation of the patient's current mental functioning. A mental status is usually divided into several parts and most frequently conducted by a psychiatrist. It is composed of behavior (appearance and interview behavior), thinking (judgment, thought process, content, intellectual functioning, memory, orientation, and insight) feeling, data gathering, and symptomology.

MERRILL, GEORGE:
George Merrill designed the first guidance program in a California school. He gave attention to exploratory experiences, counseling placement for jobs, and follow-up of former students.

NEUROSIS:
A term that reflects a generalized state of anxiety. The individual does not adapt to his or her surroundings and experiences psychological discomfort. This term over the years has changed in meaning and is rarely used.

OARS:
An acronym to represent the technique to conduct motivational interviewing. Open-ended questions (O), affirming self-efficacy and support (A), reflections-rephrasing (R), summaries-complex reflections, resolving ambivalence and promoting change (S).

PARSONS, FRANK:
Frank Parsons developed a three-stage model of vocational counseling. He is considered the father of vocational guidance.

PHRENOLOGY:
A theory developed by Franz Gall in which there is a relationship between the various bumps on the skull and the aptitudes or personality traits displayed by a person (traits).

PORTABILITY:
Portability is the process in which counselors may transfer their license without repeating the application procedure. Reciprocity is another term that is used to identify this process of portability. The effort to establish portability calls for common licensing standards. The National Credential Registry was created by AASCB to assist in gaining portability. The American Association of State Counseling Boards (AASCB), ACA, NBCC and CACREP in supporting a unification of the profession are lobbying for license portability.

PRIVILEGED COMMUNICATION:
Legal right which exists by statute and which protects the client from having his/her confidence revealed publicly from the witness stand during legal proceedings. Legal concept of privilege belongs to the client so if he/she waives this right the counselor cannot withhold. (Attorneys, marital partners, physicians, psychiatrist, and priests can exercise the rights of privileged communication)

PUBLIC LAW 94-142:
Education of all handicapped children. Part B. Confidentiality of information and funding to state. Insures an individualized evaluation for each handicapped person. This is called an IPS or Individualized Program of Study and includes some of the following:

1. statement of child's present levels of educational performance
2. annual goals and short-term instructional objectives
3. statement of specific education services provided in which the child can participate in regular programs
4. projected date for initiation and anticipated duration
5. appropriate objective criteria for determining annual basis whether instructional objectives are being met

SPECIFIER (DSM-5™):
Specifiers are used to define a more homogeneous subgrouping of a disorder that share certain features such as major depressive disorder with anxious distress.

SUPER, DONALD:
Donald Super was a vocational theorist who authored the Cyclical Theory composed of stages and tasks. The counselor is a cyclical counselor using a segmental theory. He initiated APGA's effort to develop a code of ethics modeled after APA.

SUPERVISION:
Supervision is a process of mentoring to someone with less skill. The purpose of supervision is to assist in the quality care of the client and in the developmental growth of the counselor. Supervision is intended to:

1. monitor progress
2. inform trainee on training objectives
3. assess performance of trainee

The legal aspects of supervision are:

1. to see that the counselor provides information to clients that is needed to make an informed choice
2. for the counselor to respect the confidentiality of client communication
3. that the counselor bears legal responsibility for the welfare of those clients who are counseled

SYNERGY:
Ruth Benedict's model viewing the interaction of the individual and one's culture. It is described as the degree of common goal attainment that is individual and group (Burke, 1989). Maslow adapted this term to his hierarchy of needs and self-actualization.

TIERED LICENSING:
Tired licensing refers to levels of preparation for the full license to practice. A full license informs the public that all state requirements to practice have been completed, reviewed and accepted. A license less than full may be called provisional and indicates that some rule requirements are yet to be completed such as years of supervised work experience and/or supervision requirements met and approved. The specifics of these rules may be different in terms of hours and years but the categories (work experience, supervision, etc.) are likely to be in all state laws.

THANATOLOGY:
The study of death and dying.

TRANSFERENCE:
Unconscious process whereby clients project onto their therapist past feelings or attitudes toward significant people. Stems from unrecognized or unresolved feelings concerning past relationships. The purpose is to allow clients to express distorted feelings without receiving the response they expect. The very core of the process is regression to a dependent infantile attitude. Rogers says it does not develop in Client-Centered Therapy. It is also rejected in Reality Therapy.

V-CODE:
A v-code is a diagnostic code when the clinical focus and symptoms do not meet the criteria for a DSM-5™ disorder. In the DSM-5™, V and Z codes are listed as stressors. A relational problem is when a pattern of interaction or behaviors between clients (siblings or spouses) does not meet full criteria for a disorder although there is significant impairment in functioning (Value Options, 2006). Brief, problem solving therapy is the treatment of choice.

WELLNESS:
A way of life oriented toward optimal health and well-being with an integrated mind-body and spirit.

WOUNDED HEALER:
A concept applied to a person (helper) who has experienced an emotional distress and successfully resolved it. This successful process allows the counselor in a more authentic manner to experience the client in his/her distress. Our own personal experiences can be helpful to the client.

WUNDT, WILHELM:
The father of psychology. He established the first psychology laboratory in Leipzig, Germany. He believed that people have basic components of the mind that respond to sensation with feelings of calmness/excitement, pleasure/ displeasure, and relaxation/strain.

20/20 INITIATIVE:
The 20/20 initiative was a vision of principles developed by 31 major organizations that identified issues regarding the future of counseling. These issues are; a) strengthening the identity, b) presenting ourselves as one profession, c) improving public perception/recognition and advocating for professional issues, d) creating licensure portability, e) expanding and promoting the research base of professional counseling, f) focusing on students and prospective students, and g) promoting client welfare and advocacy (Kaplan & Gladding, 2011, Loche, 2011).

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# UNIT 2 - Social and Cultural Diversity

## Introduction

The social and cultural diversity unit stresses issues related to cultural aspects of individual and family functioning within society. The unit begins with a brief summary of prominent theories related to social psychology. Also, specific areas of concern for both clients and counselors are a major focus in this preparation. Multicultural and family counseling issues as well as subgroups such as men, women, and aging clients are discussed. Finally, societal concerns such as grief, stress, crisis management, and substance issues are examined in the context of cultural differences and similarities that exist in the helping relationship. The social and cultural diversity unit has 12 content questions of which 11 count for your total score.

The 2014 Code of Ethics is an expanded and integrated set of guidelines that includes an additional section entitled distance counseling, technology, and social media. The code presents an emphasis on personal values, confidentiality, dual relationships, multicultural and diversity, recordkeeping, diagnosis, and end-of-life care and interventions (ACA, 2014). Sections for review for this unit are sensitivity (A.2.c.), values (A.4.b.), advocacy (A.7.a.), confidentiality (A.7.b.), diversity (B.1.a.), Introduction (C.), competency boundaries (C.2.a.), sensitivity (E.5.b.), social prejudice (E.5.c.), multicultural issues-assessment (E.8.), multicultural diversity (F.11.), and multicultural and disability considerations (H.5.d.).

# CACREP Objectives

CACREP objectives for social and cultural diversity are not presented in full. Those preparing for the NCE may want to visit the Web address for the full standard objectives, www.cacrep.org.

These objectives are minimal statements for social and cultural diversity. Full descriptions are to be found online for the 2009 CACREP standards.

A. multicultural and pluralistic trends, nationally and internationally
B. attitudes, beliefs, understanding, and acculturation, social justice
C. individual, couple, family, group strategies for diverse populations
D. theories of multicultural counseling, identity development and social justice
E. social justice, advocacy and conflict resolution, and other culturally supported behaviors that promote optional wellness and growth of the mind, body and spirit
F. counselor roles in eliminating biases, prejudices, processes of intentional and unintentional oppression and discrimination

**Question 2-1: (Objective A.)**
The Conformity status has long been a concern when it comes to fairness in the American school systems as well as in society, the economy, and in the work place. Conformity status can be reinforced by:

a. moving up in occupational status made available to the majority culture but not the minority.
b. pay schedule for people of color that is different than for white.
c. recognizing the majority culture's achievement contributions but not the minority.
d. not providing contradictory evidence.

Answer: d. not providing contradictory evidence. In a discussion options a, b., and c. could be explained in ways to be representative of Conformity Status. Answer d. is one specific way to demonstrate this type of status.

**Question 2-2: (Objective B.)**
As technology advances and the Internet is recognized as an acceptable way to conduct counseling, a viable source of help may not be available to the poor and minority. This is true because:

a. the poor and minority do not ascribe to veto boundaries and ethical guidelines.
b. technology does not address language in equal measures.
c. the problems of the poor do not lend themselves to the type of help that technology or Internet counseling offers.
d. the poor and minority do not have access to the Internet or e-mail communication.

Answer: d. the poor and minority do not have access to the Internet or e-mail communication. According to Hughes (cited in Remley & Herlihy, 2005) approximately 12% of the population (income under $15,000) had access to these resources.

**Question 2-3: (Objective C.)**

All of the following are considered culturally sensitive models of treatment for minorities except:

a. Cultural accommodation
b. Racism acknowledgment
c. Cognitive match
d. Cultural genogram

Answer: d. Cultural genogram. Cultural genogram is similar to the Adlerian genogram, a method to map family characteristics (marriage, divorce, death, children, etc.). Cultural accommodation (Leong & Lee , 2006), cognitive-match (Sue & Zane, 1987), and racism acknowledgement are considered sensitive models (Fuertes, Mueller, Walker, & Ladany, 2002).

**Question 2-4: (Objective D.)**

It is recognized that when counseling for a family of diversity, it is common to experience which bias?

a. age
b. gender
c. education
d. status

Answer: b. gender

**Question 2-5: (Objective D.)**

Counselors can advocate for victims of rape by:

a. developing a training program for staff and volunteers in crisis intervention.
b. helping to establish a national victim's rights week.
c. lobbying. for the passage of a victim's crime act against women.
d. all of the above.

Answer: d. all of the above

**Question 2-6: (Objective E.)**

The purpose in training counselors in the worldview is:

a. that today many clients are from a variety of countries throughout the world.
b. the advances in technology and Internet access demand counselors to have this knowledge.
c. to better assist the counselor in knowing which clients to accept.
d. that it represents the person's values, beliefs, opinions, and assumptions.

Answer: d. that it represents the person's values, beliefs, opinions, and assumptions. Pederson, et al. (2002) definition of the worldview.

**Question 2-7: (Objective E.)**
A conflicting problem for counselors is to offer services to client that may not have the funds to pay for counseling. In these circumstances the counselor or agency might consider:

a. securing training interns from a university to counsel those that are unable to pay.
b. to stay in business, they must have paying customers and in order to do so must refer this client to the county mental health program.
c. offering pro-bono services.
d. conducting an assessment session and referring financially strapped client to the client's religious leader(s) for assistance.

Answer: c. offering pro-bono services. The ACA Ethical Code indicates that professionals have an obligation to give back to the profession. This can be accomplished through some type of ratio with paying clients. Section A.10.b.

**Question 2-8: (Objective F.)**
When a minority client experiences repeated slights and has resulting inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism is:

a. invisible syndrome
b. bias
c. cognitive-dissonance
d. attribution

Answer: a. invisible syndrome. Franklin (1999) is credited with defining the invisible syndrome and how these slights frequently turn into racially adaptive behaviors for African American men as they attempt to manage racism (p.24).

# Terms

This list of terms is provided as an overview of the content of this chapter. Many of these terms are defined within and at the conclusion of the chapter.

Ableism
Acculturate
Adultism
Agoraphobia
Alloplastic
Alzheimer's Disease
Androgyny
Autoplastic
Counterculture
Cross Culture

Culture
DE individuation
Dying Trajectory
EMIC
Ethnic Group
ETIC
Fetal Alcohol Syndrome
Gateway Drugs
Gender Role Conflict
Gender Role Conflict
Homophobia
Invisibility syndrome
Life Expectancy
Life Span
Micro invalidation
Minority
Persistent Depressive Disorder
Race
Rip Van Winkle Effect
Role Conflict
Role Strain
Set-point Theory
Sexism
Social Class
Socialization
Stereotyping
Strength-based Model
Subculture
Type A Personality

# Preview Questions

**Question 2-9:**
The term that applies to the taking of two drugs in combination and has a magnified effect is:

a. synergistic effect.
b. dysthymic disorder.
c. polydrug interaction.
d. tolerance.

Answers: a. synergistic effect. Three forms of drug interactions: 1. Additive effect - effects of two drugs taken concurrently, 2. Antagonistic - when one drug blocks the effects of another drug, and 3. Synergism (potentiation) - when the effect of a drug is enhanced by the presence of another drug (Witters, Venturelli, & Hanson, 1993)

**Question 2-10:**
A client in treatment at a substance abuse center who experienced polydrug use and difficulties in anger management broke a house rule. He/she acted out by hitting another client. When asked for an explanation for the acting out he/she blamed the other client for the consequences of the acting out. This is known as:

a. alloplastic (a form of polarism).
b. scapegoating.
c. Kitty Genovese syndrome.

d. diffusion.

Answers: a. alloplastic (a form of polarism). Alloplastic is an adaptation in which the client attempts to change the circumstances (environment) when confronted. Alloplastic was a term devised by Sigmund Freud. Autoplastic the client will attempt to change himself.

**Question 2-11:**

A nonverbal communication that examines gestures, movements of the body, limbs, hands, feet, and length of gaze (time) is:

a. paralanguage.

b. proxemics.

c. motor symptoms.

d. kinetics.

Answers: d. kinetics. Kinetics is a study of motion.

**Question 2-12:**

The geriatric client often experiences the problem of forgetting because traces of memory decay over time. This is known as:

a. Alzheimer's disease.

b. interference theory.

c. decay theory.

d. fugue.

Answers: c. decay theory. Decay theory is also known as Trace Decay theory and indicates that the memories leave a trace in the brain. Supposedly, forgetting results due to automatic decay or fading of the memory. Short term memory is held for 15 to 30 seconds unless rehearsed.

**Question 2-13:**

A mixture of male and female characteristics is known as:

a. androgyny.

b. dna crossing.

c. synesthesia.

d. type C personality.

Answers: a. androgyny. A term associated with Sandra Bem and her Bem Sex-Role Inventory. Bem's inventory identified four gender role orientations: masculine, feminine, androgynous, and undifferentiated.

**Question 2-14:**

The information we possess regarding an event, the assumed causes we perceive, and the consequences we anticipate are three parts of:

a. operant conditioning.

b. honi phenomenon.

c. cognitive dissonance.

d. attribution theory.

Answers: d. attribution theory. Attribution theory, a theory espoused by Heider, indicates that when we try to explain the behavior of others we look for internal attributes. When we try to explain our own behaviors we make external attributes that tend to be situational or environmental.

**Question 2-15:**

The organization which has offered a way station for the terminally ill in order to die with dignity and comfort is:

a. iconic.

b. incubus.

c. hospice.

d. thanatology.

Answers: c. hospice. Hospice care is palliative care for the terminally ill. It is believed that hospice originated as early as 1065 but later historians note that the Religious Sisters of Charity opened one of the first hospice centers in Dublin, Ireland in 1879. Cicely Saunders is credited for developing a philosophy of caring for the patient rather than the disease.

**Question 2-16:**

The belief has been expressed that violent movies, television, books, and football games, like dreams, can allow people to release aggression. This discharge is known as:

a. displacement.

b. catharsis.

c. risky shift phenomenon.

d. deindividuation.

Answers: b. catharsis.

# OBJECTIVE 2A: Trends

Multicultural trends are to become aware of the role of the counselor in respecting the dignity and human rights of individuals. National and international persons representing different worldviews and value systems require the sensitivity extended to others that one would want for oneself. New paradigms for multicultural counseling are at the forefront along with counselor's charge to conduct a personal review of implicit and explicit values, beliefs, and conduct when interacting with persons of different backgrounds. The counselor is to commit to interpersonal and intrapersonal congruence in philosophy and actions when counseling diverse clients.

Advocacy regarding clients, client services, and modeling change at a political level are requiring action by the profession, counselors and clients. Gaining necessary skills and acting on ethical behaviors are avenues for new directions.

# OBJECTIVE 2B: Self and Culturally Diverse Clients

## Theories of Social Psychology

Social psychology is a combination of sociology and psychology and examines how individuals affect one another's behavior (Lamberth, 1980). Social psychology is the study of the manner in which personality, attitudes, motivations, and behavior of an individual influence and are influenced by social groups (Merriam-Webster, 2014). It also explores the relationships between social institutions, social groups, and individual behavior. Following are some of the prominent theories encountered in the field. Social psychology is the study of how people's thoughts, feelings, and behaviors are influenced by the actual, imagined, or implied presence of them. (Allport, 1985).

Hedonism: Behavior is determined by the motivation to pursue pleasure and avoid pain. In other words, the individual acts to maximize reward and minimize punishment. In this monistic theory, there is no such thing as altruistic behavior. All behavior is essentially self-centered and pleasure seeking (Edwards, 1979).

1. Power: A form of hedonism in which the pursuit of power brings a person pleasure and therefore is the primary motivation for action. In this view, the act of manipulation is both the means and the end in itself (Kipnis, 1976).

Sociological Theories

1. Symbolic-Interaction Theory: Derived from cognitive theory, this view states that people mentally explore the possible reactions of others prior to making a decision to act. This is done through a role-taking process. Then, the person evaluates the degree of agreement between the response anticipated and the actual response (Albrecht, et al., 1980).
2. Role Theory: Developed out of symbolic-interaction theory, but focuses on actual interactions between people. Behavior is determined by role obligations. Behavior is rewarded and punished according to evaluations of role performance. Role conflict and role strain are other concepts examined in this theory (Albrecht, et al., 1980).

Social Exchange Theory (Homans): Derived from social learning theory, social exchange theory contends that interactions between people must be mutually reinforcing. Individuals seek to imitate "profitable" exchanges with others and seek to eliminate "nonprofitable" exchanges with others (Albrecht, et al., 1980). Behaviors that have been profitable in the past will increase in frequency; those that were nonprofitable will decrease. Homans (as cited in Albrecht, et al., 1980) called this "distributive justice." This principle contends that if the costs of a behavior are high, the rewards should also be high. Adams (1965) called this "equity theory," proposing that a person seeks to maintain a balance between what he or she gives and receives and what others give and receive. If an exchange is imbalanced, pressure will build until equity is restored.

Cognitive-consistency Theories: Individuals have a need to establish and maintain consistency in their perceptions, beliefs, and attitudes toward themselves, others, and the environment (Albrecht, et al., 1980). An individual will behave in ways that seek to eliminate or reduce internal inconsistency.

1. Balancing Theory: Heider proposed balance theory, which postulated that people try to maintain cognitive balance in interpersonal relations. Two people will be more attracted to each other the more similar their evaluations of objects in their common environment. A state of cognitive balance results when attitudes, values, interests, and beliefs are similar. If a balanced state does not exist, then the individual will experience tension until the system is balanced again. Balance may occur by deciding to change one's attitude toward the other person or toward the object (Heider, 1967; Hoshino-Brown, 2012).
2. Dissonance Theory: Festinger (1957) states that two cognitions that are in disagreement produce tension within the individual until that person changes one of those cognitions. The amount of tension experienced is a function of the degree of the dissonance. Dissonance is an uncomfortable state which an individual attempts to alleviate or change by bringing cognitions closer together. Changing a behavior, changing the environment, or adding new cognitive information that will "outweigh" one of the dissonant cognitions can reduce dissonance. The individual will try to alter the cognitions to be more consistent (Dunn & Burclaw, 2012). Dissonance may be similar to Rogers's term for incongruence, an experience that is contradictory in perceptions about himself or his environment. This discomfort may be altered by a change in the physical situation, personal change, denial or distorting the sensory or visceral experiences (Mayer & Cody, 1968).
3. Congruity Theory: Osgood and Tannenbaum (Hoshino-Brown, 2012) describe their theory of congruity as a condition where an individual holds two attitudes that are opposite, he or she will work to change both attitudes in an effort to achieve congruence between them, which identified the principle of congruency.
4. Newcomb's A-B-X Model of Interpersonal Attraction: Based on Heider's theory of cognitive balance, this theory of attraction maintains that perceived similarities of values are related to initial attraction between people. Newcomb (1961) states that there is a tendency toward symmetry in interpersonal relationships. When asymmetry exists, such as a disagreement in attitudes between two individuals, communication will be directed toward restoring symmetry. In other words, the two individuals will work to reduce attitudinal differences to the extent that there is a high level of attraction between them.
5. Attribution Theory: Heider (1967) defines attribution as a process when an individual tries to understand and predict behavior of another. An individual links another person's behavior to basic attributes belonging to that person or to the environment. That is, an individual will attribute a person's behavior to internal personality characteristics or to external, environmental conditions in an effort to understand, explain, or predict that person's future behavior. Attribution theory is a collection of ideas about when and how people form casual inferences, that is, combine and use information to attain casual judgments (Fiske & Taylor, 1994). Research indicates that the attribution process is different when evaluating one's own behavior. That is, an individual is more likely to attribute situational variables to his or her own

behavior and dispositional variables to another's behavior. Other factors that influence self-attributions are the success or failure of the behavior, the self-concept of the person making the attribution, feelings toward the observed other person, and expectations of performing the observed behavior in the future

6. Cognitive Consistency: Cognitive consistency is when attempts are made to create consistency between attitudes and actions and efforts to align actions with attitudes or choices with preferences.

Theories of Collective Behavior

1. Density-intensity Theory: Freedman (1975) suggests that crowding by itself has neither good nor bad effects on people, but serves to intensify the individual's typical reaction to the situation. If the person would ordinarily find the circumstances pleasant, would enjoy having people around, and thinks of others as friends, he or she would have a more positive reaction under conditions of high density. If the person ordinarily dislikes other people, finds it unpleasant to have them around, and feels aggressiveness toward them, he or she will have a more negative reaction under the conditions of high density. If for some reason he or she would normally be indifferent to the presence of other people, increasing density will have little effect. Crowding intensifies the normal reaction, making a bad experience worse.
2. Emergent Norm Theory: Turner and Killian state a social norm emerges that is specific to a situation. The crowd gets caught up in the emotion of the situation and sanctions "deviant" behaviors consistent with the norm. In the process, the "deviant" behavior actually becomes normative and to behave otherwise is seen by the group as deviant (as cited in Albrecht, et al., 1980; Forsyth, 1990). This theory can be used to explain deviant acts such as lynching, looting, etc.
3. Smelsner's Value-Added Theory: The Value-Added Theory defines collective behavior as a six-stage process. Each stage influences or adds its value to the final outcome. If these six stages do not occur, the collective behavior terminates (Albrecht, et al., 1980).
    a. Structural conduciveness: conditions are right for the particular behavior
    b. Structural strain: stress and strain within the system
    c. Growth and spread of generalized belief: ideas on what action to be taken spread
    d. Precipitating factor: an incident sets off the collective action
    e. Mobilization of participants: through leadership and communication
    f. Lack of social control: if enough social control is present, the collective episode will be diverted

Social Influence Obedience: According to Milgram (1969) social influence is the psychological mechanism that links individual action to the political purpose. The person entering an authority system no longer views himself or herself as acting out his or her own purposes, but instead sees actions as accomplishing the purposes of the authority. Once an individual conceives of his or her behavior in this way, profound changes take place internally. The most far-reaching consequence of submitting to authority in this way is the loss of a sense of responsibility.

Theories of Aggression

1. Instinct Theories: Middlebrook (1980) defines aggression in terms of primary drives as described by Sigmund Freud and Konrad Lorenz.
    a. Freud: Aggression is a primary drive representative of the death instinct. In every person there exists the drive to create and the drive to destroy.
    b. Lorenz: Aggression is adaptive in survival of the species. It underlies vital functions such as protecting territory from invasion, defending young, etc.
2. Psychological Theory: Electrical stimulation of different parts of the brain inhibits and generates aggression. That is, increased levels of physiological arousal can lead to aggressive responses. Other studies link brain damage and hormonal levels to aggression (Albrecht, et al., 1980).
3. Social Learning Theory: Aggression is learned through reinforcement, punishment, modeling, and imitation. Research indicates that observation of aggression (including violence on television) contributes to aggressive behavior.
4. Frustration-Aggression Theory: Dollard, Miller, Doob, Mowrer, and Sears (1939) state that aggression is the outgrowth of frustrating experiences. The amount of aggression elicited is influenced by many factors. For example:
    a. A personal attack will generally result in more aggressiveness than environmental blocking.
    b. A justifiable "reason" for the frustration will reduce the aggressive response.
    c. Expecting to be and experience being unpleasant lessens aggressive responding.
    d. People take cues from the environment when experiencing frustration. The presence of guns or watching others behave aggressively will likely elicit aggression.
    e. Expected rewards and punishment ill determine how aggression is expressed. If punishment is expected, aggression may be expressed indirectly or displaced.

**Question 2-17:**

The classical studies conducted to determine how obedience was related to authority and paid subjects to shock other subjects were:

a. Milgram Studies.
b. Bandura's Division.
c. Festinger's Conflicts.
d. Kelly's Constructs.

Answer: a. Milgram Studies. These were the studies in which inflicting pain on peers when told to do so with minimal financial payment laid the groundwork for additional studies on authority and conformity.

## Social Economic Status (SES)

Social economic status refers to social standing based on income, occupation, and education.

A brief overview of social class structure will be presented to inform the counselor to differing work and value structures, economics, status, and issues that may be different as a result of membership at each level (Levi-Straus, 1966). Current reflections regarding the number of classes differs; however, most divisions list five (http://udel.edu/~cmarks/What%20is%20social%20class.htm).

1. Upper Class: This group is considered the leaders, heads of multinational businesses, foundations and universities, and thought to be the elite.
2. Upper Middle Class: Group composed of scientific and technical members. This group is considered composed of the majority of membership.
3. Lower Middle Class: Blue collar, clerical-administrative, record keeper
4. Working Class: Craft, restaurants, nursing homes, laborers
5. Poor Class: Working poor

Gilbert (2002) divided social class into six categories and Thompson and Hickey (2005) into five categories. Gilbert's categories are:

1. Upper Class: rich (1%),
2. Upper Middle Class: affluent and education (15%),
3. Middle Class: white-collar and education (30%),
4. Lower Middle Class: blue-collar and clerical (30%),
5. Lower Class: working, poor (13%)
6. Underclass (2%)

Thompson and Hickey's (2005) five categories are:

1. Upper Class (1%)
2. Upper Middle (15%)
3. Lower Middle (32%)
4. Working Class (32%)
5. Lower Class (22%)

# OBJECTIVE 2C: Social Justice (Section F.11)

Section F.11. multicultural/diversity competence in counselor education and training programs is demonstrated through recruitment of faculty and students to a program of study. This is a beginning action statement for social justice. Recruitment efforts can be followed through academic training representing information, intervention appropriate, and attitude reviews for student and faculty. Field placement is the time to act on human rights through academic learning, fairness, and held personal values or positive changes in respect and care for the dignity of each person (F.11.a, b.).

Sue, et al. (1982) defines multicultural counseling as "any counseling relationship in which two or more of the participants differ in the cultural background, values, and lifestyle" (p. 47). This definition has enlarged the application of counselor attitudes, knowledge, and skills as counselor interactions apply to all oppressed people whether they be poor or wealthy, women or men, religious or areligious, etc. Axelson (1993) defines multicultural counseling as an "interface between the counselor and client that takes the personal dynamics of the counselor and client into consideration alongside the emerging, changing, and/or static configurations that might be identified in the cultures of counselor and client" (p. 13). Ivey, Bradford-Ivey, and Simek-Morgan (1993) describe multicultural counseling starting with the "awareness of differences among clients and the importance of the effects of family and cultural factors on the way clients view the world" (p. 94). Presently, there appears to be diversity in theoretical orientations and what constitutes effective multicultural counseling. Baruth and Manning (2003) delineate, as does Ivey, et al. (1993) that there are two trends. First is the universe approach, which implies that every session contains multicultural issues, while the second approach is geared toward a more culture-specific understanding. Finally, a counselor needs to understand identity development of the culture of the client throughout life-span development.

Multicultural counseling is further defined by how counselors demonstrate cultural competence. Caldwell, Tarver, Iwamoto, Herzberg, Cerda-Lizarraga, and Mack (2008) surveyed 99 service providers for their definition of multicultural competence. There does not appear to be a consistent definition for multicultural competence in the literature. ACA stated that if counselors provide services to clients the counselor was to be knowledgeable, have acquired skills and reviewed self-attitudes. The definition has expanded to add three domains to include counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client; and developing appropriate intervention strategies and techniques. Constantine and Ladany (2001) identified six dimensions of competence:

1. self-awareness
2. general multicultural knowledge
3. multicultural counseling self-efficacy
4. ability to understand unique client variables
5. effective counseling alliance
6. multicultural counseling skills.

The outcome of Caldwell's study yielded six themes for multicultural competencies: client focused (reflected participants' focus on the clients' culture without factoring in their own cultural identity), acknowledgment of cultural differences (understanding the client's culture, awareness of cultural differences, awareness of culture, and respect), textbook consistent (participant's recognition of the need for knowledge and awareness of client characteristics), resource driven (willingness to seek and utilize community resources) , skills-based (empathy and understanding), and self-integration (cultural worldview, self-awareness, and knowledge base were key components. Sue et al. (1992) states a culturally competent counselor is one who is self-aware of values and biases, understands client worldviews, and intervenes in a culturally appropriate manner. Sue's model describes a multicultural competent counselor to be accountable for knowledge, skills, and attitude and beliefs.

## History and Background

Jesse Davis is given credit for introducing counseling and guidance in educational settings. Frank Parsons led the way for vocational guidance in community agencies. Only after the 1954 Supreme Court decision of Brown vs. Kansas Board of Education and the Civil Rights movement in the 1960s did professional members begin to recognize and reference the need to attend to various cultural groups. The urgent question was whether counseling should deal exclusively with normal developmental needs or include concerns of a broader psychological nature. Special groups began to demand that counseling become relevant to their particular needs (Wrenn, 1962). Counseling and guidance, especially in educational settings, were singled out as maintaining the status quo because of differences in philosophy and practice.

Counseling was created by and served the masses, focusing on the average homogeneous white student (often known as YAVIS: young, attractive, verbal, intelligent, and successful). This traditional approach emphasized individualism, rationalization, and self-determination. Several minority groups began to emphasize their ethnic pride and cultural identity, which did not necessarily encompass these values.

As a result, a consensus of minority writers voiced concerns that counseling was a waste of time; that counselors were deliberately directing minority students into dead-end and non-academic programs, regardless of the students' potential, preferences, or ambitions. It was believed that counselors did not accept, respect, or understand cultural differences, and that counselors held arrogant and contemptuous views of racial/ethnic minorities, feminist, gay, pacifist, and other activist minority groups (Pine, 1972).

Minorities have expressed displeasure in the social sciences because of a poor history in correcting social ills (Sanford, 1969). Sundberg (1981) in his review of cross-cultural literature found the emphasis on white, middle-class, English-speaking counselors working with Afro-American and Hispanic clients. There is substantial evidence that:

1. Asian-Americans, Afro-Americans, Hispanics, and Native Americans terminate counseling after an initial counseling session at a much higher rate than do Anglo-Americans (Sue, McKinney, Allen, & Hall, 1975).

2. Minorities are diagnosed differently and receive less-preferred forms of treatment than do majority clients (Belkin, 1988).
    a. Lee (1968) found that psychiatric inpatients with a lower-class status received a diagnosis of mental illness more often than higher socioeconomic residents.
    b. Studies show that clinical psychologists confer less favorable diagnoses on female as opposed to male clients (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970).

Although these studies are rather old, they did suggest that counselors need to be sensitive to and knowledgeable about the various cultural backgrounds and the special needs of clients. This is no less true today. Cultural differences should not be allowed to negatively influence the counseling process (Gladding, 1996, 2000; Lee, 1999). This unit specifically addresses issues related to Native Americans, Latino-Americans, Hispanics, Asian-Americans, and Afro-Americans since these minorities presently make up 20 percent of the United States population, making it even more imperative for counselors to be able to understand and address their special needs.

# OBJECTIVE 2C: Theory and Cross-Cultural Counseling

Culture is defined as a behavior, shared knowledge and values, ethnicity and nationality, worldview, and with underlying philosophical constructs. Patrick (2007, p. 54) illustrates the need to examine the philosophical constructs of ontological (nature of reality), epistemology (knowledge), cosmological (order) and axiological (values) for a fuller definition of culture. Another perspective is to understand culture from a universal perspective. The universal approach is to interpret culture from the etic-emic debate. Etic is an approach that believes that humans are similar whereas emic approach is to study culture for specific characteristics and behaviors within groups. Another approach is within-group differences versus between group-differences.

**Question: 2-18:**
The logic a counselor might hold in understanding culture from a universal perspective specifically practicing an emic approach would be:

a. clients are more alike than dissimilar.
b. traditional mental health services do not meet the needs of ethnic minority clients.
c. that treating clients of all cultures is to treat behaviors and issues related to those presenting behaviors.
d. clients are living in an integrated society and change requires accommodating to the larger culture.

Answer: a. clients are more alike than dissimilar. Sue's research points out that minority needs are not met in traditional counseling services (Sue, 1977).

Most traditional therapies have been constructed emphasizing the white, middle-class American values of individualism and an action-oriented approach to problem solving. Thus, a major theme has been the Protestant work ethic, scientific method, and an emphasis on rigid time schedules (Axelson,

1985). Therefore, it becomes questionable as to what extent existing counseling theories are applicable to clients from other cultures (Katz, 1985). Sue (1978a, 1981) described four stages in theory development relative to multicultural counseling that reveal influences of bias and prejudice:

1. Pathological View of Minorities: Some minorities could never fit into a white society.

   Section E.5.c. of the Code of Ethics (2014) refers to social prejudices in misdiagnosis and pathologizing of certain individuals and groups and to address bias in themselves or others.
2. Genetic Deficiency Model: Cultural minorities are biologically inferior to white
3. Cultural Deficiency Model: The environments of minority members are deviant or inferior.
4. Culturally Different Model: Minorities are not deviant or pathological but must function in two cultures simultaneously. Individuals are faced with the stress of stereotyping, racism, and discrimination as part of a minority culture.

Cross-cultural counseling theorists in applying theory have been concerned with cultural, class, and language differences; differences in cognitive styles; problems of identity; and the acculturation of various subcultural groups (Copeland, 1983).

The continued development of self-knowledge allows the counselor to understand and appreciate others. Each counselor begins with understanding his/her own ethnicity, culture, and race and then how this understanding affects oneself and others. Dobbins and Skillings (1991) provide the following definitions as to how individual and societal concerns are often expressed in these themes:

Bias "is a tendency or inclination in the form of a preference given that other points of consideration have been taken into account" (p. 41).

Prejudice "is a uniformed opinion or feeling formed beforehand or without knowledge, thought, or reason (p. 41)."

Acculturation "is the degree to which immigrants identify with and conform to a new culture of a different society, or the degree to which they integrate new cultural values into their value system" (Phinney, 1990). Four models of acculturation are; assimilation, separation, integration, and marginalization (see Hayes & Erford, 2010, p. 18 for interpretive meanings for the different models). Acculturation refers to the socialization influences and how one's racial identity is practiced (Hayes & Erford, 2010).

Ethnocentrism "is a positive bias for one's own ethnicity as well as a possible prejudice about others (p. 41)."

Racism "combines the preference for a given group of people with a contempt for different groups of people (p. 41)." Dobbins and Skillings include the element of power to those groups who enforce racism. This definition is similar to Webster's Third New International Dictionary of the English Language (1981) that racism is composed of an assumption that traits and abilities are biologically determined by race and that there is an inherent superiority of one race over another as to these traits and abilities.

According to Ridley (1989), unintentional racism can manifest itself in the following ways:

1. avoiding cultural differences and assume all are alike
2. too color conscious and a tendency to attribute a problem to cultural background
3. ignoring or blinded by one's own countertransference
4. co-dependency relationships with clients out of a need to be needed
5. misunderstanding defensive reactions to stereotypical thinking
6. failure to learn a client's cultural way of communicating (as cited in Remley & Herlihy, 2005, p. 53)

# Racial and Cultural Identity Models

Cross's model was one of the first models to help explain Black identity. Several models have been developed since the Cross model such as Helm's people of color, white identity model, Ponterotto's cultural identity model, Phinney's ethnic identity, and for biracial and multiracial, gender, feminist, sex, lesbian/gay, bisexual, adolescent, and spiritual identities.

Dobbins and Skillings (1991) recognize how Erikson, in his ego formation, saw the importance of identity as the link to one's culture. This identity, individual and group formed, is the "self-knowledge of one's own coherence and authenticity" (p.47).

## Minority Identity Model

Sue (1981) developed a five-stage model of psychosocial development for minority members based upon the earlier work of Cross (1975). This model suggests that a minority individual passes through developmental stages as he or she develops an identity in a majority culture.

Stage 1: Conformity – Self-depreciation and identification with dominant cultural values. This stage is, in fact, a denial or lack of awareness of one's own self and culture.

Stage 2: Dissonance – Conflicts about dominant system, cultural confusion. In fact, this stage is a questioning of one's oppressed identity.

Stage 3: Resistance and Immersion – Self-appreciation and rejection of dominant society. In fact, the person immerses into the oppressed subculture.

Stage 4: Introspection – Evaluates attitude toward dominant society. In fact, the person begins to see the limitations of a devalued sense of self.

Stage 5: Synergetic Articulation and Awareness – Accepts cultural identity. In fact, the person begins to integrate the oppressed part of self into the self-identity.

**Question 2-19:**
At which of Sue's Minority Identity Model stages would an individual most likely feel that societal forces such as racism and discrimination are against him/her and he/she is being victimized?

a. Conformity Stage
b. Dissonance Stage
c. Resistance and Immersion Stage
d. Introspection Stage

Answer: c. Feeling of victimization leads an individual to reject the majority culture.

## White Racial Identity Attitude Theory Model

Helms (1995) developed an identity model for whites. His model is a six-stage model in two phases (abandonment of racism and development of a positive white identity). A brief outline:

Stage 1: Contact – A lack of awareness or consciousness for one's own race and an immature curiosity and reserved behavior toward knowing or understanding others. The reference group is white.

State 2: Disintegration – guilt and confusion are dominant themes and the behavior is to escape painful feelings.

Stage 3: Reintegration – to further escape everything white is superior to everything that is not, a rigid belief.

Stage 4: Pseudo-Immature positive nonracist identity – intellectualization and independence paternalism are prevalent.

Stage 5: Immersion/Emersion – A struggle with moral dilemmas—here one begins to question answers to those questions come from peers of color.

Stage 6: Autonomy – Internalization, nurturing and applying a personal definition of whiteness.

Helms and Carter (1990) developed the White Racial Identity Attitude Scale (WRIAS) as a tool to assess the ego statuses for white identity.

## White Racial Consciousness Model

Rowe, Bennett, and Atkinson (1994) explain their model as one of two levels and heavily attitudinal. The levels are unachieved and achieved and incorporated within this model are two levels of seven attitudes.

Stage 1: Avoidant – Lack of consideration of one's own white identity and avoidance of racial issues

Stage 2: Dependent – Have not considered alternatives to currently held set of attitudes regarding white racial consciousness

Stage 3: Dissonant – An unclear feeling about the certainty about their sense of white consciousness; will take in new information but yet lack commitment to the ideas

Stage 4: Dominative – Strong ethnocentric perspective that justifies dominance by majority culture

Stage 5: Conflictive – Opposed to obvious discriminatory practices yet opposed to programs aimed at reducing racism

Stage 6: Reactive – Recognize racial discrimination as a significant behavior in American society

Stage 7: Integrative – An integrated sense of Whiteness with regard to racial/ethnic minorities and do not need to be reactive.

## OBJECTIVE 2D – Strategies for Advocating for Diverse Populations (Advocacy and Confidentiality - A.7.a., A.7.b.)

Several objectives in this unit address strategies and support advocating for diverse populations. Advocating for individuals, couples, family, groups, and community members requires social justice and advocating for the rights and dignity for all individuals. Mental health issues and injustices are well documented and counselor competencies to speak for clients as well for groups of individuals are covered within the ACA Code of Ethics (A.7.a., A.7.b.).

Lee, Arnold, House, and Toporek (2003) provide examples of advocacy competencies. The six major areas are client/student empowerment, client/student advocacy, community collaboration, systems advocacy, public information, and social/political advocacy. Within each of the six competency areas are specific actions to be determined.

## Counseling with Select Minority Populations

When counseling with minority populations it is important that counselors ethically integrate professional ethics with personal values. When a counselor utilizes a decision-making strategy to conduct this process to understand and implement their own resolve it will be easier to acculturate and broach with minority clients. Ametrano (2014) referenced four strategies from the combined work of Handelsman et al. and Berry. These models are marginalization, separation, assimilation, and integration. Each model or strategy has a high and low identification with the culture of origin and with a new professional culture.

Marginalization is when the counselor has limited awareness or understanding regarding ethical issues that are a part of the client's case. A separation strategy is when the counselor has a well-developed personal moral sense but does not identify with the values of the profession. An assimilation strategy is when there is a full acceptance of the new culture's values and discards values of their culture of origin. An integration strategy is an adoption of the new profession's values while

maintaining important components of the counselor's personal values (Ametrano, 2014, Berry, 2003; Handelsman, 2005).

The counselor's integration of professional ethics and personal values along with the DSM-5™'s new emphasis regarding interviewing clients of culture hopefully will advocate for client understanding and care. The DSM-5™ points out the importance in interviewing for cultural syndromes, idiom, cultural explanation or perceived cause (as a label, attribution, or feature of an explanatory mode) and folk classification of disease that are often used by layperson or healers (APA, 2013, p. 14). To be found on-line are helpful interview versions referred to as the cultural formulation interview (CFI) to guide an interviewer with instructions that focus on cultural definition of the problem, cultural perceptions of cause, context (support, stressors and supports, role of cultural identity), cultural factors affecting self-coping and past help seeking (self-coping, past help seeking, barriers), cultural factors affecting current help seeking (preferences, clinician-patient relationship).

Broaching behavior refers to "a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (Day-Vines, Wood, Grothaus, Craigen, et al., 2007). An invite is to openly indicate that the two of you are from different cultural and ethnic backgrounds and wonder if the client is open to working with someone from a different culture (identify culture). The suggesting of broaching has literature support reflecting that counselors who do broach are viewed by clients of color as being credible (Atkinson, Casas & Abreu, 1992; Day, etc. al., 2007). Race has biological connotations, ethnicity refers to groups in which members share a cultural heritage and culture is an integrated pattern of behaviors that include communication, action, customs, beliefs, values and instructions of a racial, ethnic, religious or social group (Leighton, 1982).

The Multicultural Counseling Competency Model standards indicates that counselors display competencies in a) awareness to personal assumptions, values and biases; b) worldview understanding of culturally diverse clients; and c) develop appropriate interventions.

Day-Vines, Wood, et al. (2007) identify five broaching styles:

1. avoidant (race neutral)
2. isolating (no approach)
3. continuing/incongruent (explore presenting problem and issues of race)
4. integrated/congruent (approaches race, ethnicity and culture and integrates the counselor's behavior into his/her identity)
5. infusing along with counselor interpretations, behaviors, and applications (a way of being and do not broach because it is expected of them rather than who they are.

These authors have developed a broaching and racial identity development model. Unique within this model are the same racial identity status terms (contact, disintegration, reintegration, pseudo-independence, immersion/emersion, and autonomy), description of racial identity functioning, and attitudes toward broaching.

The following are general characteristics of specific minority populations. It is important to avoid stereotyping individuals based on general assumptions. Do not let the following generalities blind the reader to the uniqueness of the individual client. Statistics are subject to change and therefore are only an indication of directions (large or small) at the time of each study. Information for each of the four populations does not reflect all individuals or subgroups of the identified population. As an example, Filipinos are one group of at least 40 Asian-American ethnicities and languages. Caution is recommended when considering differences and similarities as they may exist not only for the 40 ethnicities but also exist with other populations and ethnicities (Nadal, Escobar, Prado, David & Haynes, 2012).

## NATIVE AMERICANS

General information: (Atkinson, Morten, & Sue, 1993)

1. Approximately 2.9 million Native Americans and Alaskan Eskimos currently live in the U.S or Alaska., although at one point the population dropped from 3 million to 600,000 (U.S. Bureau of the Census, 1991, 2001, 2010). The six largest populations (100,000 or more) or tribes are Cherokee, Navajo, Choctaw, Mexican American Indian, Chippewa, Sioux, Apache, Blackfeet, Creek and Iroquois.
2. There are approximately 252 tribal languages spoken and approximately 563 federally recognized Native American entities or tribes (Thomason, 1991). Of the 563 tribes or nations 228 are located in Alaska (U.S. Bureau of Census, 2001).
3. According to Atkinson, et al. (1993): "For nearly 500 years, American Indians have been fighting a defensive war for their right to freedom, their lands, their organizations, their traditions and beliefs, their way of life, and their very lives. They have experienced massacres by the U.S. Army, have seen the Bureau of Indian Affairs systematically destroy their leadership and way of life, have known promises broken, have had their land taken away from them, and have watched their children die because of inadequate healthcare, poverty, and suicide. By almost every measure of impoverishment and deprivation, the American Indian is the poorest of the poor" (p. 119).

Value orientations: (Heinrich, Corbine, & Thomas, 1990)

1. Holistic philosophy. Everything is connected. Mind, body, and spirit are perceived as one process, with little separation between religion, medicine, and daily activity (as opposed to analytical Anglo-American values). All of life is a spiritual process (Lee, 1999; Thomason, 1991). Byrnes (as cited in Axelson, 1993) identifies four valued objects in the universe. These four are: God, self, others, and world.
2. Deep reverence for nature and life. Live in harmony and balance with nature (as opposed to subjugating it) (Baruth & Manning, 1991).
3. Often resent demand for self-disclosure in traditional counseling situations. May perceive counselor's questions as intrusive or inappropriate.

4. Cooperation, conscious submission of self to the welfare of the tribe (as opposed to competitive striving, achieving orientation of Anglo-American culture). Tribe comes before family (Baruth & Manning, 1991).
5. Reliance on extended family. Families work together to solve problems (Sutton & Broken Nose, 1996). A deep respect for elders.
6. Anonymity, humility valued. Time is not rigidly structured (Thomason, 1991). When in the present it is represented by where you have been and where you are going. Common knowledge of time is when you are ready and when things are finished.
7. Sacred rites involve the land and natural rights on native or reservation lands. Sacred places are used for pray, visions, and burial grounds.
8. Religion is a belief in a higher power, Great Spirit, a reverence for plants and animals that intermingles with the physical world. The medicine circle.
9. Issues out of balance represent a violation of sacred social or natural customs of the tribe (Locus, 1988).
10. Healing and worship are one in the same (Garrett & Garrett, 2002).

Social and economic concerns: (Atkinson, et al., 1993, Russell, 2004)

1. High unemployment rate, 3-11 times national average
2. Median income 25%-50% that of whites
3. High-school dropout rate 48-60%
4. Suicide rate 190% times more than all Americans
5. High rates of drug use
6. Alcoholism double the national average
7. Arrest rates 10 times those for whites, three times those for African-Americans
8. High infant-mortality rate

Guidelines for counselors:

1. Open up issue of Native-American/white relationships early in therapy. Work toward moving beyond stereotypes to the individual relationship. A genuine interest in identity in terms of tribal affiliation can be a source to begin connection or engagement. Counselor may need to depersonalize client's anger toward whites.
2. Show sincere respect, interest, and trustworthiness. Studies have shown that perceived trustworthiness is more important to successful treatment than ethnic similarity between client and counselor.
3. Use silence as a positive act. Speak softly. Respect for non-verbal communication.
4. Describe options and suggest solutions. Short-term, historical, action-oriented, problem-focused, directive approaches often are more successful.
5. Seek out exposure to Native American culture and acculturation. Story telling is rich in the Native American culture and tribal means to pass along their history.

6. Recognize that many Native American clients may feel pulled between traditional tribal culture and mainstream culture (Thomason, 1991).
7. Be familiar with general ideas about healing and medicine from the Native American views of the religious circle, mind, body, spirit, and natural environment and the number 4.
8. Follow the client's lead in terms of nonverbal behavior (Thomason, 1991).

Worldview

1. Human Nature: Good
2. Social relationship: collateral, extended to family even though not a blood decedent.
3. Nature: Live in harmony and balance
4. Time orientation: present, one of transition when one knows it is time to begin and when it ends
5. Activity orientation: being, a natural flow of the energy of life, an attitude of to be.

## HISPANIC-LATINO AMERICANS

General information: According to Sue and Sue (1990) the term Hispanic is controversial as the term implies the influence of colonialism and ignores American influences to Latino lives. Latinos and Latinas are terms that frequently identify a collection of ethnic groups of people who have a similar language and living in the United States (Lee, 1999). The Office of Management and Budget (OMB) requires that Hispanic and Latino are used in combination rather than separate categories.

1. The fastest growing ethnic minority in America. During the 1980s, Latino Americans increased five times faster than the nation, reaching 22.3 million (U.S. Bureau of the Census, 1992). The largest group in number are Mexicans, Puerto Ricans, Cubans, and Caribbean Hispanics/ Central and South Americans respectively (Hayes & Erford, 2010).
2. The latest 2010 census reveals an increase population of 55.8 million representing 16.3% of the population.
3. Spanish-speaking. Least "Americanized" of the ethnic groups (Zunker, 1990).
4. Have experienced discrimination in the U.S. for many years, thus reducing the group's own sense of self-esteem, self-identity, and hope.

Value orientations:

1. Reliance on extended family, therefore often reluctant to use counseling services (Gladding, 1996, 2000). Also makes them less mobile. The family is strongly patriarchal. Child-rearing is based on values of cooperation, as opposed to competition or achievement.
2. Often strong ties to Spanish-speaking country of origin.
3. Religion is largely Roman Catholic. Religious values include sacrificial living, being charitable to others, enduring wrongs done against them, remaining free from sin, being Christ-like, and placing importance on one's spiritual life, rather than on acquisition of material goods.

4. Cultural values of family, machismo (honor, loyalty, and a code of ethics), spirituality, and personalismo (personal contact and individual interactions) are important.

Guidelines for counselors:

1. Explain the counseling process. Latinos often lack knowledge of the process, despite a generally high regard for mental-health therapists.
2. Counselors should be aware of meanings for machismo, marianismo, familismo, personalismo, and confianza to understand the connectedness to family, interpersonal relationships, and gender roles (Hayes & Erford, 2010). One example is confianza, when translated to English, means trust and confidence central to building a relationship with the counselor.
3. Collateral, build trust. Trust issues are paramount, due to long history of discrimination.
4. Be willing to include the dominant male family member (authority of husband).
5. Be prepared to deal with psychosomatic complaints caused by the special stresses on Hispanic-Americans.
6. Language issues (switching/bilingual) and acculturation are important.

Worldview

1. Human Nature: Good
2. Social relationship: Extended to family even though not a blood decedent.
3. Nature: Live in harmony and balance
4. Time orientation: present, one of transition when one knows it is time to begin and when it ends
5. Activity orientation: Being, a natural flow of the energy of life, an attitude of to be.

## ASIAN-AMERICANS

General Information:

1. The Asian-American population was 7 million in 1990 and is expected to double by 2010 (Atkinson, et al., 1993). The 2010 U. S. census data revealed 14.7 million Asian alone (U.S. Census Brief, the Asian population: 2010). There were another 2.6 million with a combination of Asian American alone and other races for a combined total of 17.3 million.
2. Includes more than 20 different ethnic backgrounds, each with a different language and religion. The majority are Chinese, Japanese, Korean, Filipino, Vietnamese, Cambodian, Laotian, or Samoan. Nadal, Escobar, Prado, David and Haynes (2012) indicate there are 40 distinct Asian American ethnicities and some 20 major religions.
3. Most neglected minority. Called the "minority of minorities." Asians are stereotyped as tranquil and well-disciplined, with a low incidence of juvenile delinquency, crime, alcoholism, and divorce. The stereotype of the "inscrutable Oriental" makes Asian-Americans less attractive to mental health professionals who seek out YAVIS clients.
4. There are few bilingual counselors to present unique problems to this minority.

5. Cultural frame switching

Values orientation:

1. Philosophical orientation is mainly Confucianism. Five ethics are involved: 1) loyalty between Lord and subordinates; 2) intimacy between father and son; 3) propriety between husband and wife; 4) order between elder and junior; 5) trust between friends. The two cultures of Asian and American identity are a cultural influence requiring switching.
2. Most Eastern religions are included, such as Buddhism, Confucianism, Hinduism, Islam, Judaism, Taoism, and Christianity. Buddhism is the most popular religion of Chinese, Koreans, Indochinese, and Japanese; Shintoism is the national religion of Japanese; Taoism is prevalent among Chinese, Koreans, and Indochinese.
3. Mental illness is regarded as the result of bad blood or sin and will result in "losing face" and ostracism. Problems are usually kept at home until they are out of hand.
4. Not accustomed to time schedules when reporting for treatment. Often expect "first come, first served."
5. Suspicious of "talk therapy." Not likely to discuss problems in marriage, job, school, friends, family, or sex life with counselor. View questioning by the counselor as a sign of incompetence.
6. Value authority. Often passive or submissive to authority. Cultural inhibitions concerning aggressiveness.
7. Collectivistic-value family to include extended family and can often be a characteristic of influencing (family identity and independence). Respect is highly valued for adults and elders and protecting the honor of the family. Obligation and respect are valued and the men are the decision-makers in the family.

Guidelines for counselors (Gladding, 1996, 2000):

1. Establish a clear-cut structure for counseling process. Explain the process to the client.
2. Allow questions about you and the process.
3. Refrain from assessment. Utilize concrete goals, structure and solution-focused approaches
4. Become educated about family and cultural values.
5. Assume authority figure role for short-term therapy.
6. Cultural switching may be a theme for some issues. The bilingual influence has opened pathways for legitimacy and cultural competence allowing for the ability to be knowledgeable and to function in two cultures, when in Asia a strong sense of identity and while in America an American sense of identity is accepted (Hong, Morris, Chiu, & Benet-Martinez, 2000).
7. Asian-Americans may need smaller dosages of medications than Anglo-Americans. Interpret side effects of medication, because the client may interpret the possible weakness in the muscles as a deficiency in vital strength.
8. Use bilingual counselors.

Worldview

1. Human Nature: Good and bad

2. Social relationship: Collectivistic, collateral, extended to family.
3. Nature: Live in harmony and balance
4. Time orientation: Present
5. Activity orientation: Being-in-doing

## AFRICAN-AMERICANS

General information:

1. The 2010 U.S. Census data in two categories (Black alone and Black, combined) registered 38.9 million Black alone and 3.1 Black combined for a total of 42 million African Americans.
2. African-Americans are a diverse group displaying a broad range of beliefs (Gladding, 1996, 2000). Individual differences make stereotyping harmful.
3. The majority of white therapists' clients are white; therefore, white therapists have little experience with African-Americans in counseling.
4. African-Americans come from different socioeconomic strata: upper class 10%, middle class 40%; lower class 50%. Sowell (as cited in Axelson, 1993) proposes that black people represent three subgroups. These are: "Free Blacks," "Freed Slaves," and "West Indian immigrants." African American history has a deep seated history of slavery, abuse, stereotyping, discrimination, servitude, struggles for freedom, oppression, stigmatism, and colorism.
5. Compared to whites, African-Americans are significantly less often the recipient of individual or group psychotherapy. They spend less time in the hospital and are often discharged without referral. The literature in mental illness has recognized that African Americans are pathologized more than any of other ethnic group based on population numbers.

Value orientations (Priest, 1991):

a. Emphasis is on the Afrocentric view, that of collective (family, community) rather than on the individual. The individual is validated in terms of the others. Extended family provides emotional and psychological support. Failure to include family members can be viewed as alienation by the client.
b. Primary importance of spirituality and religion (Lee, 1999). More likely to consult a minister than a counselor. Jones (as cited in Axelson, 1993) indicates that the values of being pragmatic, magical and mysterious, secular, and family-oriented are prominent in African religion.
c. Sanctions against self-disclosure outside the family. When self-disclosure does take place African-American males self-disclose less than African-American females.
d. Often a basic mistrust of white therapists due to experiences of racism and accompanying emotional and psychological distress.

Guidelines for counselors:

1. Address the realities of oppression, racism and discrimination. Validate the client's experience of social and economic injustice.
2. Engender trust.

3. Become aware of personal cultural perspectives.
4. Avoid stereotyping. In selecting treatment, the primary consideration is the individual client's needs, not ethnicity.
5. Goals range from survival/coping in dominant culture to becoming an activist for social change and social justice.
6. Franklin (2004) illustrated the effects of the invisibility syndrome and repeated racial slights in light of efforts to maintain a healthy racial identity. Invisibility can lead to psychosocial issues as a result of; (1) Blacks are confused about the supportive efforts of individual Whites versus the destructive actions by Whites as a collective use, (2) Blacks are confused about whether they are being accepted; and (3) Blacks are confused about when, where, and how to adapt to racism" (p. 768). As a result there may be a link between invisibility and how African American men's low sense of self-worth stems from the racial slights (Franklin-Boyd-Franklin, 2000).

Worldview

1. Human Nature: Good
2. Social relationship: Collateral or collective, kinship and affiliation, extended to family even though not a blood decedent.
3. Nature: Live in harmony
4. Time orientation: Present and flexible
5. Activity orientation: Being

**Question 2-20:**
All of the following are considered examples of cross-cultural counseling except:

a. African-American therapist and an Anglo-American client.
b. Caucasian Jewish therapist and a Caucasian Southern Baptist client.
c. American therapist working in a counseling center in Japan.
d. Anglo-American therapist offering counseling to foreign exchange students at an American college.

Answer: b. Caucasian Jewish therapist and a Caucasian Southern Baptist client. If the presenting concern is not a spiritual or religious issue individuals representing the same culture frequently follow different religions and is not an issue in treatment.

# Gender Issues

Although both genders have much in common, it is recognized that the socialization process has resulted in differences beyond obvious physiological differences. These culturally determined differences necessitate specialized services to men and women that address their unique concerns. Counselors should begin this specialized training by exploring their own values and socialization. A survey by the task force on sex bias and sex-role stereotyping of the American Psychological

Association revealed that counselors are often guilty of sexism (Brodsky, et al., 1978). Sexism most often manifests itself through counselors:

1. supporting traditional sex-role notions that serve to limit choices and options.
2. having lowered expectations of female clients.
3. using psychoanalytic concepts that are sexist (i.e., penis envy).
4. respond to female clients as sex objects (i.e., sexual harassment and sexual abuse).

In addition to overt behaviors, counselors should become sensitive to their own gender identity development and how it subtly or not so subtly impacts work with male and female clients (McNamara & Rickard, 1989).

# Women's Identity Development

## Relationship Models

The limitations of traditional theories, which were often based on research with homogeneous groups of relatively privileged men and reflected Western society's devaluation of women and their unique experiences, gave rise to new feminist theories that emphasized the relational capacities of women and the centrality of relationships in women's identity development. Five of these models, summarized by Enns (1991), are briefly outlined below. The first three are modifications of traditional stage theories of development. The final two models are feminist psychodynamic models. None of these are to be used as a "blueprint" because of the wide range of individual diversity to be found within the subgroup (Enns, 1991).

## Gilligan's Moral Development Model

Carol Gilligan (1982) wrote a landmark book, *In a Different Voice,* which offered an alternative to Kohlberg's model of moral development, which was based on a 20-year longitudinal study of 84 males.

Stage 1: individual survival and self-interest

Transition: awareness of other's needs and interpretation of self-interest as "selfish"

Stage 2: responsibility to others; goodness is equated with self-sacrificial giving

Transition: awareness of the legitimacy of one's own needs

Stage 3: balance of self-care and care for others; integration; morality of care and nonviolence

## Women's Identity Status Resolution

The understanding of identity formation was made clearer through the contributions of Erikson's concept of ego identity and Marcia's focus on crisis and commitment to identity elements (Marcia, 1966). Marcia believed that for one to develop an identity the person must experience a crisis in ideas during childhood. The individual will consider options and then make a commitment and as a result achieve a clearer identity. If one does not make a commitment, confusion in his/her identity is likely. Marcia believed that a person had two options:

1. to bypass the identity stage (follow or adopt parental standards and values)
2. continue to question and attempt to resolve and make a commitment and investment of self.

Marcia believed that a person may not have gone through one or the other or either of the choices; therefore, four possible statuses are possible. These are (Marcia, 1980):

1. identity confusion: no crisis experienced and no commitments made
2. identity foreclosure: no crisis experienced but commitments have been made (forced)
3. identity moratorium: a number of crises experienced but no commitments made
4. identity achievement: a number of crises experienced and resolved, permanent commitments made

Josselson (1987), in applying these pathways, did not find them to follow the same descriptions as proposed for men. Josselson's pathways evolved out of Erikson's psychosocial stages. The female identity vs. role diffusion stage has four possible outcomes:

1. Foreclosure: an unquestioned adoption of traditional values. Females are likely to continue with beliefs and practices of childhood (take on parental standards and do not risk disappointing parents). There is a need for security and constancy yet females are thought minded and resist pressure to conform.
2. Moratorium: an exploratory identity, self-examination, reflection. Women search and test out new identities. It can be an upsetting time for women. They tend to design their own lives with acuity of vision, are responsive to social problems, take risks, are charming, and are aware of choice.
3. Achievement identity: a flexible, interdependent self-concept based on exploration and testing. These women develop an integration of need for self-assertion and connection. These women separated from their childhood and forged individuated identities and internalized values. They sort through options, develop life plans, are often flexible, open to experience, focus on internal self and are independent.
4. Identity diffusion: the lowest group in psychological functioning and sophistication. They experience difficulties with intimate relationships and exhibit low ego development. They experience the highest anxiety of the four pathways and have an undifferentiated sex-role orientation. Josselson (1987) developed four subgroups for this pathway:

a. foreclosed diffusion
b. moratorium diffusion
c. severe psychopathology
d. previous developmental deficits

Spence (as cited in Josselson, 1987) defined a healthy identity associated with achievement, individualism, self-determination, mastery, and personal success.

## Women's Ways of Knowing

This model of intellectual development arose from the realization that women do not seem to follow Perry's model that was based primarily on male Harvard University students (Perry, 1970). Belenky, et al. (1986) describes five positions that women adopt as they approach knowledge. These reflect women's development but are not a linear progression or hierarchy (as cited in Enns, 1991).

1. Silence: Women do not perceive themselves as able to learn.
2. Received Knowing: Listening to authorities, external learning.
3. Subjective Knowing: Intuitive, personal knowledge; quest for self-understanding; acknowledge uncertainty of external authority.
4. Procedural Knowing: Connected or objective reasoning.
5. Constructed Knowing: Integration of internal/external knowing and intuitive/ objective reasoning.

## The Self-In-Relationship Model

Jordan and Surrey (as cited in Enns, 1991) emphasize the positive contribution of the mother-daughter dyad in women's development. The outcome of healthy development is relationship-differentiation, rather than separation-individuation.

Developmental problems are not the result of a failure to separate, but the result of difficulties in remaining connected while establishing a differentiated self-concept. Western culture makes it difficult for women to meet their basic needs for interpersonal relatedness while maintaining a positive sense of self.

1. early emotional attentiveness between mother and daughter
2. mutual empathy and bonding
3. expectation that relationships are a major source of growth
4. mutual empowerment, which encourages maturation within relationships; daughters learn to be both givers and receivers in relationships

## Feminist Object Relations

Eichenbaum and Orbach (1983) emphasize how women have internalized patriarchal values that have been conveyed through the mother-daughter relationship. The mother unconsciously projects on her daughter the negative, culturally prescribed feelings that she has about herself. This theory explains how traditional patterns of socialization can be internalized without conscious, overt "teaching" of conventional values and roles.

1. Daughter identifies with mother's care-taking role and develops sensitivity to others' needs.
2. Mother unconsciously rejects daughter's "needy" side and leads her daughter to deny her own needs and to give up expectations of being nurtured.
3. Daughter responds to others' needs as a way of dealing with her own unmet need to be nurtured while searching for a nurturing relationship to make her feel complete.
4. Outcome: self-sacrificing, lack of sense of self.

### Strengths of Relationship Models

1. Affirm previously devalued relational qualities in women.
2. Positive view of relationships in identity formation.
3. Connectedness is seen as a strength. (Traditional models place higher value on separateness/ autonomy.)

### Weaknesses of Relationship Models

1. Emphasis on differences between men and women can create artificial dichotomies that perpetuate inequalities.
2. Emphasis on mother/daughter relationship results in "mother blaming" and does not take into account how fathers, families, and broader sociopolitical context influence development (Enns, 1991).
3. Can result in over-romanticizing women's care-giving roles and fail to recognize women's achievement needs.
4. Lack of emphasis on promoting social change through political activism.

**Question 2-21:**
Relationship models for female identity development have emphasized that women typically define themselves:

a. in the context of intimate relationships.
b. through separation-individuation.
c. in terms of achievement.
d. in context with male associates, father, brother, husband.

Answer: a. in the context of intimate relationships

## Models of Androgyny

Collier (1982) recommends that therapists use the concepts of androgyny and sex-role transcendence in working with both women and men. This model for the development of people allows both men and women the flexibility of integrating all their human qualities. It offers to both sexes a way out of traditional polarities. The goal of therapy is self-actualization, not social conformity to prescribed roles. The emphasis is on developing underused aspects of the personality so that men and women have a wider range of options in their choices of behavior. Cook (1985) presents several models of androgyny as a means to understanding the evolving nature of the dimensions of masculinity and femininity.

1. Conjoint models:
    a. Modulation or balance—both extremes and when both present each tends to modulate the other
    b. Additive widest acceptance—high levels of both
    c. Interactive—combination of masculinity and femininity
2. Developmental:
    a. Kaplan's Hybrid Stage—synthesis and integration of dimensions or qualities such as anger/love, assertiveness/dependency, coexist.
    b. Sex-Role Transcendence—sex role standards become irrelevant in determining behavior.
3. Cognitive Schema theory:

    Sandra Bem is perhaps the name most closely associated with androgyny. Her cognitive schema theory views androgyny as a particular method of processing information; whereas "androgynous persons do not use sex-related connotations as guides in their information processing, and may in fact be unaware of sex-appropriate distinctions in a given situation" (Cook, 1985, p. 23).

    Bem Sex Role Inventory

    Bem developed a scale called the Bem Sex Role Inventory, which measures the extent to which an individual displays traditionally male and female characteristics. Twenty of the items are highly associated with the societal view of masculinity, such as athletic, dominant, and risk-taking, while the other 20 items are more "feminine"-like qualities, such as gentle and yielding. Within the inventory is an androgyny scale. This scale measures to what degree the individual reveals a balance between the traditional male and female characteristics (Reber, 1985).
4. Personality trait model:

    Internally located responses that are a variant of instrumental agents and are expressive/communal distinction.

**Question 2-22:**
Which of the following androgyny theorists is against gender stereotyping and believes that children's thinking should not be guided by traditional roles for males and females?

a. Kaplan
b. Kohlberg
c. Mussen
d. Bem

Answer: d. Bem. Sandra Bem challenged the traditional idea of a male-female continuum. She believed that a balancing of desirable male and female traits resulted in psychological androgyny. There are two separate dimensions of personality. Therefore, the androgynous person possesses masculine and feminine qualities.

## Feminist Identity Model

Downing and Rousch (1985) developed a feminist identity model based upon Cross's (1971) model of Black Identity development.

Stage 1: Passive-Acceptance – The female buys into the traditional male-oriented system, accepting all of the traditional sex roles.

Stage 2: Revelation – A crisis occurs to bring the inconsistencies and discriminations to awareness. Anger and guilt emerge over past passivity. Men are seen as negative and women as positive.

Stage 3: Embeddedness-Emanation – Close emotional ties with other women are developed so that anger can be released in a supportive environment.

Stage 4: Synthesis – A positive feminist identity is created. Personal and feminist values merge to form an autonomous identity.

Stage 5: Active Commitment – A meaningful and effective action for social change takes place. Research indicates that within the framework of this model, women entering therapy in the passive-acceptance stage would most likely prefer male therapists; women in the revelation and embeddedness stages would prefer female therapists; and the final stages would reflect no particular gender preference. Complying with these preferences may result in greater satisfaction and a more positive therapeutic outcome (McNamara & Rickard, 1989).

## Feminist Vs. Nonsexist Therapies

The fundamental difference between feminist therapies and nonsexist therapies is the political agenda that is made explicit in feminist therapies. Feminist therapies begin with the basic assumption that women have less economic and political power than men and that patriarchal society is detrimental to women's mental health. Therapy involves exploring the social/political nature of women's problems (McNamara & Rickard, 1989). The ultimate goal of feminist therapies is

sociopolitical change as well as individual growth toward psychological and economic autonomy. Nonsexist therapies, on the other hand, work toward humanistic goals of individual freedom, responsibility, and autonomy within society (Collier, 1982). The goal for males and females is sex-role transcendence. Both types of therapy promote the client's right to determine his/her own identity. Both are egalitarian models.

**Question 2-23:**
An alternative model to Kohlberg's Moral Stages that specifically relates to women was developed by:

a. Margaret Mead.
b. Erik Erikson.
c. Sandra Bem.
d. Carol Gilligan.

Answer: d. Carol Gilligan. Carol Gilligan charged that Kohlberg's theory was biased, as he utilized an all-males interview database for this theory. Gilligan theorized that girls were reared to be nurturant, empathic, and concerned with the needs of others, and to define their sense of "goodness" in this way.

# Adolescence

Adolescents are in search of their identity, taking on adult roles, and achieving independence. Dependence is both wanted and rejected. Adolescents' needs from a personal and community viewpoint are seen as counseling issues for those in counseling roles.

## Identity Formation and Status

James Marcia has made major contributions to the field of identity through his research on identity status. Marcia believes that there are two important factors in the achievement of a mature identity. First, one must endure several crises when choosing from life's alternatives. Second, the individual must make a commitment, an investment in what alternative he or she has chosen. It is possible that an individual avoids the crises of choice and/or commitment. Based on his research, Marcia developed the following model of identity statuses (Marcia, 1980):

Identity confusion: No crisis has been experienced and therefore no commitments have been made (usually early adolescence and forced by parents)

Identity foreclosure: No crisis has been experienced, but commitments have been made which were likely forced by the parents (usually middle adolescence)

Identity moratorium: Several crises experienced, but no commitments made (usually middle adolescence)

Identity achievement: Several crises experienced and commitments have been made (usually late adolescence)

## Self-Image

A major developmental task for young adolescents is forming a new self-image. Characteristics of a self-image include but are not limited to:

1. Competence

   Research emphasizes that girls are concerned about appearing too bright or intelligent.

2. Self-concept or Self-esteem

   How the person perceives himself/herself and receives feedback. The self-concept is often acted out in some of the following ways:

   a. Girls are socially more competent, make friends easier, share their feelings, grades are higher than boys, see mistakes as their inadequacies, spend more time on homework, are afraid of success, less pleased about being female, feel less able and competent, and less attractive to others when compared to boys.

   b. Boys rate themselves as smart, see mistakes as bad luck, are competitive, share fewer feelings, spend less time on homework than girls

3. Issues which worry girls more than boys

   their looks, school performance, how well other kids like them, how their friends treat them, fear of losing best friends, sexual abuse.

4. Fear of success

   a term coined by Matina Horner describing "a fear of accomplishing one's goals or of succeeding in society's eyes" (Reber, 1985, p. 744)

5. Concerns adolescents face

   Sexual activity, binge drinking, depression, frequent alcohol use, attempted suicide, tobacco use, depression, theft, group fighting, absenteeism, and vandalism.

   Cole and Hall (1964) outline the goals of adolescence to be social and maturational. These are achieving social poise, self-control, constructive expression of emotions, and self-acceptance of sociability.

**Question 2-24:**
A life-cycle theorist believes which one of the following?

a. Issues in adult development are a result of childhood issues.
b. Maturation is dependent upon changes in the interpersonal environment.
c. Individuals go through discrete stages in a chronological fashion.
d. Psychological changes are continuous throughout life.

Answer: d. Psychological changes are continuous throughout life. Life-cycle theorists believe life-cycle development is an increasing number of role transitions.

# Gerontological Counseling

People over 65 comprise over 12% of the population, yet these groups of people remain a far distance from the counseling centers. They often avoid seeking treatment because they do not define their difficulties as mental health problems, recognize a stigma attached to coming for help, have found it difficult to locate a therapist who is sensitive to the issues of old age, often feel relegated to a dependent role, and/or find it difficult to locate a counselor their age. On the other hand, older people do benefit from supportive, appropriate counseling services that address their unique concerns. These concerns are the same for other age groups except they are age-specific and do find higher frequencies of occurrence with such issues as relationships, economics, transportation, loss, health, and death and dying. As with other ages, some of these issues are associated with developmental human growth and others with life-span experiences.

## Developmental Issues

1. Retirement: Older people often struggle with feeling incompetent and underutilized. Very often they are thrust into an environment that removes opportunities to exercise competence and fulfilling achievement needs and, as a result, suffer low self-esteem and feelings of unproductivity.
2. Changing Roles: Confusion over age-appropriate behavior and expectations of society is often an issue. Older people suffer from ageism and sexism. The loss of previous roles and significant others can lead to feelings of depression and grief.
3. Physical Changes: Loss of vital capacities in the body (i.e., diminished reserve capacity, increased vulnerability to infection, increased recovery time).

## Relationship Issues

1. Marital Adjustment: Widowers and widows must find new supportive relationships. Friendships may have been underdeveloped.
2. Divorce: Although marital satisfaction is often higher in later life than in earlier stages, divorce is common (Skolnick, 1981). In 1979, 11,000 divorces were granted to people over 65 (Atchley, 1993).
3. Remarriage: Remarriage raises issues around support or lack of support from family members (McKain, 1969; Vinick, 1979).
4. Disabled or Ill Spouse: Taking care of a spouse with a long-term illness or disability creates strain and stress in relationships. Resentment often surfaces and is material for counseling (Johnson, 1985). The fear of senile dementia and Alzheimer's disease begins early for some personality types or those who have a family history of these conditions.
5. Sexual Difficulties
    a. Women: Many women experience painful intercourse, lack of available partner, lingering Victorian concepts prohibiting sexual expression, physical infirmities in

desired partner, inhibited sexual desire, and use of menopause as excuse for total abstinence.

   b. Men: Performance declines with age, yet sexually active males can remain active into their 80s. Some men struggle with impotence.

6. Sandwich Generation: Some consider this time in life individuals experience issues with aging parents, adult children, and grandchildren.

## Grief/Loss Issues

1. Physical illness and physical decline
2. Death of spouse and significant others
3. One's own death: keen awareness of limited life span
4. Loss of choice

## Age-Related Mental Health Issues

1. Depression
2. Suicide. Blazer (as cited in Ginter, 1995) cites that older adults account for 25% of all completed suicides. This is about twice the rate of their presence in society (12%).
3. Neurocognitive Disorders: Delirium, dementia and depression are common.
   a. Delirium: reduced consciousness, reduced ability to maintain focus, and shift attention to outside stimuli and a cognitive disturbance such as memory problem, disorientation, language disturbance and perceptual disturbance.
   b. Dementia: many cognitive dysfunctions, such as memory deficits (short or long), a cognitive disturbance such as aphasia, inability to carry out sequential motor behaviors (apraxia), failure to recognize familiar objects (agnosia), and in higher cognitive functioning such as abstract thinking-planning-organizing.
   c. Depression: depression symptoms include a depressed mood, reflected in somatoform symptom form, such as sleep disturbances, lack of appetite, and a lack of energy. These physical symptoms, plus bereavement, adjustment disorder, and dysthymia, are clues that depression is a reasonable diagnosis (Gintner, 1995).

## Physical, Psychological, and Social Aspects of Aging

Vickers (as cited in Gintner, 1995) indicates that 80% of those over 65 have a chronic physical disease.

1. Physical Aspects (Atchley, 1987)
   a. Decline in functioning of the immune system that leads to increased vulnerability to disease.
   b. Loss of capacity for peak performance.

c. Many declines in physical functioning can be compensated for (i.e., wearing glasses, using a cane, hearing aid, etc.) so that older people can remain actively engaged until well after 75 years of age.

2. Psychological Aspects (Atchley, 1987)
    a. Mental functioning: While motor coordination, vision, reaction time, and memory may decline with old age, learned functions such as problem-solving, creativity, vocabulary, etc., may remain stable or even increase.
    b. Personality:
        1) Stage theories
            a) Erikson (1963) Psychosocial stages: early adulthood: intimacy vs. isolation middle adulthood: generativity vs. stagnation late adulthood: integrity vs. despair
            b) Levinson (1978), *The seasons of a man's life*. The main work of adulthood is to structure life so as to enhance it through intimacy, occupational development, and mentoring activities.
        2) Process theories
            a) Identity development occurs as an individual interacts with the environment and subsequently organizes and interprets his or her experience and assigns subjective meanings (Atchley, 1987). Older adults have usually formed stable identities. The reduction in social responsibilities in later adulthood often reduces role conflict and further stabilizes identity (Atchley, 1987). Identity crisis, which results from an extreme change in the individual or environment that cannot be readily integrated without fundamental reorganization of the self-concept, can happen in later adulthood. Issues are disability, death of spouse, or retirement. Whether an event leads to an identity crisis depends on the individual's subjective interpretation of the event (Atchley, 1987).

3. Social Aspects (Atchley, 1987)
    a. Social Roles: Age often makes people ineligible for social roles they value (the role of workers, for example). People expect older people to behave in prescribed ways. Many times, they are expected to not function well in social roles simply because of chronological age. This is one form of age discrimination.
    b. Age Norms: There are often arbitrary rules about how people of a certain age should behave or how they are capable of behaving. Age is used to define a person's capabilities and opportunities. For example, retirement age is arbitrarily set at 65-70 and is enforced by legal and social structures.
    c. Socialization: Older people are often denied opportunities to learn more skills and develop new knowledge that would help them remain effective and integrated in

society. For example, senior citizens need basic computer skills which few have the opportunity to learn (Atchley, 1987).

**Question 2-25:**
As a person ages, she or he can expect to decline in all of the following areas except:

a. reaction time.
b. memory.
c. creativity.
d. coordination.

Answer: c. creativity. Long-term memory remains much intact, while short term-memory appears to diminish. Creativity remains as long as the mind is able to function.

# Grief Counseling

Counselors and crisis workers frequently conduct recovery work with those who experience a personal loss. Bereavement and grief are terms linked with loss and both are natural responses. Counselors work with individuals who experience and recover along normal developmental patterns as well as those who experience minor to major difficulties in the grieving response. James and Gilliland (2001) contend that many individuals find comfort in drawing upon faith as a resource for recovery and growth. The three patterns identified by Rando (1984) that are responses to death are: death-accepting, death-defying, and death-denying.

## Counseling the Dying Person (B.2.b.)

Section B.2.b. of the ACA Code of Ethics for the terminally ill who are considering hastening death have a confidential option depending on applicable law and specific situations after consulting or supervision processing (ACA, 2014).

Counselors expect clients to encounter physical, cognitive, and affective aspects of imminent death (Atchley, 1987):

Physical: Somatic distress, energy loss, dry mouth, sense of being uptight, sleep disturbance, loss of appetite.

Cognitive: Need to go over all of the events leading up to the death to include everyone's part in the death process. Need to make specific preparations for death (burial plans, etc.).

Affective: Depression, guilt, anger, sadness, relief, denial, and dreams. A person who is dying may fear being abandoned, rejected, isolated, humiliated, and/or lonely as death approaches (Weisman, 1972). Feelings of helplessness and loss of control over life (family and medical personnel may be making all the decisions).

## Death Anxiety

Numerous studies have found that older people often do not have an extreme fear of death (Marshall, 1980). Even when terminally ill, it seems that older persons generally fear death less than younger persons. Kalish (1976) found that this was due to the following:

1. Older people see their lives as having less value and fewer prospects for the future.
2. Older people who live past the age when they expected to die have a sense of living on "borrowed time."
3. Dealing with the deaths of friends has helped socialize older people toward acceptance of their own deaths.
4. Older people who are extremely religious have fewer fears of death.

## Stages of Death/Grief

Elizabeth Kubler-Ross developed five stages of dying and grief. Kalish (1985) points out that these stages occur with considerable fluctuation. They are not necessarily uniform, progressive steps that everyone proceeds through. There are many variations among individuals. Counselors should not use this framework to make a dying person feel guilty about not "achieving" acceptance or otherwise not "conforming" to a model. Counselors should, above all, recognize and respect the individuality, dignity, and integrity of the dying person (Atchley, 1987).

Stage 1: Denial and Isolation

Stage 2: Anger and Rage

Stage 3: Bargaining

Stage 4: Depression

Stage 5: Acceptance

## Needs of the Dying Person (Kalish, 1985)

1. food, shelter, clothing, rest, and warmth
2. freedom from pain
3. reassurance they won't be abandoned
4. need to maintain sense of self and self-esteem
5. most need to know they are dying
6. need to complete unfinished business/ prepare for death

Guidelines for caring relationships with the dying (Kalish, 1985)

1. Read up on what others have found to be effective.
2. Be aware of your own feelings about death and about aging and how these might affect the relationship.
3. Be honest with yourself about what you are able to give to the relationship.
4. Emotional and physical presence and attentiveness are more important than always doing something; be there.
5. Pace yourself and avoid burnout.
6. Do not try to impose your philosophy of death and dying on the dying person.
7. Allow the dying person to talk about death.

The Process of Grieving model by Schneider (1984) is an eight-stage holistic, growth-promoting model. This model encompasses and integrates the individual's physical, cognitive, emotional, behavioral, and spiritual responses of the person to the loss. Schneider's stages are:

Stage 1: The initial awareness of loss—shock, confusion, numbness, detachment, disbelief, and disorientation

Stage 2: Attempts at limiting awareness by holding on—concentrating on one's thoughts and emotional energy on the positive aspects of the loss and use of inner resources available

Stage 3: Attempts at limiting awareness by letting go—recognizing one's personal limits to the loss—letting go of unrealistic goals, unwarranted assumptions, and unnecessary illusions

Stage 4: Awareness of the extent of loss—mourning, lonely, helpless, and hopeless

Stage 5: Gaining perspective on the loss—reaching a point of acceptance, discovering balance and realization of the extent and limits of the loss

Stage 6: Resolving the loss—can see and pursue activities unconnected with the loss

Stage 7: Reformulating loss in a context of growth—personal growth of strengths and limits, morality, and finiteness of time.

Stage 8: Transforming loss into new levels of attachment—recognition of a greater capacity for growth

## Hospice

The hospice movement arose in response to the dying and their families' desire for a pain-free death in a supportive, family—like atmosphere. Most people prefer to die at home in the presence of loved ones. In actuality, though, more people still die in hospitals (Atchley, 1987).

# Counseling the Bereaved

## Grief Reactions

Grief is a severe stressor that has physical, emotional, and intellectual components. Bereavement is the loss of a loved one and grief is the deep and personal distress caused by the bereavement (Collins & Collins, 2005).

1. Physical: shortness of breath, tightness in chest, feelings of emptiness in stomach, loss of energy, lack of muscular strength, digestive problems, insomnia, exhaustion, headaches, dizziness, dreams (Kalish, 1976).
2. Emotional: confusion, despair, sadness, longing, emptiness, fear, anger, guilt, depression, relief, anxiety, preoccupation with thoughts of the person who died (Matz, 1979).
3. Intellectual: positive, idealized memory of the deceased forms; disorganized thinking, "magical" thinking, poor memory, poor concentration (Matz, 1979).

Healthy Grief: In healthy grieving, the overall thrust is toward stable reorganization. The bereaved person works through emotions by thinking and talking about the loved one (Staudacher, 1991).

Dysfunctional Grief: In pathological grief, mourning is arrested and the person becomes stuck in some form of denial, repression, or suppression of the painful emotions of loss. Instead of experiencing and resolving these emotions, the bereaved may exhibit addictive behaviors, chronic grief, delayed grief, or absent grief (Staudacher, 1991). Matz (1979) mentions two other examples of pathological grief:

Behavioral rehearsal: The bereaved acts in the opposite way of the behavior at the time of death in an effort to magically "undo" the death.

Anniversary hypothesis: The bereaved has an unconscious fear that she or he will suffer the same fate as the loved one when he/she reaches the same age or similar circumstances of the loved one.

Mourning Grief: Mourning grief is an expression of grief and sorrow. The form in which mourning may take is often culturally bound. This is a form of an internal expression given to external expression.

Uncomplicated Grief: Uncomplicated grief is an expression of grief that is not due to a person's ability to mourn. Uncomplicated grief is usually associated with a death that has been expected for some time, for example due to the aging process or a lengthy illness culminating in death.

Complicated Grief: Complicated grief is frequently associated with a very troublesome death. Rando (as cited in Collins & Collins, 2005) listed seven high-risk factors for complicated grief. This list includes:

1. unanticipated death (sudden)
2. extremely long illness
3. loss of a child

4. mourner's perception of death as preventable
5. premorbid relationship with the deceased was either anger, ambivalent, or dependent
6. prior history of unresolved losses or mental health problem
7. mourner's perceived lack of social support.

Disenfranchised Grief: Disenfranchised grief is when the grief cannot be openly expressed or socially supported (Doka, 1996).

# OBJECTIVE 2E: Counselor Role

The counselor role when serving diverse clients is to maintain awareness and sensitivity regarding the cultural meaning of confidentiality and privacy (B.1.a.). The counselor is to respect differencing views in terms of disclosures and who has access to shared material.

Several European therapy models or theories are viewed by some minorities as negative helping attitudes and are underutilized by minorities (Frey & Roysircar, 2006). The counselor is to develop cultural self-awareness, promoting social acceptance and to examine beliefs one holds regarding respect and dignity for all people. When reviewing cultural sensitive models various authors list specific counselor training that incorporates self-awareness. Roysircar (2009) listed the following culturally sensitive treatment models and some counselor recommendations.

1. Cultural Accommodation Model (CAM) views clients as belonging to three groups
    a. members of humanity and share traits and characteristics with all people
    b. clients must be perceived in the "group dimension" (race, gender, class)
    c. client is to be seen as an individual, separate but distinct from the group
2. Multicultural Relationship Model (MCRM)-counselors are to learn five interpersonal engagements to create a connection:
    a. affective communication
    b. relationship building
    c. diunital/dialectical reasoning
    d. observation of a client's local culture
    e. model management through self-reflexivity
3. Cognitive-Match Model
    a. what is at stake in the client's local social world to determine what is culturally important to the client
    b. empower the client
    c. utilize family support
4. Racism Acknowledgement Model (RAM)

    a. address oppression, racial identity development, and recognition of various intersecting group identities
5. Accultural Model
    a. play role of adviser, advocate, facilitator of support systems and healing systems
6. Spirituality or Religion Model

## Worldview

Before culturally sensitive models were developed ACA recommended that counselors are accountable for three tasks when providing services to diverse client backgrounds or identity. The first is to acquire the information that is pertinent for a cultural client. Second is to be trained in theories, techniques and/or strategies used for client intervention. The third is to review one's attitude regarding a cultural group that is different than that of the counselor. In terms of information Sodowsky and Johnson (1994) define worldview as one's inputs shared by members of one's reference group. The inputs consist of individual experiences, moral, social, religious, educational, sociological, economic, and political meanings and understandings. Sue's definition of worldview was the way in which an individual perceives how he or she relates (relationship) to the world. Sue incorporated into the worldview Rotter's (1975) internal and external locus of control. In further developing the worldview Sue added the dimension of responsibility to the internal and external locus of control (Sue, 1978b).

## Scale to Assess Worldview

Along with the development of identity the multicultural counselor enhances his/her effectiveness by becoming knowledgeable about the worldview of his/her client. Sue (1978b) pointed out the significance of understanding how one views oneself in relationship to the world. Sue developed a model for worldview based upon two dimensions: locus of control and locus of responsibility. Ibrahim (1991) offers a model of the worldview based upon the earlier work of Kluckhohn's values identity model. Ibrahim's model is based upon human nature, social relationships, nature, time orientation, and activity orientation. More specifically, the model is broken into dimensions, which will assist in surfacing the ethnicity, culture, gender, age, life stage, socioeconomic status, education, religion, philosophy of life, beliefs, values, and assumptions. The model components have been translated into an instrument called The Scale to Assess World Views. When counseling with these dimensions, the counselor attempts to determine how well the client fits in his or her primary group, how the larger society has been assimilated and to what degree acculturation has taken place. These scales are (Ibrahim, 1991):

1. Human nature: good, bad, or a combination
2. Social relationship: lineal-hierarchical, collateral-mutual, individualistic
3. Nature: subjugate and control, Live in harmony, accept power and control
4. Time orientation: past-present-future oriented

5. Activity Orientation: being, being-in-becoming, and doing

A brief example of this model has been applied for African-American women by Jackson and Sears (1992):

1. Human nature: view people as good and bad
2. Social relationship: group and interpersonal
3. Nature: live in harmony (oneness)
4. Time orientation: past and present
5. Activity orientation: being

As each of these relationships is explored, the actual behaviors would determine if the individual adheres to the cultural givens or otherwise. In either situation, the individual expresses how these behaviors cause issues. Addressing the identity model provides an understanding of the ethnic and cultural identification along with assimilation and acculturation.

## Multicultural Counselor Preparation

The Code of Ethics (2014) addresses multicultural/diversity in counselor education programs regarding faculty and student diversity and competence (F.11.a, b., c.). The code subsections encourage recruiting and retaining a diverse student body and faculty and to value and recognize the diverse cultures and types of abilities faculty and students bring to the program. Section A.2.c. emphasizes communicating information that are developmentally and culturally appropriate and sensitive to include clear language regarding informed consent. Qualified interpreters should be secured where needed to ensure comprehension by clients or students.

Multiculturalism can be defined from an inclusive or exclusive perspective. An exclusive definition is limited to ethnic minority and racial groups (Locke, 1990). Inclusive definitions relate to "differentness across terms such as cross-cultural, multicultural, culturally sensitive, cultural competence, and cultural-relevant interventions found throughout the literature (Weinrach & Thomas, 1996). Included within this definition are an emphasis on age, culture, disability, educational level, religion, sexual orientation, race, gender and socioeconomic status. Pederson (1990) broadens the definition of culture to include ethnographic, demographic, status, and affiliation variables. He further breaks the concept of ethnographic into ethnicity, nationality, religion, and language while demographics include age, gender and place of residence. Status includes social, economic, and educational variables and affiliation is the membership of the individual in informal or formal networks.

Locke (1993) postulated that a counselor must go through certain areas of awareness when counseling a culturally different client. This process is called the Multicultural Awareness Continuum.

## Multicultural Awareness Continuum

1. Self-awareness of one's own culture: Self-understanding is necessary in order to understand others. This awareness gives the counselor a sense of the cultural "baggage" he or she brings to the situation.
2. Awareness of one's own culture
3. Awareness of racism, sexism, and poverty: A counselor must come to grips with his or her beliefs on racism, sexism and poverty. How does this view affect oneself and others?
4. Awareness of individual differences: A counselor must not over generalize what he or she knows about a specific culture to all members of that culture. An awareness of the uniqueness of the individual must be achieved.
5. Awareness of other cultures: An awareness of the varied dynamics of specific cultures is essential. A counselor must be knowledgeable about the different languages, body languages, and other nonverbal behaviors to which cultural significance is attached.
6. Awareness of diversity: It is important to recognize that the United States is much like a "salad bowl" where each culture maintaining a unique cultural identity but capable of living and working with other cultures.
7. Skills/techniques: The last level on the continuum is to put into practice what has been learned about working with different cultures. Techniques for working with the culturally different should be added to one's practice.

## Guidelines for Culturally Effective Counseling

Characteristics for culturally effective counseling are "an awareness of self, developing multicultural counseling competencies and recognizing and addressing their values and biases, as well as understanding clients' worldviews, learning culturally appropriate intervention strategies, and understanding and adhering to ethics associated with multicultural counseling" (Baruth and Manning 2003, p. 62). Sue (1978a) provides the following guideline to train counselors in effective cross-cultural counseling.

1. Recognize which values and assumptions you hold regarding the desirability or undesirability of human behavior.
2. Become aware of the generic characteristics of counseling that cuts across many schools of thought. Recognize the cultural values implicit in counseling theories and traditions.
3. Understand the sociopolitical forces (oppression and racism) that have impacted the identity and perspective of minority cultures.
4. Share the worldview of your clients without imposing value judgment.
5. Be eclectic in practice so that skills and techniques can be matched to the specific lifestyles and experiences of the client.

## Barriers in Cross-cultural Counseling

1. Language: affects rapport, causes misidentification of strengths and weaknesses. Counselor should be aware of minority-group nonverbal communication styles.
2. Class-bound values: includes attitudes, behaviors, and beliefs concerning such things as:
    a. importance of keeping appointments
    b. expectations of advice and suggestions from the counselor
    c. differing sexual mores
3. Culture-bound values: involve attitudes, beliefs, customs, and institutions identified as integral parts of a group's social structure (Belkin, 1988). Examples of their interference with cross-culture counseling include:
    a. referring to a client as "culturally deprived".
    b. straight male counselors making sexual remarks about females in front of gay clients.
    c. focusing on self-disclosure and emotional expression when it is incongruent with some cultural values (Asian-Americans, for example).
    d. some minority clients tend to be confused, frustrated, and/or threatened by lack of structure in the traditional counseling relationship. Often, African-Americans and Asian-Americans prefer a more directive style.

## Types of Cross-cultural Counseling Relationships

1. The counselor is a member of the dominant American population and the client is a member of a racial or ethnic minority.
2. An individual from a Western-oriented country transports therapy to a non-Western country.
3. Counseling services are offered to foreign students in the United States.
4. Ethnic-racial professionals counsel members of the dominant culture or members of another subcultural group.

## Perceiving Clients' Diversity: Issues for Multicultural

Counselors employ intervention strategies and their attitudes toward cultural backgrounds may affect choices in these strategies. Baruth and Manning (2003) suggest that counselors study models of cultural deficiency and difference, genetic deficiency (deficits), cultural deficiency (deficits), culturally different, and approaches such as etic-emic, autoplastic and alloplastic, existentialist, communication (verbal/nonverbal language), life span differences, and intracultural, as well as generational, sexual orientation, disability, geographical, and socioeconomic differences.

A transtheoretical approach focusing on wisdom for effective multicultural counseling includes culture, context, dialectical thinking, awareness, metacognition, deep interpersonal insight, and advanced empathy. Understanding the approach to wisdom may require an understanding of the

different definitions offered by several authors that include cognition, affect, coping skills, insight into the nature of self and others, good judgment, and characteristics of listening, concern for others, maturity, deep psychological understanding of others, high capacity for self-knowledge and awareness, take an overview of problems, and the ability to frame a problem for solution (Hanna, Bemak, & Chunk, 1999). According to these authors wisdom is composed of dialectical and metacognition functioning. Metacognition, the second component of wisdom, is the ability or skill to 'be aware of being aware' (Pesut, 1990, p. 109).

A distinction these authors make regarding wisdom and intelligence is in the traits and characteristics of each. Wisdom is a concern for the recognition of limits, presuppositions, and origins of knowledge. Intelligence regarding knowledge is a concern for the recall, classification, analysis and application of knowledge. What may be unique to this approach, especially for training, is that wisdom tends to deautomatize habitual thought routines and behaviors whereas intelligence tends to automatize. Characteristics of wisdom includes affect and awareness (recognition of affect deautomatization, sagacity) and cognition (dialectical thinking, efficient coping skills, tolerance of ambiguity, perspicacity, problem finding and solving and metacognition). This approach focuses on depth, fluidity, and richness of understand (Hanna, et al.). The complexity of this approach to training counselors for multicultural counseling needs further study.

Dialectical reasoning uses opposing views in thought processes, focuses on the essence of a problem, uses multiple levels of meanings in communication, combines meaning, penetrates interpersonal insight and discernment (perspicacity), recognizes context, and can move from culture to culture without confusion. The movement from culture to culture implies that knowledge can be transferred. Hanna, Bemak and Chunk (1999) suggest that dialectical thinking takes place when the counselor can see beyond ethnocentrism in order to differentiate the limits and assumptions of a cultural mindset, thus begins the process of deautomatize. Caution in recommended with this brief reflection on this newer approach to multicultural counseling without further understanding of the specifics of the introduction.

**Question 2-26:**
Dialectical thinking or reasoning principles endorse all of the following except:

a. opposing views in thought processes
b. cutting to the essence of a problem
c. multiple levels of meanings in communication
d. separate meanings rather than combine them

Answer: d. separate meanings rather than combine them. Dialectical reasoning combines or bridges meanings.

# OBJECTIVE 2F: Biases, Prejudices, Discrimination

Preparation for working with diverse clients includes achieving self-awareness in relation to self and others regarding one's beliefs and attitudes toward individuals that are different than oneself (Section A introduction, A.2.c., A.4.a., imposing values, A. 4.b.,values, B.1.a., client rights, and 5.5.b., cultural sensitivity to problems identified and experienced and socioeconomics.

Multicultural competence begins with a definition of a bias. According to Boysen (2009) a definition for bias has expanded to include implicit and explicit bias definitions from the writings of Greenwald and Banaji (1995) and Greenwald, McGhee, and Schwartz (1998). Explicit bias is a conscious and intentional self-report. Implicit bias is covert without conscious intention and not self-reported. Explicit bias is the easier to detect as this form is intentional, the behavior is overt and the message is sent verbally, non-verbally, physically and/or through a combination of group behaviors. Implicit biases is often seated in acquired values within the family, cultural group or the larger society desirability and below the surface of awareness by the sender. These types of biases are not only for people in general but also for counselors, service providers, clients representing diversity and for minority group members toward other minority groups and the majority culture. It might be good to consider the pessimistically biased literature. Fur and Funder (1998) researched personal negativity and personal biases. The results of their study suggested that people who are optimistically negative have a tendency for:

1. a desire for personal control
2. egocentric thinking
3. selective comparisons with others who are less fortunate or more at risk than oneself
4. positive illusions
5. the availability of personal examples
6. a desire to enhance or protect self-esteem
7. a desire to make downward social comparisons

Helweg-Larsen and Sheppard (2001, 2002) further refined this data and found that an optimistic bias is a result of negative affect, perceived control and characteristics of the comparison situation appear to consistently influence the optimistic bias.

Microaggressions are subtle forms of verbal and behavioral discrimination toward individuals or groups of minorities. Nadal, Escobar, Prado, David and Haynes (2012) conducted a study of microaggression experienced by individual American Filipino. This study pointed out several important outcomes for counselors preparing for delivering services to individuals of diverse backgrounds especially American Filipino. Using their illustration and information shared by Nadal and Sue (2009) for Filipino Americans Nadal, Escobar, et al.(2012) point out that there are 40 different Asian American ethnicities, hundreds of languages, and more than 20 major religions that may differ in specific values and attitudes. Significant results from this report for any diverse group experiencing

racial slights are 13 categories of microaggression. Six of the themes were similar to Asian Americans such as:

1. alien in one's own land
2. second-class citizen
3. invalidation of inter-ethnic differences
4. eroticization and sexualization of women and demasculinization of men
5. pathologizing of cultural values and behaviors
6. invisibility and lack of knowledge of Filipino Americans.

Two themes matched Black Americans:

1. assumption of criminality or deviance
2. inferior status or intellect.

Five themes were new:

1. use of racist language
2. assumption of Filipino stereotypes
3. exclusion from the Asian American community
4. assumption of universal Filipino experience
5. mistaken identity

These themes are specific to Filipino Americans; however, what is important for the counselors working with other diverse groups is to recognize when providing treatment is to incorporate or be aware of these forms of direct and indirect forms of insults and to enlist the client to share with the counselor those unrecognized. Counselors should recognize that many of the European traditional treatments applied to people of diversity have not been appropriate. Training access and use of more culture sensitive models are recommended. Competency standards of the ACA Code of Ethics (C.2., C. 2.a.) emphasize that counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. Of importance is to learn historical experiences that have influenced the culture, family values and experiences, microaggression experienced personally, identity development and use of mental health services.

In summary, Pierce, Carew, Pierce-Gonzalez, and Willis (1978) state that microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color:"(p. 271).

# Unit 2 - Terms

ABLEISM:
A term that reflects ability or functioning capacity that is developmental and based on age, gender, socioeconomic status, education, geographic location and references a set of social attitudes. A person who has full functioning physically and mentally is perceived as exhibiting ableism.

ACCULTURATE:
To undergo the process of learning a culture.

ADULTISM:
A discrimination against young people. Adultism consists of beliefs and actions that do not reflect respect and contribute to forms of discrimination (oppression and disempowerment).

AGORAPHOBIA:
Fear of leaving a familiar environment and a fear of open spaces.

ALLOPLASTIC:
Shaping the external situation to one's needs.

ALZHEIMER'S DISEASE:
Blockage or narrowing of blood vessels to the brain. Loss of chemicals critical to the firing of brain nerve cells. Early stages reflect recent memory loss followed by disorientation to time, place, and people.

ANDROGYNY:
Combining of male and female characteristics based on the premise that each person, to some degree, possesses both masculine and feminine behaviors.

AUTOPLASTIC:
Accommodating to the givens of a social setting.

CORRESPONDENT BIAS:
A tendency to infer behaviors of a person to internal characteristics instead of situational dispositions (Franklin & Boyd-Franklin, 2000). An example might be skin color that infers a particular ethnicity and attached negative stigmas/stereotype.

COUNTERCULTURE:
A group affiliation that stands in opposition to the cultural norms and values prevalent within the dominant culture.

CROSS-CULTURAL COUNSELING:
A counseling relationship in which two or more of the participants differ with respect to cultural background, values, norms, roles, lifestyle, and method of communicating.

CULTURE:
The sum total of knowledge, beliefs, morals, customs, and ideologies acquired by a member of society.

DEINDIVIDUATION:
A state of reduced self-awareness and lowered concern for social evaluation.

DYING TRAJECTORY:
The rate of decline in functioning leading to death. It is used to estimate the time frame within which dying will take place (Kalish, 1985).

EMIC:
Understanding culture from a position within the system, making a counselor better able to understand the client's worldview. To live within a specific culture would be to learn the EMIC view.

ETHNIC GROUP:
Formed on the basis of real and assumed physiological traits and national and regional group traditions. An ethnic group shares a common identity and common heritage. Henderson indicates the characteristics of ethnicity are a shared group image and sense of identity derived from values, behaviors, beliefs, communication, and historical perspective; shared political, social, and economic interests; and shared involuntary membership with a specific ethnic group (cited in Baruth & Manning, 2003).

ETIC:
Understanding culture from outside the system of an observer. An ETIC approach would be to make a comparative study of some specific aspect of the culture.

FETAL ALCOHOL SYNDROME:
Baby born an alcoholic due to maternal drinking during the prenatal period of development.

GATEWAY DRUGS:
These are drugs that usually precede the use of illicit drugs such as cocaine, heroin, and LSD. Gateway drugs such as tobacco, alcohol, and marijuana are considered readily available.

GENDER ROLE CONFLICT:
When rigid, sexist, or restrictive gender roles learned during socialization result in restriction, devaluation, or violation of others or oneself.

HOMOPHOBIA:
The irrational fear of homosexuals and homosexuality.

INVISIBILITY SYNDROME:
The invisibility syndrome consists of repeated slights that are integrated into racially adapted behaviors for African males in order to manage racism. Franklin (1999) coined this syndrome to mean "an inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism" (p. 761). These stereotype threats may reflect the fear of confirming a negative racial stereotype (Aronson, Quinn, & Spencer, 1998).

LIFE EXPECTANCY:
The average length of time a group of individuals of the same age will live given the current mortality

rates. Life expectancy is most often calculated from birth. Life expectancy for humans born in the year 2000 will be 85 years.

LIFE SPAN:
The length of time that is biologically possible for a given species to live. Human life span is 120 years.

MICRO-INVALIDATION:
Microassaults, microinsults, and microinvalidations are all forms of microaggression which is/are brief, common intentional and unintentional verbal, behavioral and environmental indignities that convey derogatory slights and insults to the client-often based on some cultural dimension of difference such as race, sexual orientation, disability, and gender (Sue, Capodilupo et al., 2007, p. 273).

MINORITY:
Group whose members share racial or ethnic traits different from the dominant group.

PERSISTENT DEPRESSIVE DISORDER:
A depressed mood that occurs for most of the day, for more days than not, for at least 2 years, or at least 1 year for children and adolescents (APA, 2013, p. 169).

RACE:
In the strictest sense, race refers only to distinguishing biological characteristics such as skin pigmentation, head shape, stature, facial features, as well as the color, distribution, and texture of body hair. The term is often attached to political and social meanings.

RIP VAN WINKLE EFFECT:
Sleeping more than 11 hours results in poor performance on tasks requiring alertness and vigilance.

ROLE CONFLICT:
The demands of two or more roles that a person occupies produce a dilemma forcing the person to choose between allegiances.

ROLE STRAIN:
Occurs when an individual occupies too many roles and cannot adequately perform each one due to limited time, energy, and resources.

SET-POINT THEORY:
The body's regulating mechanism that determines what one's ideal weight should be.

SEXISM:
Any attitude, action, or institutional structure that devalues, restricts, or discriminates against a person because of biological sex, gender role, or sexual preference. "The belief that the person should be treated on the basis of his/her sex without regard to other criteria, such as interests and abilities" (Gladding, 2001, p. 110).

SOCIAL CLASS:
The assignment of rank and privilege to some individuals while assigning disdain and restriction to others.

SOCIALIZATION:
The process through which a group encourages and/or coerces its members to conform to its culture (Atchley, 1987).

STEREOTYPING:
Rigorous preconceptions that are applied to all members of a group or to an individual over a period of time without regard for individual differences (Belkin, 1988). Minorities are harmed through stereotyping by others and by internalizing stereotypes.

STRENGTHS-BASED MODEL:
An approach designed to build upon client strengths and resources. This approach views client resistance and denial as healthy (van Wormer & Davis, 2003).

SUBCULTURE:
A distinctive pattern of shared values, behaviors, and ideologies manifested in a style of life significantly different from that of the dominant culture and from those of other subcultures.

TYPE A PERSONALITY:
Highly driven, competitive person who feels rushed and pressured.

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# UNIT 3- Human Growth & Development

## Introduction

Human growth refers to the changes a person goes through from conception to death. These changes include behavioral, physical, cognitive, emotional, moral, personality, and social development as influenced both biologically and environmentally. Siegelman and Shaffer (1995) define lifespan development as physical, cognitive, and psychosocial.

When reviewing each of the above content areas be sure you are able to answer any question which will reflect how one progresses through a developmental stage or phase of life. An example is Erikson's Psychosocial Stages. Erikson's stages center upon a series of conflicts that he believes must be successfully resolved before one can proceed to the next stage. Attempt to frame a question for each theory. As you do so, be conscious of any developmental issues a counselor-client might encounter. For the most recent administrations of the NCE, there have been 17 content questions of which 12 count toward your total score.

# CACREP Objectives

CACREP objectives for Human Growth and Development are not presented in full. Those preparing for the NCE may want to visit the CACREP website for the full standard objectives. The 2009 Standard objectives for Human Growth and Development are:

A. theories of individual and family development through life-span
B. theories of learning and personality-understanding neurological behavior
C. effects of crises, disasters and trauma
D. theories and models of individual, couple, family resilience
E. understanding exceptional abilities and strategies for interventions
F. human behavior, including an understanding of developmental crises, disability, psychopathology for normal and abnormal behavior
G. theories and etiology of addictions and addictive behaviors, strategies-interventions-treatment
H. wellness over the life-span

**Question 3-1: (Objective A.)**
Bruner devised a stage theory of language development. Which stage suggests that a child will imagine pictures to represent something?

a. symbolic
b. enactive
c. iconic
d. equilibration

Answer: c. iconic. Iconic stage is imaginal.

**Question 3-2: (Objective B.)**
Piaget found nativism and empiricism incomplete and therefore created constructivism. Constructivism is:

a. when concepts are not acquired through exposure but inborn.
b. when concepts are acquired through exposure.
c. a world view of regularity and structure.
d. exposure to the world and activities that cause precursors to more fully developed ideas.

Answer: d. exposure to the world and activities that cause precursors to more fully developed ideas. Piaget believed the child had precursors to forming concepts.

**Question 3-3: (Objective C.)**
During an intake assessment, a client indicates that she is in an abusive relationship with her husband. The most appropriate therapy for this client is:

a. individual therapy.
b. group therapy.
c. a battered wives support group.
d. to refer to a battered women's shelter.

Answer: a. individual therapy. Individual therapy would be the choice until a counselor is able to determine how severely hurt, emotionally, physically, and otherwise. A referral to a sheltered may be considered except this question asked for therapy.

**Question 3-4: (Objective D.)**
A developmental theorist believes that children form human attachments in phases. This person is:

a. James Marcia
b. Jane Ainsworth
c. Arnold Gesell
d. Lev Vygotsky

Answer: b. Jane Ainsworth

**Question 3-5: (Objective E.)**
A counselor, who has been counseling a family for eight sessions during supervision received feedback from his/her supervisor that he or she is experiencing boundary naiveté issues. The supervisor is suggesting that the counselor is:

a. lacking cognitive knowledge.
b. lacking affective awareness.
c. experiencing a social deficit and maybe a knowledge deficit.
d. experiencing impulse control issues.

Answer: c. experiencing a social deficit and maybe a knowledge deficit. The two possible choices are a and c; however, letter a. is only partially correct.

**Question 3-6: (Objective F.)**
A researcher studies a group of gifted children from age 10 through their 21st birthday. Their growth rates in height and weight are recorded yearly along with respective scores on various intelligence, aptitude, and achievement tests. What type of research is appropriate?

a. longitudinal
b. survey
c. naturalistic

d. correlational

Answer: a. longitudinal

**Question 3-7: (Objective F.)**
Vygotsky did not use the term developmental crises. It was his belief a crisis in intellect took place when which one of the following existed in the early life of the child?

a. speech and practical activity did not merge
b. intellect and physical development were not commensurate
c. nutrition was less than adequate
d. social engagement with other playmates were non-existent.

Answer: a. speech and practical activity did not emerge. Both start out as independent and with merging of speech and practical activity practical and abstract intelligence is the result.

**Question 3-8: (Objective G.)**
Marlatt advocates for harm reduction as a method or treatment for addiction that endorses all of the following principles except:

a. managing one's daily functioning versus moralistic idealism.
b. alternative to moral/criminal and disease models.
c. holding the same level of consumption but not to increase.
d. meeting the individual where he or she is.

Answer: c. holding the same level of consumption but not to increase. This approach is to prevent or at least reduce the harmful effects of use, not use itself (Marlatt & Witkiewitz, 2002).

**Question 3-9: (Objective H.)**
Wellness over the life span includes a well thought out plan for optimal development. Most plans include physical, mental, nutrition, spirituality, self-care, leisure and several other components. Literature support for exercise suggest certain benefits. All of the following are considered benefits except:

a. essential in preventing disease
b. key ingredient to healthy aging
c. increases strength and confidence
d. little effect on self-esteem

Answer: d. little effect on self-esteem. a) Ory & Cox, 1994, b) U.S. DHHS, 1990, c) Fontane, 1996, d) International Society of Sport Psychology, 1992-increases self-esteem.

# Terms and People

Definitions for the following terms are found at the end of the chapter.

Apgar Rating
Canon-Bard
Centration
Clang Association
Cohort Effect
Dembers Ideational Addiction
Developmental Norm
Equilibration
Field Theory
Harlow, Harry
Hierarchical
Imprinting
Internal-External
James Lange
Lamaze method
Learning
Mainstreaming
Maturation
Maturity
McClelland, David
Neuroscience
Ontogenesis
Opponent Process
REM
Rites Passage
Schachter Cognition
Schema

# Developmental Research

Naturalistic: Data are collected in the natural setting, such as a home, school, or work situation. This research design has been used successfully with children, because observation is easier to attain than verbal reports from young children. A couple of disadvantages are the inability to pinpoint the reason for the behavior, as other factors may be causing the behavior in question. Secondly, the presence of an observer will affect the outcome and frequency of behavior in question. "Nature" performs the experiment and the researcher is an observer (Dacey & Travers, 2002).

Case Study: Data are collected from a single individual. A disadvantage of the case study is the inability to generalize the findings. It is very difficult to systematically compare individuals. Piaget used the case study for much of his accumulated data.

Cross-Sectional: Data are collected from people of different age groups. Frequently, a stratified random sample is attained. Age cohorts may be the differences rather than maturation (Dacey & Travers, 2002).

Longitudinal: Data are collected over a repeated time period. A performance of a group of individuals can be ascertained, such as Terman's genius study, which has been researched for longer than 60 years. An advantage is deriving lasting behaviors such as habits. A disadvantage is any change in the environment.

Survey: This method is composed of the interview and various types of questionnaires in order to sample subjects for their feelings, thoughts, or actions under prescribed conditions.

Correlational: Subjects are observed under identical conditions. Variables are not manipulated. The researcher measures existing phenomena. A correlation coefficient is derived that expresses the degree of relationship between two variables.

# Developmental Concepts

Brown and Srebalus (2003) approach the understanding of developmental theory according to a stage-hierarchy or stage-progression. Differences in the two stage approaches center upon the concept of change. Change is viewed as occurring at different developmental ages whereas the hierarchy theories describe change as it occurs. Both sets of theories believe that earlier stages of development are central and necessary before moving onto the next stage. Stage-progression theories indicate that each successive stage prompts advanced functioning different than the previous one. The outcome is new and different with developing coping strategies. Kohlberg's Moral theory and Piaget's Cognitive theory are examples. Stage-hierarchy theories focus on how adaptive resources build although these theories do not point out what actually influences the movement to an advanced stage. These authors suggest that a disadvantage of the stage-hierarchy theories is that little understanding is offered as to what influences movement from one stage to the next. For each age group such as pre-school age years, elementary school, middle school, high school (adolescents), young adults, middle age, and older it is advisable to be aware of issues that frequently are seen by counselors. Coleman (1981) listed several issues encountered during the adolescent years.

Some of these adolescent issues for males are: changing relationships, masturbation, premarital sex, unwanted pregnancy of a sexual partner, sexually transmitted diseases, and drug problems. Other authors suggest for both males and females that social development is taking place, often creating a same-sex grouping or cliques, narrowing to couples, concurrently with body image, sexual orientation, and attraction to the opposite gender.

# OBJECTIVE 3A: Individual & Family

Specific ethical family references in the ACA Code of Ethics are expanded in groups and families (B.4.), couples and family counseling (B.4.b.), sensitive to cultural diversity in family (B.5.b.), friends or family members (F.3.d.), and the ability/inability to remain objective (ACA, 2014).

## Theories of Human Development Across Life-Span

Human growth can be explained from a collective sense by understanding a variety of theories that attempt to provide meaning for the life span. The following areas of human functioning will be explained by at least one prominent theory developer

Ethological: study of behavior in the natural setting-example-Bowlby ethological theory of attachment

Humanistic: development of a self-unified system (self-concept)-Abraham Maslow, Carl Rogers

Language: learning rules of language, phonology, semantics, syntax, and pragmatics-Jerome Bruner

Learning: cognitive development, changes in mental processes involved in perception, language use, learning and thought. Jean Piaget's theory

Moral: to be good, truthful, kind, wise, just, courageous, and virtuous-Kohlberg moral development theory.

Physical: includes changes in the growth of the body and its organs-Robert Havighurst and Arnold Gesell

Psychosocial: changes in personal and interpersonal aspects of development such as motives and emotions, personality traits, interpersonal skills and relationships, and roles played in the family.-Erik Erikson psychosocial theory of crises.

Each developmental area and at least one theorist will be reviewed. As each theory is developed, the reviewer is to become aware of the differences in four critical areas in which issues surface for counseling. These have come to be known as the assumptions of human nature vs. nurture, activity vs. passivity, continuity vs. discontinuity, and universality vs. particularity.

## Psychoanalytical Theories

Psychoanalytical theorists assume that biological forces drive people and that the individual must struggle to control or channel them. They also believe that development proceeds in stages, and that personality characteristics developed in childhood remain stable over time.

### SIGMUND FREUD

Freud believed biological drives (sex and aggression) were the primary motivators of human behavior. He believed the personality developed in psychosexual stages. The following is provided for a quick review. For more about Freud's theory of personality, see Units Helping Relationships and Group Work.

Pregenital Period:

Oral Stage - Pleasure focuses around the mouth. Age birth to 10 months.

Anal Stage - Pleasure focuses around the anus and the process of elimination. Age 1 to 3 years.

Phallic Stage - Pleasure focuses around the genitals. Age 3 to 5 years.

Latency - Dormancy of sexual desires. Age 6 to 12 years.

Genital - Period of normal adult sexual behavior that begins at puberty and carries on throughout adulthood.

ERIK ERIKSON

Erikson (1968), a social learning theorist, was a close follower of Freud. His theory is considered Neo-Freudian. He based his theory on the types of learning and social interaction that take place at different age levels, rather than on development of biological systems as did Freud. Conflicts between individuals and society are central to psychosocial theory. Thus, his stages are called psychosocial stages.

## Psychosocial Stages

During each stage individuals are faced with a particular type of conflict that must be resolved before moving on to the next stage. In resolving the conflict the individual will risk positive or negative outcomes, positive affirmations or negative affirmations. This theory is epigenetic in nature, meaning one stage builds upon another.

Trust vs. Mistrust (sensory state-infancy) Age birth-2 years: If feeding is pleasant, trust develops. Parents are central to social expansion of the child.

Autonomy vs. Shame Age 2 years.: Growing mastery of motor skills. If not allowed some independence at this stage, child may begin to feel ashamed and begin doubting own powers.
Parents are central to social expansion of the child.

Initiative vs. Guilt (locomotor or genital age) Age 3-5 years: Awareness begins to extend to other people and things. Curiosity develops. Sharing with others takes place as well as role exploration, which develops initiative. Parents are central to social expansion of the child.

Industry vs. Inferiority (latency period) Age 6 to adolescent years: Child begins learning values and skills of society. Recognition for accomplishments promotes industry. Peers are central to social expansion of the child.

Identity vs. Role Confusion (puberty and adolescence) Age 12-18 years: Process of finding out "Who am I?" Failure leads to false sense of self Peers are central to social expansion of the child.

Intimacy vs. Isolation (young adulthood): The stage at which meaningful and intimate relationships are developed. Peers are central to social expansion of the young person.

Generativity vs. Stagnation (middle adulthood): The ability to continue producing, reproducing, and developing vs. sitting back, not growing and furthering oneself. Partners and intimate friends are central to social expansion.

Integrity vs. Despair (late adulthood): Those who have been successful in solving life's crises reach ego integrity. They look back with a sense of achievement as opposed to a feeling of despair because of an incomplete life. Mankind is central to social expansion.

**Question 3-10:**
According to Erikson's psychosocial stages by what age does a child normally begin investigating various roles, for example, playing house or pretending to be a fireman?

a. birth to 2 years
b. age 3-5
c. age 6-11
d. age 12-18

Answer: b. age 3-5. During the initiative vs. guilt stage, initiative is developed by trying out new roles. When these attempts fail, the result is guilt.

## JANE LOEVINGER

Ego Development: Ego development plays a major role in individual differences in a person of any age. Jane Loevinger believes that Erik Erikson's psychosocial development theory is much like her ego development theory. She believes that stages are important in revealing one's impulsiveness, self-protectiveness, conformity, conscientiousness, and autonomy.

Characteristics of Conception of Ego Development

1. Stages are potential fixation points. They define types of children and adults.
2. Stage conception is structural. There is inner logic to the stages and their progression.
3. There are specific tests, experiments, or research techniques that become the instruments for advancing knowledge in the domain. The conception is applicable to all ages.

Stages of Ego Development

1. Presocial Stage - Awareness of objects. Baby constructs a self-differentiated from outer world. Object constancy and conservation of object.
2. Symbiotic Stage - Differentiation of self from others. Language plays a part in this distinction.
3. Impulsive Stage - Affirmation of separate identity. Demanding of attention. Bodily feelings.
4. Self-Protective Stage - Beginning of self-control. Understanding of rules.
5. Conformist Stage - Development of trust. Identification of one's welfare with family. Obeys rules because they are group-accepted. Appearance, social acceptance.
6. Self - Awareness Level Transition from Conformist to Conscientious Stage - Stable position in mature life. Perception of alternatives and exceptions. Adjustment.
7. Conscientious Stage - Internalization of rules. Major elements of adult conscience. Morality.
8. Individualistic Level Transition from Conscientious to Autonomous Stages - Greater conceptual complexity. Desire for individuality. Awareness of inner conflict.
9. Autonomous Stage - Ability to cope with inner conflict. High tolerance for ambiguity. Self-fulfillment as goal.

10. Integrated Stage - Consolidation of a sense of identity. (Loevinger, 1976).

# Social Development

## LAWRENCE KOHLBERG

Kohlberg developed a theory of moral development considered to be a stage hierarchy. He believed that an individual's morality requires weighing the views of others against self-interest (Dacey & Travers, 2002). Kohlberg's theory places an individual's moral development at one of three levels. He suggested age parameters for each level, but these should not be considered fixed. For example, a 13-year-old could be at the preconventional stage and an adult could be at the conventional level. In fact, Kohlberg's research reveals that over 60% of his middle-class male subjects had not reached the postconventional level (Rosenthal, 1993). It is also important to realize that one's moral development can differ from his/her moral behavior. The individual may know what is right, but choose to act differently (Dacey & Travers, 1994, 2002).

# Levels of Moral Development

Preconventional (ages around 4-10) Often well-behaved and sensitive to labels such as good and bad. No self-determined morality yet, morality is determined by power of authority and the consequences of action.

Conventional (ages around 10-13) Conformity to the existing social order and a desire to maintain that order. (Most adults operate at this level, according to Kohlberg.)

Post Conventional (14-adulthood) Governed by universal moral principles that are independent of the authority of groups who believe in them. Legal principles are important.

**Question 3-11:**
According to Kohlberg, most adults operate at what moral level?

a. Preconventional
b. Conventional
c. Postconventional
d. Exconventional

Answer: b. Conventional.

Values Clarification: Specific reference to purposeful attention to values clarification, beliefs and attitudes are highlighted in the 2014 Code of Ethics in Sections A. 4.b. (personal values), F.8.c. (self-growth), and F.8.d. (personal concerns).

### SIDNEY SIMON

According to Sidney Simon, the goal of the values clarification process is not to instill a specific set of values and beliefs, but to help people apply the following three steps and seven subprocesses of valuing in their lives to already-formed values and those still developing (Simon, Howe, & Kirshenbaum, 1972).

1. Choosing from alternatives
    a. chosen freely
    b. chosen from alternatives
    c. chosen after considering consequences
2. Prizing one's beliefs and behaviors
    a. prizing and cherishing
    b. publicly affirming
3. Acting on one's beliefs
    a. act upon
    b. act with consistency

**Question 3-12:**
John works for an environmental agency and lobbies for recycling. He believes recycling is good for the environment and encourages others to recycle, yet at home John does not recycle his aluminum cans or newspapers. Which of the three stages of valuing has John not applied in his life?

a. choosing
b. choosing freely
c. acting
d. prizing

Answer: c. acting

## Ethological Theory

Ethology is the study of the biological bases of behavior. The basic thesis of the ethological approach is that all animals, including man, possess species-wide characteristics that are the foundations for the development of some social behaviors. People are born with certain innate behaviors that are the result of evolution and the process of natural selection. Ethnologists do admit that learning can modify these innate behaviors, but these innate behaviors also affect the learning experiences themselves and are therefore worth studying.

Ethnologists believe in studying people in a natural setting. They look for evolutionary causes for behaviors.

## KONRAD LORENZ

Nobel Prize-winning ethnologist Lorenz has shown that there is a short period of time early in the lives of geeselings and ducklings in which they begin to follow the first moving object they see: their mother, a human being, a rubber ball, etc. (imprinting). Once imprinting has occurred, it is irreversible; the object becomes "mother" to the birds; therefore, they prefer it to all others and will follow no other.

Critical Period is the short period of time early in life during which a permanent and binding attachment to a particular object is formed, the time during which imprinting takes place (McMahon & McMahon, 1986).

## JOHN BOWLBY

Human infants are born with a number of behavior systems ready to be activated by appropriate "elicitors" or "releasers." Bowlby believes that inborn mechanisms account for attachment behaviors. An example is a human face triggering an infant's smile.

Attachment theory formulates the idea a child has the capacity to develop an emotional bond with a caregiver (parent) and has the security to explore his/her surroundings. As a result, the child begins the process of being able to form interpersonal relationships. Bowlby (1982) studied prolonged separation from and its effects. He noted that if separation continues the baby will protest. This protest is in the form of crying and refusing care by others. Refusing care by others is followed by despair, withdrawal, and finally detachment. Finally the child will accept the care of others. Theorists who interpret Attachment Theory suggest that a failure to form these attachments during early life leads to psychological concerns later in life, often surfacing during the adult years. Ainsworth (1989) and Bowlby's (1988) interpretation of attachment for the adjusted child is that as his/her cognitive development expands, the child internalizes the caregiver in the form of expectations. These expectations are in the form of the child being able to:

1. access the adult and responsiveness to the child
2. elicit responses from the adult

Bowlby (1988) referred to these as working models and Ainsworth (1989) developed three behavior patterns that reflect different adaptations for attachment. These are:

1. secure - explore their environment and protest separation behaviors from the adult
2. avoidant - explore without their base (adult) and ignore separation, avoid reunion
3. anxious-ambivalent - refuse to explore and express anxiety during separation

## MARY AINSWORTH – Attachment

Ainsworth (1989) worked with John Bowlby and believes that infants gradually become developmentally ready to form a genuine attachment to another person (interpersonal). Ainsworth used the Strange Situation technique to determine the secure base of a mother-child attachment.

Those studies were the basis for Ainsworth's classification of attachment. By the time a child is three years old, he or she has passed through four phases of attachment.

Four phases of attachment in human infants (Ainsworth, 1989):

1. Social Responsiveness - During the first two or three months of life, infants use signaling and orienting behavior, such as crying, to establish contact with others. They do not yet distinguish primary caregiver. At 3 to 6 months, they begin to signal and orient more toward primary caregiver.
2. Discriminating Social Responsiveness - 2 to 7 months. The child is becoming aware and is showing a preference for a familiar person yet would not show a preference for one over another.
3. Active Proximity Seeking - 7 months to 2 years. Child actively seeks contact with caregiver and resists separation. The first clear attachment is formed, frequently with the mother. Shortly thereafter, attachments with others are formed.
4. Partnership behavior - Around age 3, the infant begins to see the caregiver as a separate person and develops a give-and-take relationship with the caregiver. The child is able to make adjustments based upon another person.

Her four classifications are (Dacey & Travers, 2003):

1. Securely attached: the mother is the base from which to explore, separation intensified attachment, exhibited a great deal of distress, ceased exploration, and upon reunion sought contact.
2. Avoidantly attached: rarely cried during separation and avoided mothers at reunion. Mothers were indifferent to contact.
3. Ambivalently attached: manifested anxiety before separation and distressed at separation, and upon reunion resisted.
4. Disorganized/disoriented: confused at reunion - little emotions.

Her work on attachment reflected a child's responding to an intimate interpersonal relationship. As a result she identified three patterns noted above with Bowlby that were later modified by Bartholomew and Horrowitz (1991) in their efforts to measure attachment. The modified terms and brief descriptions are as follows:

1. secure (find intimacy and autonomy comforting)
2. preoccupied (relationships a priority)
3. fearful (avoid intimacy)
4. dismissing (counterdependent and dismiss intimacy)

Main (1996) has extended the attachment research to establish the link of early attachment to present continuity and classifies adult as:

1. Autonomous: value relationships, attachments help their development
2. Dismissing: denied influence of attachment on their lives
3. Preoccupied: speak of parents in angry format
4. Unresolved/disorganized: unresolved loss

Descriptions of these classifications have been abbreviated and for a fuller description of the research and classifications consult Main, 1996 source.

**Question 3-13:**
A counselor who is trained in the ethological theory and attachment theory is conducting counseling with an adolescent male who was referred by his high school counselor. The youth indicates he is confused by his feelings for his father, who is a traveling consultant and frequently away from the home. He misses his father, wants him to be at home (return from his trips), and yet has feelings of anger when he does come home. He finds that he develops reasons to be away from the home when he knows his father is returning. While away he feels a gnawing desire to be there for his father's return. The counselor would identify this as which one of Ainsworth's attachment patterns?

a. anxious/ambivalent
b. secure
c. avoidant
d. strange situation

Answer: a. anxious/ambivalent. The two characteristics of the pattern have to do with responses to separation and reunion.

# Physical Growth and Maturation

## ARNOLD GESELL

Arnold Gesell established norms for the development of early-motor and sensory-motor behavior. The development of these norms was an attempt to chart the course of human growth according to significant markers, which would signal normal, accelerated, or retarded development in the individual child. This view of human development stresses the maturational "readiness" of children to perform particular motor acts. Arnold Gesell was one of the first theorists to develop a model for identifying the physical growth and subsequent behaviors for infants. The Gesell Scales were such norms developed for this purpose of comparison. He studied motor behavior and adaptive behavior (tasks) and considered them to be age-specific. Although these scales have been criticized as poor predictors of intelligence and as poorly normed, they are widely applied. The scales measure adaptive behaviors, language, and personal-social abilities. Gesell believed that the child's growth process is at the center of the child's potentialities. All of the child's development is sequential and progresses through stages (Gesell, 1949).

1. Day Cycle: Growth is an expanding process that occurs every day.

2. Self-regulatory fluctuations: Instability and growth occur at the same time, moving the person toward maturation.
3. Constitutional Individuality: Each child is unique and has his own growth mode (Gesell, 1949).

Four Major Fields of Behavior/Growth:

1. Motor behavior: Gross bodily control and finer motor coordination, such as postural reactions, head balance, sitting, standing, creeping, walking, grasping, and manipulating objects.
2. Adaptive behavior: Fine motor coordination, eye-hand coordination, and initiation of adjustment for simple problems.
3. Language behavior: Visual and audible forms of communications such as facial expression, gesture, vocalizations, words, comprehension of the communications of others.
4. Personal-social behavior: Feeding abilities, sense of poverty, cooperativeness, responsiveness to training and social conventions.

## Developmental Stages

INFANCY (Birth to two weeks old.)
Completed when umbilical cord falls from navel, and child has regained weight lost at birth. Radical adjustment (four changes):

1. temperature (from in mother's body to outside)
2. breathing (cord to own)
3. sucking/swallowing
4. elimination

BABYHOOD (two weeks to two years)

1. gradual decrease in helplessness
2. Erikson's trust vs. mistrust stage
3. negativism
4. socialization-egocentrism - attachment behavior (Bowlby)
5. sex-role typing
6. walk, talk, solid foods, partial control of some organs, sleep increases from 8 1/2 to 10 hours (night sleep)
7. handedness
8. emotions: anger, fear, curiosity, joy, affection
9. play reinforces problem-solving and creativity (Bruner)
10. morality by constraint; obedience to rules without reasoning or judgment

Novelty paradigm: Infants show a preference for new stimuli over familiar stimuli.

Surprise paradigm: Infants show surprise when their expectations are not met. This is measured by changes in breathing or galvanic skin response.

Visual Cliff: A testing tool that simulates a drop-off to test depth perception of infants.

Object Permanence: When infants are about 18 months old, they begin to realize that objects continue to exist though they are no longer in sight.

EARLY CHILDHOOD (two to 13 years for girls, and 14 years for boys; Parten, 1932, Tomlin, 2008)

1. toy age until school year
2. formal education begins at age 6
3. after children become sexually mature, they are adolescents
4. Mildren Parten's six levels or stages of social play/interaction (Gander & Gardiner, 1981)
    a. Unoccupied play (behavior): not playing or watching anyone
    b. Onlooker play: most of time watching others play-do not engage in play
    c. Solitary play: plays alone, no connection or conversation is made
    d. Parallel play: plays alone but with toys that are shared with others-limited communication
    e. Associated play: child shares materials and interacts with other children, but does not share the same goal of play (independent)
    f. Cooperative play: child plays with others and engages in same goals of play with others, such as playing house with an agreement on the rules

LATE CHILDHOOD (six years to sexual maturity)

1. troublesome era
2. reject parental standards
3. age of conformity, acceptance by their peers
4. skills
    a. self-help
    b. social-help
    c. school
    d. play
5. play interests include constructive play; exploring, curiosity; collecting - from skills to cards, and games/sports
6. antagonistic attitude toward opposite sex

Reversible thinking The child not only sees that the liquid can change shape and remain the same in volume, but the child knows that it could return to the first shape if poured in the original container.

Metacognition Process of monitoring one's own thought processes (around age 6).

ADOLESCENCE (puberty to 18 years)

1. puberty (period of about two to four years)
2. caused by hormonal changes
3. girls first menstruation
4. boys nocturnal emissions
5. changes in body size, body proportions, development of primary sex characteristics, development of secondary sex characteristics
6. search for identity
7. change is internal
8. more permissiveness in sexual behavior
9. family relationships change, in some cases drastically
10. task is to make transition to maturity
11. issues adolescents bring to the counselor's office include physical hazards, homeliness, heterosexual interests, friendships, suicide
12. sexual behavior

Sexual Behavior: During puberty, adolescence, and through adulthood, sexual development is ongoing. It is a time of acquiring first information of gender sexual anatomy, coping behaviors, and patterns related to sexual behaviors. Masters and Johnson (1966) developed a four-phase response cycle. A description of each phase is as follows:

1. Excitement Phase: This is the phase of sexual stimulation where heart, respiration, and blood pressure rates increase. Additional physiological activity occurs such as erection, engorgements, etc.
2. Plateau Phase: This phase prepares the body for orgasm. There is increased stimulation of the body parts and functions.
3. Orgasm Phase: Heart and respiration reach their peaks. Muscles in female and male sexual organs contract rhythmically.
4. Resolution Phase: The body returns to a comfortable and level state.

## ROBERT HAVIGHURST

Robert Havighurst described four stages of adulthood: early adulthood, middle adulthood, later adulthood, and very old age. Each stage is composed of three or four tasks to be accomplished. Havighurst (1951) listed three tasks for each stage of life. These tasks ideally were midway between the needs of the individual and the ends of society. To succeed in life, a person needs to accomplish these tasks in order to acquire the skills, knowledge, functions, and attitudes in his/her development. He

referred to these as developmental tasks. Adolescent development was composed of nine tasks and covered two stages:

1. accepting one's physique and accepting a masculine or feminine role
2. forming age/mate relations of both sexes
3. independence of emotions from mother and father as well as other adults
4. economic independence
5. occupational selection and preparation
6. achieving civil competence via intellectual skills and concepts
7. acquiring socially responsible behavior
8. preparing for marriage and family life
9. conscious values in harmony with current world

It was his belief that society guided the individual in the skills that needed to be acquired for each age. Learning developmental tasks occurred at times when a person was ready to acquire a specific skill. Havighurst referred to these times as teachable moments that occur at sensitive periods or times. If an individual did not learn the appropriate skill during the sequence, it would be difficult to learn at a later time. Havighurst developed stages and developmental tasks from birth to very old (death).

EARLY ADULTHOOD
(exploring intimate relationships, work, lifestyle)

1. Selecting a mate
2. Learning to live with the mate
3. Starting a family
4. Rearing children
5. Managing a home
6. Getting started in an occupation
7. Taking on civic responsibility
8. Finding a congenial social group

MIDDLE ADULTHOOD
(management of career, nurturing marital relationship, caring relationships and household)

1. Achieving adult civic and social responsibility
2. Establishing and maintaining an economic standard of living
3. Developing adult leisure-time activities
4. Assisting teenage children in becoming responsible adults
5. Relating oneself to one's spouse as a person
6. Adjusting to physiological changes

7. Adjusting to aging parents

LATER ADULTHOOD
(intellectual vigor, new roles and activities, acceptance of life, point of view regarding death)

1. Adjusting to decreasing physical strength
2. Adjusting to retirement and decreased income
3. Adjusting to death of spouse
4. Establishing an explicit affiliation with one's age group
5. Meeting social and civic obligations
6. Establishing satisfactory physical living arrangements

VERY OLD AGE
(coping with physical changes)

MATURITY
A mature person is a realistic individual with a thoughtful sense of values and an underlying meaning to life that is maintained with integrity. The individual has achieved a state of harmony between self and social groups.

1. Increased stability of organizations; maintains identity routine; behavior is less impulsive and comes under control of cognitive processes
2. Progressive integration of new information
3. Increased allocentrism
4. Increased autonomy

# OBJECTIVE 3B: Learning-Personality

## Learning Theories

Learning theorists believe that human beings are born neither good nor bad. The prominent idea is that people do nothing more than respond to their environment. Some of the ways learning can occur are classical conditioning (Pavlov), operant conditioning (Skinner), and observational learning (Bandura).

### IVAN PAVLOV

Classical Conditioning: Unconditional stimulus - the stimulus that already evokes an unconditional response.
Example: meat (UCS) —> salivation (UCR)

Conditioned Stimulus - the stimulus that is paired with the unconditioned stimulus in hopes that it will eventually evoke a similar response when presented alone.
Example: meat (UCS) —> salivation (UCR) buzzer (CS)

After several pairings, the CS (buzzer) will hopefully be able to evoke a conditioned response (salivation) when presented without the UCS (meat).
Example: buzzer (CS) —> salivation (CR)

Delayed conditioning in which the conditioned stimulus is presented and continued throughout the presentation of the unconditioned stimulus is the most effective way to condition a response.

## Classical Techniques (Developed by various theorists)

Systematic Desensitization - Developed by Wolpe from the work of Jacobsen (anxiety/fear) (relaxation response). Based upon principles of counterconditioning.

Reactive or Internal Inhibition - Flooding, anxiety evoking stimulus is presented continuously, leading to fatigue and eventual unlearning.

Counterconditioning - A stronger pleasant stimulus is paired with a weaker aversive stimulus.

Aversive Conditioning - Application of an aversive or noxious stimulus, such as rubber band snap on the wrist when a maladaptive response occurs.

### B. F. SKINNER

Operant Conditioning: A response is learned because of the consequences that follow. The organism has to do something before it can be conditioned.

1. Primary reinforcement satisfies a primary need. (example: food)
2. Secondary reinforcement includes reinforcers that have somehow been associated with primary reinforcers in the past so that they have acquired reinforcing qualities. (example: money)
3. Positive reinforcement occurs when something positive or pleasant is received by an organism after a particular response is made. (example: a child receives a sticker for picking up toys)
4. Negative reinforcement occurs when something unpleasant or negative is stopped when the organism makes a particular response. (example: an inmate is released from prison for good behavior)
5. Reinforcement, both positive and negative, increases the likelihood of a response. Punishment decreases the likelihood of a response.

Reinforcement Schedules: Continuous reinforcement is presented each time a response is made.

Intermittent: Reinforcement is not provided each time a correct response is made. Intermittent reinforcement can be in an interval or ratio form.

1. Variable-ratio: Reinforcement is presented so that it averages a particular number of correct responses. A random assignment is made, such as one out of every four as an average.
2. Fixed-ratio: Reinforcement is presented after a set number of correct responses, such as every third correct response.
3. Variable Interval: Reinforcement is presented so that it averages a particular time interval, such as an average of one reinforcement every seven minutes.
4. Fixed-Interval: Reinforcement is presented at the end of every set time period, such as, after every seven minutes, but the response has to be correct.

Operant Techniques: Operant techniques have been developed by various theorists and are frequently referred to as instrumental type learning. The individual learner must first provide a response and then he/she will associate the response with a positive or negative consequence. This premise, made famous by B. F. Skinner, was that the learner will do again what he or she found to be pleasant and will cease behaviors he/she finds unpleasant. Thus, reinforcement will strengthen and increase the likelihood that those behaviors will be repeated. Below are some operant techniques:

1. Contingency Contracting (Ayllon & Azrin, 1968):
    a. Identify problem
    b. Collect data
    c. Set goals
    d. Apply techniques and methods
    e. Measure observable change
    f. Reloop if not successful: (Reason for developing contingency contracts is the realization that parts of the plan might not work.)
2. Self-Management: Client has an extremely participatory role in his or her own therapy. Therapist is a motivator.
3. Shaping: Reinforcing new behavior that approximates desired behavior. Therapist looks, waits, and then reinforces.
4. Biofeedback: Any technique that uses an instrument to provide immediate feedback on physiological functions.
5. Modeling: Exposure of the client to one or more individuals in real life or film who are emitting the behavior that is desired of the client.
6. Token Economies: Used for groups. This economy is based upon tokens that can be traded for other reinforcers and are given or taken away for various behaviors. This technique should be used to get clients to begin new behaviors, but should not be used indefinitely.
7. Behavior Practice Groups:
    a. Weight loss
    b. Study habits
    c. Assertiveness training

    d. Communication skills
    e. Negative addictions
8. Extinction: Terminating or withholding reinforcement from the problem behavior. Extinction is most effective when used in conjunction with reinforcement of another, more desired behavior.
9. Punishment:
    a. Punishment serves to draw attention to undesirable behavior but does little to indicate what the desirable behavior should be.
    b. Punishment does not eliminate behavior but usually only suppresses it. What is affected is the rate of responding.
    c. Punishment can lead to emotional states that will probably not be associated with love or happiness or any other pleasant feeling. These negative emotional states may, through contiguity, become associated with the punisher rather than with the undesirable behavior.
    d. Punishment often does not work.
10. Aversive Training: Aversive training is to punish certain behavior with the intent the behavior will be eliminated. A technique for aversive training is time out. A time out is designed such that the behavior in question is followed by a brief amount of time in isolation or inactivity. This technique is recommended for temper tantrums in public places. An example might be a small child who becomes upset while company is present. The child can be secluded to his/her room for a short period of time.

**Question 3-14:**
John's parents are trying to teach him to pick up his toys. They decide to first reward him when he walks near the pile of toys. This is an example of?

a. modeling.
b. self-management.
c. negative reinforcement.
d. shaping.

Answer: d. shaping.

**Question 3-15:**
An employee is congratulated twice in one week by his boss but is not congratulated again for a month. Which one of the following reinforcement schedules does this follow?

a. variable-ratio
b. fixed-interval
c. variable-interval
d. fixed-ratio

Answer: c. variable-interval

## JOHN B. WATSON

Watson, the father of behaviorism, believed that the mind of an infant is a tabula rasa, or a "blank slate." He also believed that human development occurred due to the learned associations between stimuli and responses. To Watson, development was a continual process, rather than one which proceeded in stages.

Watson was not concerned about motivation as much as about all behavior. He said humans inherit only three basic emotions: fear, love, and rage. Watson is often cited with the famous Watson-Raynor experiment in which fear was to be conditioned and then deconditioned or eradicated. This study is referred to as the "Little Albert" experiment.

## JOSEPH WOLPE

Joseph Wolpe, in his efforts to treat phobias and fears, developed systematic desensitization. He believed that psychosis was learned. Systematic desensitization is a process of developing a fear hierarchy and a set of relaxation exercises. The two lists are paired so that the fear is elicited but does not pass beyond (is not stronger than the relaxation) the threshold. The relaxation that is paired with the fear is to be stronger than the fear.

Reciprocal Inhibition: According to Wolpe, nonadaptive behavior is learned through conditioning and is accompanied by anxiety (Patterson, 1966).

Basis of Learning: Pavlov and Clark Hull provided the learning principles that govern classical conditioning. A response is connected to a conditioned stimulus, thus learning. Reinforcement strengthens the connection and reduces drive. No reinforcement means response extinction.

Pathology: Neurosis is experimentally induced in animals has been known to be generalized to humans. Neurosis is the persistence of nonadaptive behavior that reduces anxiety (learned).

Therapy: Therapy is the removal of nonadaptive behavior through reciprocal inhibition. This is a process of inhibiting, eliminating, or weakening of old responses by new behaviors through drive reduction.

Methodology:

1. Assertive responses
2. Sexual responses
3. Relaxation responses
4. Desensitization and hypnosis
5. Respiratory responses
6. Direct conditioning

7. Explanation
8. Prescribed activities
9. Encouragement and assurance

Nature of Man: Man is an organism with neural capacity to respond to stimuli. These responses form the basis for learning.

## EDWARD L. THORNDIKE

Thorndike believed that all learning consisted of associative bonds between situations and responses (Byrnes, 2001, 2008). Thorndike introduced the terms Law of Exercise and Law of Effect, better known today as operant conditioning. His basic position was as an associationist. The basic understanding to his theory is connectionism (S-R), a sensory impression with impulses to action. Thorndike developed a learning curve and used cats to develop his learning theory. He proposed the Law of Effect and five subsidiary laws to explain learning (LeFrancois, 1982).

Law of Effect: Instrumental Learning: An organism will be influenced by the consequences. Responses that occur just before a reinforcing situation are more likely to be repeated and connected. The reverse is also true. A bond is developed between a situation and a response if a satisfactory state of affairs is present.

Five Laws of Learning

1. Multiple Response - Individuals attempt to solve problems through trial and error.
2. Set or Attitude - Learning also involves sets or attitudes that a culture has imposed, predisposing an individual to react in a certain way.
3. Prepotency of Elements - Individuals can react to certain prepotent (significant) elements in a situation and ignore the irrelevant ones.
4. Response by Analogy - In a new situation, an individual will transfer responses from other situations.
5. Associative Shifting - It is possible to shift a response from one stimulus to another.

If learning is to take place a lot of repetition is recommended plus rewards should follow correct responses. Thorndike also believed that related subjects should be separated in time (Bryne, 2001).

## EDWARD L. GUTHRIE

One-Shot Learning: Guthrie believed that everything was learning and that it took only one pairing (LeFrancois, 1982). The strength of a bond is made on the first pairing. Practice will not strengthen or weaken the connection or the learning. Complete learning occurs in one trial (Lefrancois, 1982).

Breaking Habits: Guthrie postulated three ways of breaking habits and each of these methods has been applied to theory.

1. Fatigue Method: Continuous presentation and repetition of a stimulus. Often called Bronco Busting.

   Example: Implosive Therapy by Thomas Stampfl

2. Threshold Method: Presenting the stimulus at an intensity level that will not elicit the habit, which will in turn present a different behavior. One then begins to increase the intensity of the stimulus, keeping it low enough not to elicit the habit but increasing the likelihood of the new habit being stamped in and retained.

   Example: anxiety and relaxation response

3. Incompatible Stimuli: Creating a situation where the old response is unable to be displayed. That is, present the stimulus when the habit cannot happen, thus creating a new behavior. Contiguity-The stimuli are paired together in time and space. When they are together they are paired and learned. Postremity - you remember the last thing you learned.

   Example:  A child comes home and drops his coat on the floor and wants to go to his room to play a game on his computer. Have the son put his coat back on and go back out and come back in again. Putting his coat back on and going back outside to walk back in and put his coat on the coat rack is incompatible with going to his room to play a game. This is similar to withdrawing a positive.

### JOHN DOLLARD AND NEAL MILLER

Dollard and Miller (cited in Shaffer, 1985) thought neurosis developed as a result of experience. Much of their explanation for this understanding was tied to their involvement in Hullian learning. The development of neurosis or learning occurs when a child's behavior is changed as a result of his or her experiences. As the child develops, the child forms a collection of habits that cause the child to respond to various stimuli with the appropriate social responses, which in turn reduce a primary or secondary drive.

Theoretical Orientation: Dollard and Miller integrate Hullian behaviorism, psychoanalytic concepts, and contributions of social science in their approach to psychotherapy.

The four fundamental factors that are important for all learning are:

1. drive or motivation
2. cue or stimulus
3. response
4. reinforcement

## Terminology

Habit: The stable aspects of one's character. The building blocks of the personality.

Primary drives: Unlearned motives, such as thirst and hunger.

Secondary drives: Learned motives not present at birth, such as the need for parental approval.

Primary reinforcers: Unlearned reinforcers, such as food and sex.

Secondary reinforcers: Learned reinforcers, such as money.

## Pathology

Neurosis is the result of conflict produced by two or more strong drives leading to incompatible responses.

## Therapy

Therapy is a learning situation in which neurotic responses are extinguished and better, normal responses are learned.

The following are elements of therapeutic learning:

1. lifting of repression
2. transference relationship
3. learning to label
4. learning to discriminate.

The desired outcome is the restoration of the higher mental processes. These processes require verbal and other cue-producing responses and thus depend on the removal of repression and on labeling.

## Six Conflict Behavior Assumptions

1. Tendency to approach the goal increases with nearness to the goal.
2. Tendency to avoid a feared goal increases with nearness to the goal.
3. The strength of avoidance increases more rapidly than the strength of approach.
4. Strength of approach and avoidance varies as a function of drive.
5. Response tendency depends upon number of reinforced trials.
6. When two responses are in conflict, the stronger will occur.

## Types of Conflicts

Approach-Approach Conflict: Two positive choices exist, but only one can be chosen, which means one will be lost or given up. The conflict in not deciding is that the two choices are equally attractive.

Example: A young child is given a choice between a power ranger or a Sponge Bob video for his birthday and he likes them equally well.

Approach-Avoidance Conflict: A conflict where the approach is something the person wants but is afraid of getting punished or receiving a negative reaction.

Example: A young man wants to date the homecoming queen but is afraid of being rejected by her and in front of others.

Avoidance-Avoidance Conflict: A third type of conflict where the person loses either way. If the behavior is performed, it will be painful; and if it is not conducted, it will be painful.

Example: A mother who wishes to avoid conflict by not disciplining her child, but wishes to avoid the embarrassment of her child's behavior. Either choice requires that she face something she wishes to avoid.

## Techniques and Methodology (Dollard & Miller, 1950)

Permissiveness: The therapist is warm, friendly, understanding, and not shocked by what he or she hears.

Free Association: The client is encouraged to report everything that comes into his/her mind, immediately and without reservations.

Rewards for Talking: The therapist gives full attention, accepts what the client says, understands and remembers what the client has said, calmly faces important revelations, of which the client is ashamed or anxious, and does not cross-question or make definite pronouncements.

Handling the Transference: The therapist attempts to overcome transference-induced reactions by the following:

1. interpretation of silence
2. pointing out that avoidance is an escape and urging the client to resume work
3. reframing from inferring that the transference reactions are purposely produced by the client
4. identifying transference responses and finding out how they arose
5. handling these reactions without anger or irritation

Labeling

1. The client may discover or create the new verbal unit, under the compulsion of free association.
2. The therapist may selectively strengthen the client's responses that he/she thinks are important without contributing his or her own ideas.
3. The client may rehearse responses provided by the therapist as interpretation.

Teaching Discrimination:

1. The therapist calls attention to problem areas in order to evoke new discriminations by failing to understand the client.
2. The therapist may discourage certain responses by labeling them as false or doubtful.
3. The therapist points out similarities between similar sets of stimuli.
4. The therapist points out the difference between the past and the present.

A counselor, in applying this approach, will identify and assess the personal and environmental events that shape decisions at critical points (choice points). These learning experiences are of three types:

1. Instrumental: These are reinforced behaviors that are repeated while punished behaviors are avoided. The repeated ones become self-reinforcing.
2. Associative: The individual associates past affective neutral stimulus with an emotional stimulus and the affective stimuli will be strengthened.
3. Vicarious: The individual learns by observing others.

The individual learns to apply a wide range of skills, involving work standards, work values, work habits, and perceptual habits that become modified by experiences and feedback. These interactions will bring about certain consequences based upon self-observation generalizations, task-approach skills, and world generalization. For more information, review the above three learning experiences in Unit Four.

**Question 3-16:**
A person is afraid to receive a flu shot because it is painful. She is also fearful of getting the flu. Which of Dollard and Miller's conflicts is she facing?

a. approach-approach
b. avoidance-avoidance
c. annoyance-avoidance
d. approach-avoidance

Answer: b. avoidance-avoidance

### ALBERT BANDURA

Albert Bandura, a social learning theorist, claims a great deal of behavior is learned through modeling and observing others. His theory is based on operant conditioning. In addition to imitating the behavior of adults, children mentally encode a model's behavior, thereby acquiring certain types of information and capabilities. Learning takes place as a result of observing and imitating people in the environment. By watching the behavior of others, people learn novel responses without having had the opportunity to make the responses themselves. Bandura recognized that learning was not permanent by observing but that a cognitive change had to take place. Today, Bandura's theory is called Linear-Interactionist Social-Cognitive Theory and is defined as an interaction of individuals with their perceived meaningful environments.

## Behavior-Control Systems

Stimulus Control (autonomic acts, under the control of stimuli or antecedents)

Outcome Control (under the control of consequences)

Symbolic Control (influenced by internal processes; self-instruction, imagining)

Observational Learning-most important contribution, as Bandura claimed there were three effects of observational learning:

1. the acquisition and performance of new skills
2. to disinhibit or further inhibit performance of already learned skills
3. to facilitate performance of previously learned behaviors

## Factors that enhance modeling

Characteristics of the model: Observers tend to be models with similar sex, age, race, and attitudes. Other characteristics of a model are competence, warmth, nurturance, and reward possibilities.

Characteristics of the observer: A moderate level of anxiety and uncertainty about the behavior to be modeled, and the ability to process and retain information.

Characteristics of the presentation: The model can be either live or symbolic, covert, multiple, and a master of the task or a learning, coping model. The model can use graduated modeling procedures, give instructions and rules, and can allow the observer to summarize. The presentation can be rehearsed, and distracting stimuli should be minimized (Kanfer & Goldstein, 1991).

**Question 3-17:**
If modeling were used to teach adolescents how to say "no" to drugs, who would make the most effective model?

a. teacher
b. coach who the children all respect
c. teenager who uses drugs
d. older teenager who does not use drugs

Answer: d. older teenager who does not use drugs. The model would be closest in age and attitude to the observers. Also, the teenagers are likely to look up to an older teenager. The fact that he or she is not known to use drugs would make the teenager appear more competent.

### JULIAN B. ROTTER

Rotter describes his social learning theory as expectancy reinforcement of developed constructs (Patterson, 1966).

Basis of Learning: Learning situations are inextricably fused with needs requiring satisfaction through mediation by others-attribute influences are based upon the work of Lewin, Adler, Kantor, Thorndike, Hull and Tolman.

Basic Concepts:

1. Behavior Potential - likelihood of a behavior occurring in a given situation.
2. Expectancy - individual's subjective probability estimate that particular behavior will attain reinforcement.
3. Reinforcement Value - degree of preference for a particular reinforcement.

Pathology: Pathology is avoided behavior because of some previously experienced specific punishment and/or learned inappropriate ways to attain satisfaction. A maladjusted person has expectancy that maladjustive behavior will lead to greater gratification than would constructive or adjustive behavior.

Therapy: Lowering expectancy that behavior will lead to gratification and increasing the expectancy that alternate behaviors will be gratifying.

Methodology:

1. Direct reinforcement.
2. Place a client into a situation where he can observe other person as a model for alternate behavior or retrospectively through discussion of other's behavior.
3. Deal with history to reduce expectancy of negative reinforcement of specific behavior.
4. Discuss and introduce alternatives and how they are carried out.
5. Create and reinforce expectancy that he is capable of looking for and trying out alternative behaviors.

Nature of Man: Man is physiological. Psychological needs are learned in relation to drives defined as physiological.

## Cognitive Theories

The cognitive theorists believe that there is a strong biological basis for development. Children have a strong need to actively explore their surroundings and adapt to their environment. Their cognitive abilities will largely determine personality development.

### JEAN PIAGET

Structural patterns of thought change as children mature and interact with their environment. Piaget worked with these changes that occur in the child's mode of thought. He believed there were sequential periods in the growth or maturing of an individual's ability to think, gain knowledge, and develop an awareness of one's self and the environment. Piaget's research and theory explanation was with how growing children intellectually adjusted to the world in which they live. He stated that children act upon, transform, and modify the world in which they live. In turn, they are shaped and altered by the consequences of their own actions. Furthermore, Piaget indicated that this dynamic interplay between an individual and the environment is the foundation of all knowledge and intelligence. Piaget defines and describes development as adaptation.

Adaptation is the most important process in intellectual functioning as it involves two processes (LeFrancois, 1982).

Assimilation: The process of taking in new information and interpreting it in such a manner that the information conforms to a currently held model of the world.

Accommodation: The process of changing a schema to make it a better match to the world of reality. A schema is a formation of mental or cognitive representations derived from adaptations. A child assimilates new information and attempts to fit it to present schemas and if this representation does not fit an accommodation takes place.

Children gradually modify their repertoire of behaviors to meet environmental demands. Children develop concepts or models for coping with their world. These concepts or schemas are the terms Piaget uses for cognitive structures that people evolve for dealing with specific kinds of situations in their environment. Equilibrium (equilibration) is a balance between assimilation and accommodation. As a result of this resolution, the child moves to a higher level of understanding - often abstraction.

Four Stages of Cognitive Development: (LeFrancois, 1982)

1. Sensorimotor Stage (0-2 years)-This stage is a relationship in the here and now where sensations and motor behaviors are learned. The child masters the principle of object permanence where he/she learns to differentiate between various objects and experiences and to generalize about them. The child does not play by rules. The child understands the world by the action one can take.
    a. Object permanency-Lack of object permanency in infants under a year old causes infants to not understand that when a toy is out of sight, it still exists.
    b. Symbolic substitution-The child learns that mental symbols can replace physical actions.

    Example: language
2. Preoperational Stage (2-7 years)-When the child can imagine doing something, there is movement into this stage. During this state the child develops the capacity to employ symbols especially language. Symbols enable the child to deal with things in another time and place. Egocentrism occurs in this stage meaning that children four or five years of age consider their own point of view to be the only possible one. They are not able to put themselves in another's place. The child will break and change rules many times. At this stage, the child can think in the past.

    Piaget listed four limitations of this stage. The four are:
    a. strong ties to perception, similarity, and spatial relations. That is, the dog is a cat, the dog is a duck, etc.
    b. unidimensional-think only of one aspect at a time. Example: conservation—centration
    c. irreversible—what is done cannot be undone. If you pull the tape out it cannot be retracted.

d. distinguishing between reality and fantasy. The difficulty reveals itself when children talk of their dreams and people as real people.

**Question 3-18:**

A couple has been referred by the school counselor because their first grade boy has some imaginary friends and possibly was developmentally delayed. Their friends, who had a boy about the same age, told them that their child, the same age, gave this up some time ago. They thought the couple should check for Autism spectrum because the child tells others that he has friends, gives them names, and that he sees them at night in his dreams. The counselor asked the couple for more child activity information which appeared to be normal for his age. The counselor decides the child is about to emerge into which of Piaget's stages?

a. Sensory
b. Preoperational
c. Concrete operational
d. Formal operational

Answer: c. Concrete operational. Piaget believed that the four limitations of the preoperational stage often disappear as the child enters the concrete operational stage. Children at this stage do not confuse reality and fantasy. Other learning researchers disagree with Piaget's reality-fantasy time and believe the child often reaches this as early as four or five (Bryne, 2001).

3. Stage of Concrete Operations (7-11 years) - Beginning of rational activity and mastery of logical operations. The young person will adhere to the rules in a rigid way.
    a. Classes, Seriating, Number, Conservation - At approximately age 7, children begin to understand that a liquid or a solid still contains the same amount of material, no matter how it is shaped.
4. Stage of Formal Operations (11 years and above) - Begins dealing with abstractions and can engage in hypothetical reasoning based on logic. The rules will change now by mutual consent.

**Question 3-19:**

In which of Piaget's stages of development does the child achieve object permanency?

a. Sensorimotor
b. Preoperational
c. Concrete Operational
d. Formal Operational

Answer: a. Sensorimotor. Object permanency is usually obtained just before a child's first birthday.

**Question 3-20:**

At which of Piaget's developmental stages does the child understand conservation?

a. Sensorimotor
b. Preoperational
c. Concrete Operational
d. Formal Operational

Answer: c. Concrete Operational. Schemata serves four functions. These functions are to categorize, remember, comprehend, and problem solve (Bryne, 2001).

## LEV VYGOTSKY: MIND

A fairly recent theory of cognitive development is that of Lev Vygotsky's sociocultural theory of psychological and elementary processes (Vygotsky, 1978). Learning occurs when these two processes interconnect. Biological processes that are qualitatively transformed into higher psychological functioning easily explain his concept of cognitive development in speech, thought, and learning. An important concept is internalization where interpersonal processes are transformed into intrapersonal processes. Speech is the main human tool used to progress developmentally.

Vygotsky's two main terms are function and concepts. Concepts are considered categories. A concept was a class of things that could be defined by criteria. If a child understood many concepts, that child possessed "true," which usually emerged during early adolescents. Prior to that time the child might describe a concept by one or two of the criteria for that concept. An example might be a blanket as soft or soft and light. Modeling and self-regulation are critical to the guiding process from dependent to independent learning.

Vygotsky's theory is known for five cognitive functions: language, thinking, perception, attention, and memory. Self-regulation is through the language function of communicative speech (external speech), egocentric speech (external speech), and inner speech (speech to self).

Higher order thinking is from lower forms of thought to higher forms. Vygotsky's definition of higher forms of thought is when there is a shift of control from the environment to the individual. That is from other-regulated to self-regulation. Secondly, the child has conscious access to the activity under learning and has a social origin. Third, symbols or signs now mediate the cognitive activity (Wertsch, 1985).

Zone of Proximal Development: The "distance between a child's actual developmental level, as determined by independent problem solving, and the higher level of potential development, as determined by problem solving under the guidance of an adult guidance…" (Valsiner, 1998, p. 36). The zone is the difference between what the child can achieve with guidance and what he can achieve through individual effort.

Scaffolding: a process where the child can move from a point of difficultly in learning to where, with help (teacher), he/she can eventually achieve the task independently. The intent is to provide just enough guidance where the child can learn independently. Instruction should be just ahead of where the child's current learning is at the presence. Instruction should be in three phases; 1) teacher models skill with verbal instructions for the 'why' of doing something, 2) child imitates what instructor does

with the verbal instructions, and 3) teacher is to "fade" or withdraw slowly from the instructional concept (Palinesar & Brown, 1984).

It is Vygotsky's belief that social and cultural processes shape children. That is, any cultural experience is experienced from two processes: the first, an interpsychological, a social exchange with others; the second, an intrapsychological, within the child an inner speech.

## Language Acquisition

Language acquisition is explained primarily through three different theories: learning, nativist, and interactionist.

Learning emphasizes that language is acquired through listening and imitating those in their environment. Language acquisition is a process of being reinforced for closer and closer approximations to the correct speech.

Nativist believes the child's biological capacities explain language acquisition. This acquisition is through a language acquisition device (LAD). This device has universal features of language, and the child has the capacity to figure out the rules of any language. The child only needs to hear someone speak and he/she will learn to grasp the meaning (Chomsky, 1968).

Interactionist uses both learning and nativist understanding. It is believed certain skills such as perceptual, cognitive, motor, social, and emotional development are vital to language acquisition. Jerome Bruner's three stages of language acquisition are outlined below:

### JEROME BRUNER

Jerome Bruner was one of the first language theorists to comment upon how children without a developed language learn when it is appropriate to respond.

Individuals follow a pattern and/or go through a series of stages in order to reach a level of sophistication they reveal in adult verbal communication (Bruner, 1983). Bruner's theory is based upon the following modes:

1. Enactive mode: Motor behavior that is movement of arms, legs, and body muscle in such a fashion to represent some type of object. This mode is mainly physical. In frustration, a child will shake a fist as an attempt to get attention. The ultimate is in dance, in which all movement is symbolic.

2. Iconic mode: This mode centers on images and represents objects, an important development toward symbols. The child imagines pictures that represent something.

3. Symbolic mode: The child starts to devise symbols, words, or gestures that stand for certain people, objects, or actions, but these symbols bear no resemblance to the real thing.

Problem-Solving: Problem solving is understood as higher ordered thinking and can be explained through two different approaches. These two approaches are developmental and definitional (Bryne, 2001).

Developmental Approaches: Piaget, Vygotsky, Bloom, and Novice-Expert focus on the acquiring of a learning taxonomy of terms such as abstraction, self-regulating, logical, conscious, and symbolic, to name a few.

Piaget's approach is to use terms of abstract and logical. Vygotsky's ideas of lower forms to higher forms start with a shift of control from the environment to the individual (self-regulation). The person that has an awareness of cognitive activity followed by the cognitive awareness has a social origin, and will use symbols to solve the problem. Bloom relies on the knowledge taxonomy he developed (knowledge, comprehension, application, analysis, synthesis, and evaluation). The Novice-Expert teaches novice-experts to study problem solving strategies of experts and compare to their own (novice). This theory has seven dimensions of expertise. These domains are:

1. Domain specificity-usually not transferable from one expert area to another area.
2. Greater knowledge and experience
3. Meaningful perceptions-experts see the whole while novice see the parts
4. Reflective qualitative problem solving
5. Principled problem representation-understand in a deep way
6. Effective strategy construction
7. Post analysis speed and accuracy

Definitional Problem Solving Approaches: Sternberg and Resnick developed models that reflect the definitional approach to problem solving.

Briefly, Sternberg's Information processing approach has three clusters, metacognitive (problem definition, planning, and resources), performance (encoding, inferences, mapping), and knowledge acquisition (selective encoding, selective combination, and selective comparison).

The Ideal problem solver uses two domains, a set of problem solving strategies and specific knowledge.

Resnick approach focuses on higher order thinking that is not visible from any one point. She indicates there are many solutions (complex) and is effortful (mental energy).

The additional steps are to involve nuanced judgments, multiple criteria, uncertainty, self-regulation, and meaning.

The Actively Open-Minded approach has two components for higher order thinking, which are: competence and performance (Bryne, 2001). McMahon and McMahon outline a four-stage model for problem solving.

Stage 1: Preparation-understanding what the problem is and bringing together information that will help to solve the problem (McMahon & McMahon, 1986)

Stage 2: Incubation-letting the problem wait a while so possible solutions will occur to us

Stage 3: Illumination-the actual occurrence of the solution

Stage 4: Verification-the process of verifying that the solution chosen was the correct one

Obstacles to Problem-Solving:

1. Set-the tendency to solve new problems the way old ones were solved.
2. Functional Fixedness-the tendency to see objects for their most obvious function and ignore possible alternatives

**Question 3-21:**
What do good problem-solvers do after they have found a solution to a problem? They:

a. verify the solution.
b. put the problem out of their minds.
c. create alternative solutions.
d. reward themselves.

Answer: a. verify the solution. The problem-solver verifies that the solution he or she has chosen is correct.

## Cognitive Therapies

The most common cognitive therapy approaches are Aaron Beck's Cognitive Therapy and Albert Ellis's Rational Emotive Therapy. Twenty other therapies are listed in Mahoney and Lyddon (1988). Some of these are:

1. Personal Construct Therapy - George Kelly
2. Logotherapy - Victor Frankl
3. Multimodal Therapy - Arnold Lazarus
4. Rational Behavior Training - Maxie Maultsby
5. Cognitive Behavior Modification - Donald Meichenbaum
6. Cognitive Developmental Therapy - Michael Mahoney

Problem-solving Therapy (Dobson, 1988)

1. Interpersonal Cognitive Problem-solving (ICPS) - Spivack and Shure
2. Self-control Training - T. D'Zurilla and M. Goldfried
3. Personal Science - Michael Mahoney

4. Self-control Therapy - L. P. Rehm

Cognitive Restructuring (Dobson, 1988)

1. Rational Emotive Therapy - Albert Ellis
2. Cognitive Therapy - Aaron Beck
3. Self-Instructional Training - Donald Meichenbaum
4. Rational Behavior Therapy - Maxie Maultsby

Coping Skills (Dobson, 1988)

1. Anxiety Management Training - R. M. Suinn and B. Richardson
2. Stress Inoculation Training - Donald Meichenbaum
3. Systematic Rational Restructuring - M. Goldfried

## Cognitive Change Procedures

Cormier and Cormier (1998) point out two important assumptions of cognitive therapy. The first is that a person's thoughts and beliefs can contribute to maladaptive behavior. The other is that maladaptive behaviors can be changed by targeting the person's beliefs, attitudes, and thoughts. Two change procedures are cognitive modeling and cognitive self-instructional training. The plan is to teach the client the procedure and rationale and finally for the client to self-initiate self-instruction as needed.

1. Cognitive Modeling:

   Counselors demonstrate to clients a cognitive change procedure in "what to say to themselves while performing a task" (Cormier & Cormier, 1998, p. 344).

   Steps:

   a. Counselor serves as the model and first performs the task while talking aloud to him/ herself.
   b. Client performs the same task while the counselor instructs the client aloud.
   c. Client is instructed to perform the same task again, while instructing himself/ herself.
   d. Client whispers instructions while performing the task.
   e. Client performs the tasks and instructs himself/herself covertly.

   Procedure:

   a. Provide rationale
   b. Cognitive modeling of the task and of self-verbalization.
   c. Client practice
   d. Overt external guidance

e. Overt self-guidance

f. Faded overt self-guidance

g. Covert self-guidance

h. Homework and follow-up

2. Thought-stopping

Thought-stopping was introduced by J. A. Bain but was developed by J. G. Taylor. The rationale is to control unproductive or self-defeating thoughts and images by suppression or eliminating negative cognitions. Empirical evidence is limited.

Procedure:

a. Provide rationale

b. Counselor directs thought-stopping:

b1. Interruption: Counselor assumes control of the interruption (LOUD STOP). Client is instructed to verbalize all thoughts and images aloud.

b2. Second effort: Visual again, but this time does not talk loud. Instead, uses hand signal to inform: STOP.

c. Client directs thought-stopping: Client now assumes responsibility for interruption: LOUD STOP

d. Client-directs thought stopping: Covert Interruption Client stops thoughts covertly.

e. Shift to assertive, positive, or neutral thoughts. Explain reasons for substituting positive thoughts. Different thoughts should be used so that saturation does not occur.

3. Cognitive Restructuring or Cognitive Replacement:

Focus on faulty reasoning and illogical or irrational inferences and beliefs.

Goal: Alter irrational beliefs or negative self-statements.

Clients: Socially anxious clients.

Rationale: Self-talk can influence performance especially changing self-defeating thoughts or negative self-statements that cause emotional distress and reduce performance.

4. Reframing:

Modifies or restructures a client's perception or view of a problem.

Procedure: Cormier and Cormier (1998) list six components of cognitive restructuring.

Goal: Correct mistakes in encoding, identifying, and modifying client's perceptions.

5. Stress Inoculation:

Stress inoculation is a method to teach physical and cognitive coping skills. A psychological protection set of skills that function the same way as medical inoculation, a prospective defense or set of skills to deal with future stressful situations. Resistance is enhanced by exposure to a stimulus strong enough to arouse defenses without being so powerful that it overcomes them. Meichenbaum (1993) points out that stress inoculation equips the client with knowledge, self-understanding, and coping skills.

Goal: Teach physical and cognitive coping skills, anger control.

Procedure:

a. Before: anticipate, prepare
b. During (very angry): confront self, lose control (cope)
c. After: encourage yourself
d. Information on Coping Skills
e. Acquisition and Practice

**Question 3-22:**
A counselor is helping a client to avoid negative self-talk. Each time the client says something negative about himself, the counselor yells, "STOP." Which technique is the counselor putting to use?

a. cognitive restructuring
b. reframing
c. thought-stopping
d. cognitive modeling

Answer: c. thought-stopping

# Humanistic Theories

Humanistic theories resist both the biological determinism of the psychoanalytical theories and the environmental determinism of the learning theories. Humanistic theories focus on the individual's perception of himself or herself. Humanistic theories are more or less holistic; they reflects that people can make choices about their lives. They believe that humans are intrinsically good and are more than the sum of their parts.

## ABRAHAM MASLOW

Maslow believed that people have an innate need for self-actualization. However, self-actualization cannot be met until other needs are filled. These needs are arranged on a pyramid-shaped hierarchy (Maslow, 1954). No level can be achieved until the level below it has been achieved. The hierarchy is as follows:

1. Self-actualization
2. Esteem needs (confirmation)
3. Belongingness needs (love, be loved)
4. Safety needs (to feel secure in daily life)
5. Physiological needs (like food, warmth, rest)

Self-actualized people are older. Most of the self-actualized people Maslow studied were over 60 years of age.

## Neuroscience

CACREP objective 3.b recommends that counselors develop an understanding of neurobiological behavior regarding the nature and needs of persons at all developmental levels. This understanding involves brain chemistry and effects regarding human growth and development. Understanding the developments and implications when issues arise cuts across all eight objectives of this unit. Neurobiological behavior is defined as "the relationship among brain anatomy, function, biochemistry, learning, and behavior" (CACREP, 2009, p. 60). This form of feedback is essential in recognizing, monitoring, and training clients to self-regulate in those areas where brain waves and chemistry is of such importance to improved health. For interested readers a comprehensive article written by Myers and Young (2012) provides an extensive coverage of biofeedback, neuroscience feedback and potential uses in counseling. A summary of their findings will be included for an appreciation for this training and intervention implementation of neuroscience research.

Darwin was the first to suggest that emotions such as anger and fear have an innate neural basis. Emotions of panic, sadness, surprise, interest, happiness, and disgust are part of the early understanding of the mind-body connections (Ross, Homan, & Buck, 1994). Heilman, Bowers, and Valenstein (1985) refer to the relationship between the right brain and primary emotions. As a result neuroscience feedback is based on this relationship. The smart vagus nerve is associated with the active processes of attention, motion, emotion, and communication. For readers interested in learning about the relationship among emotions, attachment, communication, and self-regulation read Porges (2011) The Polyvagal Theory.

The function of neuroscience feedback is to allow clients to monitor and make changes with brain wave patterns that assist in self-regulation and symptom reduction. Research by several authors have identified changes in alpha, beta, and theta waves that are associated with different emotions and disorders. If clients learn to regulate brain waves it will improve autonomic regulation, promote brain competencies, help remediate brain-based disorders, and improve underlying conditions (Arns et al., 2009). Another positive outcome is there have been no side-effects reported.

Understanding how the brain works in terms of neuronal transmission and the blood-brain barrier has been helpful in understanding how medication and drugs alter the chemistry of the brain and neural receptor activity and changes. The impact for the counselor and intervention strategies is to educate

clients how issues are linked to normal functioning. As such the client can understand the bridge to awareness how their experience might link to their issue. The counselor will be able to teach the client the symptom impact. Jencius (2014) pointed out from research of others that there are mirror neurons. These neurons fire whether the person is in action or observing. If this activity is present whether in activity or observing the implications for intervention during the therapy hour is enhanced and suggestive of new techniques for clients. Jencius likens the mirror neurons to empathy.

For research purposes findings and knowledge acquisition Henirich et al. (2007, p. 54) describe wave length during sleep as delta (1-4 cp), drowsing or daydreaming takes place as delta (less than 4 Hz), theta (4-7 cps, 4-8 Hz), alpha waves (8-12 cps, 8-13 Hz) as brain idling and ready for action, beta waves (13-21 cps*, 13-30 Hz) thinking, focusing and sustaining action and high beta waves (20-32) with hyperactivity and anxiety (p.22).

*cp(cycles per minute), hz (hertz)

Research findings:

1. Low frequency brain waves are associated with relaxation and meditation and trainable (Othmer, Pollock & Miller, 2005)
2. Too little alpha in right hemisphere correlates with social withdrawal and depression
3. Too much beta in the right hemisphere is correlated with mania (Soutar & Longo, 210, p. 70).
4. High beta wave frequency was found with OCD, sleep disorders, ADHD, anxiety, depression, and learning disorders (Demos, 2005)
5. Alcohol abusers have lower levels of alpha and theta waves and extra beta waves (Peniston & Kulkowsky, 1989)
6. When beta waves reach a range of 20-32 cps it is often associated with hyperactivity and anxiety.
7. Most ADHD children have slow theta wave activity (Loo & Barkley, 2005)

Counseling Implications

Ivey et al. (2009) points out that there is a relationship between biological and psychological functioning that has implications for counseling. These concepts are:

1. The brain can change and remodel itself
2. The brain is capable of building new pathways
3. Counseling skills such as attending are measurable with brain imaging, empathy can be identified/measured
4. Each person's emotions fire in different parts of the brain
5. Training in the frontal cortex will promote strengths and wellness.

**Question 3-23:**
Biofeedback and neuroscience feedback has identified a relationship that exists between biological and psychological functioning and can be measured. Two that can be measured are?

a. anger and confrontation
b. rescuing and empowerment
c. attending skills and empathy
d. frustration and fear

Answer: c. attending skills and empathy

# OBJECTIVE 3 – Disasters, Crises, Trauma

## Trends, Disaster, Effects, and Response

Trends for disaster preparedness and response are evident in both medical and psychological training for victims, administrators and service providers for increasing numbers of disasters. Disasters throughout the world have focused the attention on national and international figures for immediate responses. During and after a trauma first responder efforts have been rescue and after-care for victims of earth quakes, mud slides, tornadoes, typhoons, hurricanes, tsunamis, and disasters resulting from human causation. Large-scale disasters such as the Asian tsunami and Hurricane Katrina (Fernando & Herbert, 2011), garment factor collapse in Bangladesh killing 100, Hurricane Andrew, and 9-11 have accounted for serious loss of life and major life adjustments for those survivors. The sustained stress and decision-making during life and death decisions such as those taking place during the Katrina hospital patient evacuation resulted in desperate actions (Fink, 2013). These have become global concerns ranging from the mud slides in Oso, Washington, Japanese power reactor spills, New York City Sandy flooding, multiple tornadoes striking a community, Hurricane Haiti, typhoon in the Philippines, Twin Towers, Fukushima nuclear disaster in 2011, and loss of lives in the thousands at several of these sites.

These disasters have called upon local, state, and federal relief efforts for locating living and dead victims, notifying and reconnecting family members, housing, food, medical assistance, debriefing and psychological assistance in the form of counseling. In the past agencies responses have been by the American Red Cross and federal agencies such as FEMA, military presence for civil order, evacuations, and needed supplies, and international assistance.

Physical and psychological recovery efforts for many reach beyond the time of the disaster. In fact, the prevailing thought is to wait and observe before attempting debriefing and or restorative efforts (documentations lacks effectiveness studies for debriefing). At risk victims are those who do not respond immediately and who may lack coping skills, resources, and family and community connections for assistance. The trauma involved in surviving the magnitude of the disaster as many experienced horrific deaths of loved ones and others, language difficulties in communicating needs,

experienced physical harm themselves, witnessed their homes destroyed along with possessions, fear of the disaster returning, and saw a breakdown in civil obedience has shaken the internal self of survivors.

Fernando and Herbert (2011) interviewed and counseled victims in two different disasters and found commonalities across the experiences. Some of these commonalities had to do with surviving and others centered on the trauma. These authors site several other authors who have researched factors that are important to survive a disaster. The accumulated research identifies post trauma processing of the disaster by the survivor. During and immediately after a disaster certain behaviors and responses take precedence such as physical safety, food, lodging, and the basic needs of life. Medical practices have found the best opportunities for healing are at the time of the insult and is likely to be true for psychological issues. If a client is able to process the event soon after the disaster or trauma initiated changes for a quicker recovery are improved. That is not to indicate that counseling practices later are not helpful as they are. A second survival factor is the ability of the person to have the necessary stamina (resiliency) to confront the trauma along with the secondary losses sustained by the disaster survivor. The secondary trauma or losses may be a home, work, finances and social support. There is no single pathway for victims to process the trauma as many variables are to be considered such as age, gender, type of disaster, intensity and severity of personal loss, ethnic diversity, support systems and previous personal experiences with trauma. Psychological first aid is to offer support, reassurance, comforting and calm communication and a physical presence. The emotional well-being through psychological first aid includes basic human responses of comforting and consoling. Newtown shooting Mary Trentini, parent, stated that what she recalls was "there was one person who was just kind, she just came and sat with me and held on" (Aleccia, 2013).

Coping during and after a disaster is reliant upon past understanding of processing skills. Carver, Scheier, and Weintraub's (1989) suggest a combined approach with problem-oriented (solving a problem) and emotional-oriented (reducing negative components) skills to be important for coping. Disasters are experienced and often perceived by survivors as larger than the person thus feelings are magnified and frustrations quickly multiply resulting in feelings of fear and hopelessness. Survivors experience a series of feelings ranging from an inability to meet what is before them, to resume their life, and that life will never be what it was before the disaster. Victims feel totally in the care of relief workers, first responders, medical and psychological personnel to make available pathways to stabilize a resemblance of normalcy and to resume their lives. Roysicar, Thorn, and Thomas (2008) in a powerpoint presentation (slide 18) identified internal and external coping mechanisms. Internal characteristics were humor, optimism, intelligence and creativity, high levels of self-esteem, internal locus of control, empathy, and hardiness. External characteristics included an absence of additional life stressors, strong social and family support network, education, employment, and material resources, health and property insurance. Two other support resiliency elements were noted by Fernando and Herbert, that of religion and hopefulness for the future.

Ryan and Deci (2000) utilize the term disaster agency which is the ability of the victim to possess the internal stability (stamina) to address the trauma. This stamina appears to be a trait in which the person confronts his or her purpose in life and strives to embrace survival (persistent strength, resourcefulness, and surviving will).

Responding skills regarding large scale disasters require triaging, immediate assessment and planning for the relief actions for the service provider as needed. SAMHSA publishes TAP 34: Disaster Planning Handbook for Behavioral Health Treatment Programs (.Substance abuse and mental health services administration, 2013).

In summary, psychological first aid is to offer support, reassurance, comforting and calm communication and a physical presence.

# Stress

Dr. Hans Selye (1956), a medical researcher, was one of the first pioneers to study and write of the effects of stress. He is credited with the first model to understand stress and stress reactions. As a result of his work, the field of wellness and lifestyles has emerged. Selye's stage theory is called the General Adaptation Syndrome (GAS) and is an organism's typical way of dealing with demands.

## General Adaptation Syndrome (GAS)

Stage 1: Alarm reaction. This is the body's response to an attack on its system. The blood is concentrated, pupils dilate, breathing becomes faster, heart rate increases (Matheny & Riordan, 1992).

Stage 2: Stage of resistance. This is the stage of adaptation. Blood is dumped into the bloodstream to combat the stressor.

Stage 3: Stage of exhaustion. Systems appear similar to the stage of alarm reaction. A sort of premature aging due to wear and tear on the body occurs.

Selye also coined the word "eustress" which is "healthy stress." He theorized that the body would undergo less wear and tear when it is under a moderate amount of stress and pressure than when it is inactive (Matheny & Riordan, 1992). Distress is an unpleasant or disease-producing stress. Later Selye added hyperstress and hypostress, an over-and-under stress reaction. The hypostress person lacks self-realization.

The diathesis stress model explains psychopathology results from an interaction of a predisposition to a psychological disorder and experiencing stressful events. Some therapists point to this explanation for depression.

1. Coping with Stress

   Stress can be dealt with through primary prevention and through remediation. Primary prevention involves attention to diet, exercise, cognitive-behavioral coping strategies, etc. The goal of primary prevention is to keep the body functioning normally, instead of engaging the stress reaction. Helping the client experience a sense of control over stressful situations helps in relaxation, which in turn prevents tension from mounting (McMahon & McMahon, 1986). Remedial strategies in coping with stress include palliative and instrumental coping techniques. Palliative measures involve those that work to change the client, such as relaxation

training and cognitive restructuring. Instrumental techniques work to change the environment to make it less stressful. An example of an instrumental intervention is changing some aspect of the work environment to reduce stress.

2. The Effects of Stress

   Continued stress weakens the immune system. This increases vulnerability to illness and disease. Studies indicate, however, that if a stressful event can be predicted or at least partially controlled, the negative effects are reduced (McMahon & McMahon, 1986). If the stress endures over a long period of time, though, the organism will begin to wear down.

3. Stress and Personality

   According to Matheny and Riordan (1992) there are three personality types that induce the stress response more often and at a detrimental level.

   a. The Anxious Reactive Personality: This type of person overreacts to stressful experiences and, as his/her arousal level increases, he/she reacts anxiously to his/her own symptoms.

   b. Coronary Prone Personality: Friedman and Rosenman (1981) discovered the Type A behavior pattern, which they defined as "an action-emotion complex that can be observed in any person who is aggressively involved in a chronic, incessant struggle to achieve more in less and less time, and, if required to, does so against the opposing efforts of other things or persons" (p. 194). These people suffer from the "hurry sickness" and are stuck in a chronic state of arousal that can deteriorate the body. Friedman and Rosenman suggest that 60% of Americans are Type A. Friedman and Rosenman (1974) refer to Type A as the hurriness syndrome, and these individuals tend to be prone to stress-related illnesses. Type B individuals are those who tend to relax without feeling guilty.

   c. Type C behavior: An outgrowth of Type A and B, when research data with Type A individuals began to reveal this group of individuals might be composed of two different reactions. Thus, a hardiness description was identified by Maddi and Kobasa (as cited in Peterson & Nisenholz, 1995).

      These individuals enjoy and feel they can control the stressful events and do not view these pressures as a threat or stress.

   d. Disease-Prone Personality: This personality type involves the following three emotions: depression, anger, and anxiety. According to Friedman and Booth-Kewley (1987), an individual with these negative dispositions is more likely to suffer from disease.

4. Other Names and Terms Associated with Stress

   a. Walter Cannon (1929)-The body sets off adjustments to change and disruption. Holmes and Rahe (1967) developed the Social Readjustment Rating Scale that lists common life events that are rated according to the amount of stress they produce. A total score of 300 or more indicates likelihood of depression or illness in the coming 24 months (McMahon & McMahon, 1986).

b. Martin Seligman (1975) developed the concept of learned helplessness. Distress exists when a person does not have control over his or her environment.

c. Learned Helplessness

d. This is a unified theory that integrates motivation, cognition, and emotional disturbances in explaining helplessness, depression, anxiety, childhood failure, and motivational development. Learned helplessness results from anxiety caused by unpredictability and uncontrollability. Helplessness is a condition that results when events are perceived as uncontrollable (Seligman, 1975).

e. The primary element of helplessness is based upon the fact that individuals learn that results are independent of their actions. One learns that it is futile to respond and if the outcome is severe, anxiety will increase and often result in depression. The depressed person believes that he or she cannot control his or her life so that gratification is achieved, suffering is relieved, or nurturing is obtained. The person loses the incentive to respond and so does not act when events are controllable.

**Question 3-24:**
The General Adaptation Syndrome was developed by:

a. Seligman.

b. Selye.

c. Simpkin.

d. Holmes and Rahe.

Answer: b. Selye. Hans Selye, a Canadian physician, first studied and wrote a book on the body's reaction to stress.

# OBJECTIVE 3D - Resiliency

## Resiliency-Individual, Couple, Cultural, Family and Community

Resiliency is the "ability to cope in the face of adversity" (Ward, 2003, p. 17). Fink-Samnick (2009) defined professional resiliency as a "commitment to achieve balance between occupational stressors and life challenges, while fostering professional values and career sustainability (p. 13). Lambert and Lawson (2013) found that in their study of professional counselors that they experienced burnout and compassion comparable to that of the general survivors of Hurricanes Katrina and Rita. They found that counselors who volunteered and were personally affected by the hurricanes had higher levels of posttraumatic growth than did counselors who volunteered and were not affected by the disasters.

Resiliency as a strength-based factor has been a research topic in family dynamics, children, women, burn-out, stress, and trauma studies. Compassion fatigue is an area of concern where characteristics of resiliency is researched. Jean Baker Miller in her relational cultural model defined relational resiliency as growing in a relationship and being able to move forward despite setbacks (Miller &

Stiver, 1976, 1997). McCubbin and McCubbin (1996) family model emphasizes a resiliency model for family stress, adjustment, and adaptation. Stamina is a characteristic of resiliency. Osborn (2004) identified seven key salutary variables for stamina: selectivity (S), temporal sensitivity (T), accountability (A), management (M), inquisitiveness (I), negotiation (N), and acknowledging agency (A). Relational resiliency is a movement to a mutually empowering, growth-fostering connection in the face of adverse conditions, traumatic experiences, and alienating sociocultural pressures and the ability to connect, reconnect, and/or resist disconnection. Movement toward empathic mutuality is at the core of relational resilience (Jordan, 2004).

Fernando and Herbert (2011) researched recovery variables for women who were survivors of the Asian tsunami and Hurricane Katrina. Their research pointed out the importance of internal and external resources which existed for the 14 women in the study. Internal resources involved optimism, creativity, humor, high levels of self-efficacy and self-esteem, internal locus of control, empathy, and cognitive hardiness. External resources included strong social and family support and network, education, employment and material resources (Roysircar et al., 2008). The core factors for the women in the tsunami and Katrina disasters found religiosity, hopefulness, church and worship, self-agency (sense of self), stamina, social support, and feelings of belonging (Fernando & Herbert).

Individual characteristics of resiliency

1. Self-attitudes (healthy self-relationships, goals, self-discipline, flexibility, sense of purpose)
2. Social attitudes (social responsibility, tolerance, ability to forgive, gratitude, morality)
3. Skills (communication, sense of humor, insight, problem solving, critical thinking, planning)
4. Noble abilities (faith, wisdom, creativity, dreams, hope, goal of highest good, courage)

Resiliency is a process that sustains individuals through change and is a/an:

1. process that draws upon characteristics, abilities and skills
2. capacity possessed by all people
3. inner strength that does not change while we are being changed
4. internal song that anchors us within ourselves, linked to self-familiarizing activity, belief, or other self-soothing behavior
5. innate dignity in spite of powerlessness
6. moving forward, moving inward and moving upward. Crisis workers use resiliency to strengthen the human spirit of clients

# OBJECTIVE 3D - Family Life Cycle

Duvall (1977) proposed an eight stage family life cycle. The stages are (Table 14.1, p. 440):

1. Married couple (without children)
2. Childbearing

3. Family with preschool children
4. Family with school-aged children
5. Family with teenagers
6. Family launches young adults
7. Family without children
8. Aging family

Siegleman and Shaffer (1991) highlight the following trends:

1. increased years without children
2. increased numbers of single adults
3. postponement of marriage
4. decreased childbearing
5. increased female participation in the work force
6. increased divorce
7. increased numbers of single-parent families
8. increased remarriage

## OBJECTIVE 3E: Exceptional Abilities

Even though children and adults develop mentally they differ from one another physically and intellectually as well as in applying learning attributes, some can act with what they have learned while others need to repeat and practice. Exceptional people differ from the norm and need individualized programs. Exceptional individuals can be those who have difficulties in physical abilities and learning while those of superior qualities also require special needs. Individuals with exceptional abilities either excel or are lacking in characteristics of cognition, affect, and intuitive ideas, physical and social skills. Terms such as impairment, disability, and handicap do not have the same meaning. An impairment is the loss or reduced function of a body part. A disability exists when an impairment limits the person. A person is not handicapped unless a disability leads to educational, personal, social, vocational, or other problems.

Characteristics for cognition can include quantity of information, advanced comprehension, ability to generalize, use abstract, see unusual and diverse relationships, generate original ideas and interests, intensity of interest/commitment and has goals, language development, and determine appropriate approach to self and others. Characteristics of affect are humor, sense of justice, sensitivity to others, heightened self-awareness, emotional depth and intensity, high expectations, inner locus of control, need for consistency. Intuitive characteristics consist of the ability to predict outcomes, interest in the future, creative, and intuitive knowledge. Societal characteristics include interest in social problems, ability to conceptualize, and leadership skills. Hollingworth (1942) in studying the highly gifted children indicated that they are early in talking, reading, imagination, and practice extreme precision.

Categories found to be common with exceptional individuals might be intellectual disability, learning disabilities, emotional and behavioral disorders, autism spectrum, communication disorders, hearing impairment, visual impairment, physical and health impairments, traumatic brain injury, multiple disabilities, and giftedness and special talents. Special education in some form is required in each situation (Heward, 2010).

Differentiation of exceptional abilities is the task of a competent psychometric or school psychologist with an experienced background.

The Rehabilitation Act of 1973 Section 504 and The Americans with Disabilities Act of 1990 (ADA) protects the rights of individuals with exceptional abilities. Public Law 94-142 allows for assessment and individualized programs of remediation.

## OBJECTIVE 3F: Developmental Crises

A developmental crisis occurs if a change or transition is too extreme for the coping mechanism of an individual. One coping mechanism that may be lacking is a skill deficit, overload in demand (stress) and a transition is out of synch with societal expectations. An assessment is the first step regarding the person's perception of the crisis. The counselor gathers data in the form of behavioral, affective, somatic, interpersonal and cognitive. An example may be the use of Erikson's psychosocial stages in terms of resolving the crisis at that stage. A crisis can be developmental, situational, existential, and ecosystemic. James (2008) outlined four intervention models in the literature to be the equilibrium (Caplan, 1961), cognitive (Ellis, 1962), psychosocial transition (Dorn, 1986), and contextual-ecological (Myer & Moore, 2006).

Erikson believed that his first two stages transcending all of the stages. That is if the individual's needs were met by others positive social development took place. Secondly, attitudes toward self and others emerge together. If the two are met and one finds a balance between positive and negative feelings successful resolution takes place if the positive outweighs the negative.

## DSM 5™ Disorders

As previously stated the amount of material regarding the DSM-5™ may be more than needed at this time. The DSM was originally published in 1952. DSM-II in 1968, DSM-III in 1980, DSM-IIIR in 1987, DSM- IV in 1994. DSM-IV-TR in 2000 and the DSM-5™ in 2013 to help providers diagnose their clients' psychological problems. It provides definitions and descriptions of behaviors defined as mental disorders (APA, 1994, APA, 2013). Regarding the DSM-IV-TR and the DSM-5™ it is possible there is more DSM-5™ information in this unit regarding the clinical disorders that will not be required for some time in the NCE.

According to Rosenhan and Seligman (1995) a mental disorder is defined as "a behavioral or psychological pattern that either causes the individual distress or disables the individual in one or more significant areas of functioning" (p. 191). Each disorder is given a DSM-5™ diagnosis. Each

diagnostic classification of a mental disorder in the DSM-5™ includes a time frame for each disorder, the number and types of symptoms necessary, removal of the NOS usage and replacement with specified and unspecified disorders, intensity levels, and deletion of the diagnostic multiaxial system. The DSM-5™ uses a dimensional approach to the measurement of distress disability and severity (APA, 2013). In addition several other changes are noted in the DSM-5™ such as a developmental lifespan approach, severity measures, biological markers, an increased focus on culture and gender, inclusion of ICD-9CM and ICD-10CM codes, category changes for neurodevelopmental disorders (autism spectrum, ADHD, learning disorders, coordination disorder, movement disorder and tics), continuum changes for autism and substance use, separate disorders for panic disorder and agoraphobia, name changes such as persistent depressive disorder for dysthymia and somatic symptom disorder for somatic disorder.

To be ethical, professionals are to use the DSM-5™ with the full knowledge that the DSM-5™ is based on the medical model where problems are considered to reside within the individual. Coding systems now include the ICM-9 and ICM 10. The DSM-5™ does consider that the environment has involvement in the diagnosis whereas the DSM-IV-TR did not. Literature supports that the DSM-IV-TR has traditionally pathologized problems in the counseling of racial and ethnic minorities and women. The use of the DSM-IV-TR perpetuated a paternalistic approach to mental health care and reinforces societal oppression of women and minority clients (Remley & Herlihy, 2005). The multiaxial system for diagnosing and recording are no longer a part of the DSM-5™ (Axis I, II, III, IV, V).

## Clinical Syndromes

Clinical syndrome disorders are manifested by acute symptoms. These include syndromes and disorders diagnosed in infancy, childhood, adolescence, or adults; mental disorders due to general medical conditions, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, factitiousness disorders, dissociative disorders, eating and sleeping disorders, and adjustment disorders. V-codes are stressors where symptoms do not meet full criterion for a DSM-5™ disorder. To assign this diagnosis it is critical that a primary mental health diagnosis is ruled out (Value Options, 2006).

Axis II no longer exists in the DSM-5™. Ten personality disorders are categorized into three clusters: A, B, and C and symptomology remains the same for the DSM-5™. The ten personality disorders are manifested by chronic, relatively stable abnormalities, mainly including personality disorders such as paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, and dependent. In addition personality disorders due to another medical condition, other specified personality disorder and unspecified personality disorder are included. The DSM-5™ renamed mental retardation to be intellectual developmental disorder (APA, 2013).

## General Medical Condition

All medical problems and past surgeries are often, but not always, related to the chief psychological problem. These include such maladies as infectious diseases, cancer, heart conditions, post-surgical

complications or difficulties, injuries, thyroid deficiencies, and disorders related to nutrition, substances, and aging.

## Psychosocial and Environmental Problems

All stressors are listed for the past year as well as any anticipated difficulties with the client's primary support group, social environment, education, occupation, finances, health care, legal system, crime, and any other psychosocial stressor. Psychosocial stressors may also include past traumatic events (i.e., childhood sexual abuse, war, etc.). These stressors are described as acute if they are less than six months in duration and enduring if more than 6 months in duration.

Global Assessment of Functioning (GAF) was eliminated from the DSM-5™ (APA, 2013). The adaptive functioning estimate is based upon social relations with family and friends, occupational functioning, and use of leisure time. The DSM-5™ contains two levels for assessment (APA, 2013). Level 1 is Self-Rated Level Cross-Cutting Symptom Measure –Adult and Parent/Guardian-Rated DSM-5™ Level Cross-Cutting Symptom Measure-Child Age6-17. The second level is the World Health Organization Disability Schedule 2.0 (WHODAS-2).

The DSM-5™ provides an exhaustive list of classifications and includes definitions, symptoms, time frames, and additional suggestions for assessment of which this manual will provide only a representative sample. As of this manual printing there appears to be a limited testing of the DSM-5™ psychological disorders. It is anticipated that additional questions will appear as CACREP recently integrated into the curriculum a requirement for a course in diagnostic assessment. This would likely suggest material from the DSM-5™. The ACA Code of Ethics recommends caution when applying labels, of any type, to clients due to historical and social prejudices in diagnosing pathology (Section E. 5.c.).

# DSM-5™ Organizational Structure

| | | |
|---|---|---|
| Neurodevelopmental | Dissociative Disorders Disorders | Substance-Related and Addictive Disorders |
| Schizophrenia Spectrum | Somatic Symptom Disorder And Other Psychotic Disorder | Neurocognitive Disorder |
| Bipolar and Related Disorders | Feeding and Eating Disorder | Personality Disorders |
| Depressive Disorders | Elimination Disorders | Paraphilic Disorders |
| Anxiety Disorders | Sleep-Wake Disorders | Other Mental Disorders |
| Obsessive-Compulsive | Sexual Disorders | Movement Disorders |

| | | |
|---|---|---|
| | And Related Disorders | and other Adverse Effects of Medication |
| Trauma and Stressor Related Disorders | Disruptive Impulse Control and Conduct | Other Conditions That May Be a Focus of Clinical Disorders |

## New Disorders and some changes

There were changes in the DSM-5™ and the following list is not exhaustive as there are others.

## New Disorders

1. Disruptive mood dysregulation was developed because of over diagnosis and treatment of childhood bipolar
2. Premenstrual dysphoric disorder was previously in the appendix.
3. Hoarding disorder and excoriating disorder are now disorders within obsessive-compulsive and related disorders category.
4. Illness anxiety disorder may have been diagnosis as hypochondriasis in the past.
5. Sexual aversion disorder has been removed and replaced by sexual desire and arousal disorder. Genito-pelvic disorder now includes vaginismus and dyspareunia.
6. Gambling disorder placed within substance-related and addictive disorders and removed from impulse control disorder.

7. Intellectual Disability replaces mental retardation
8. Severity is assessed by adaptive functioning rather than IQ
9. Catatonic is no longer a subtype and becomes a specifier
9. Bipolar and Related Disorders and Depressive Disorders are now separate categories
10. Persistent Depressive Disorders replaces Dysthymia
11. Acute Stress Disorder, PTSD, and OCD no longer included in Anxiety Disorders
12. Panic Disorder and Agoraphobia are unlinked and are now two disorders, Panic Disorder and Agoraphobia Disorder
13. Selective Mutism now an anxiety disorder
14. Somatic Disorder is renamed to Somatic Symptom Disorder, Insomnia Disorder replaces Primary Insomnia
15. Disorder, Sexual Desire and Arousal Disorder replaced by Sexual Interest/Arousal

16. Disorder, Vaginismus and dyspareunia combined and now genito-pelvic pain/penetration disorder
17. Sexual Aversion has been removed
18. Substance dependence and abuse replaced by Substance Use and Addictive Disorders
19. 20 categories as opposed to 16

**Question 3-25:**
The DSM-5™ has a different philosophical approach for diagnosis which is:

a. developmental life-span.
b. multiaxial presentation eliminated but united with ICM-9 and ICM-10.
c. diagnosis with an emphasis on physical mind/body distinction.
d. mental disorders are represented by reactions of the personality to psychological, social, and biological factors.

Answer: a. developmental life-span. -- b. multiaxial system was deleted, c. and d. were and remain a part of the over-all considerations when diagnosing.

A brief introduction and overview to several of the DSM-5™ (APA, 2013) disorders will be presented. Not all of the 20 categories will be highlighted rather a few and some of the newer disorders.

## Childhood Disorders

The DSM-5™ has ordered the disorders developmentally so the 20 classifications are no longer identified as childhood, adolescent, and adult rather are presented in each classification according to age onset.

Rosenhan and Seligman (1995) classify childhood disorders into disruptive, emotional, habitual, and developmental categories. Disruptive disorders are those types which are referred to as attention deficit hyperactivity disorder (ADHD), conduct disorder, and oppositional defiant. Emotional disorders are depression, phobias, separation anxieties, and reactive attachments. Habitual disorders have to do with elimination, speech, tic, anorexia nervosa, and bulimia nervosa. Developmental disorders include mental retardation, learning, and autism (p. 601).

The order begins with neurodevelopmental disorders that includes intellectual disabilities, communication disorders (language, speech, childhood onset fluency disorder), social communication disorder, unspecified communication disorder, autism spectrum (4 previously separate disorders into a single disorder), attention-deficit hyperactivity disorder (ADHD and age of onset raised from 7 to 12), specific language disorder, motor disorder, and tic disorder. The second category is schizophrenia spectrum and other psychotic disorders (subtypes dropped), bipolar and related disorders, depressive disorders, anxiety disorders and the remaining categories.

In summary, this introduction to personality and behavior disorders is not intended to be an exhaustive review of the DSM-5™ nor of the behavioral and personality disorders. The reader will note some redundancy in material.

**Question 3-26:**
A disorder of middle and late adulthood that is considered to be influenced by genetic factors is:

a. Agoraphobia.
b. Attention Deficit disorder.
c. Depressive disorder.
d. Alzheimer's disease.

Answer: d. Alzheimer's disease.

## Anxiety Disorders

The DSM-5™ includes anxiety disorders, separation anxiety, selective mutism, specific phobias (animal, natural environment, blood-injection-injury, situational), social anxiety (social phobia), panic, panic attack, agoraphobia, generalized anxiety, substance/medication-induced anxiety, anxiety due to another medical condition, and specified and unspecified anxiety (APA, 2013).

The four elements of fear (Rosenhan & Seligman, 1995) are:

1. Cognitive: the expectation of impending harm
2. Somatic: the emergency physical reaction to danger
3. Emotional: the feeling of dread, terror, and panic
4. Behavioral: the fight-flight response reactions are prominent in both phobias and posttraumatic stress disorder.

These elements are prominent in the following disorders.

1. Phobias (animals, environment, blood, injections, and injury) are persistent fear reactions that are out of proportion to the reality of the danger.
2. Posttraumatic Stress Disorder (PTSD) is no longer an anxiety disorder rather the DSM-5™ includes it in the category trauma and stressor-related disorders. Symptoms for individuals older than six years include exposure to actual or threatened death, serious injury, or sexual violence in one or more (directly experiencing, witnessing, and learning that trauma event involved family or close friends, and aversive details (p. 271). It also includes intrusive symptoms such as dissociative reactions. A feature to consider during the assessment are efforts to avoid stimuli associated with the trauma.
3. Anxiety: Anxiety has the same four elements of fear except that it is more pervasive, lacks a specific object, and its source is internal rather than external (Rosenhan & Seligman, 1995). The various anxiety disorders include the following: panic disorder, panic disorder with

agoraphobia, obsessive compulsive disorder, acute stress disorder, and posttraumatic stress disorder.

4. Panic disorder is manifested by both emotional and physical elements, i.e., intense apprehension, depersonalization, terror, dizziness, shortness of breath, racing heart, chest discomfort, and chills. These symptoms are usually unexpected (uncued), situationally triggered (cued), recurrent, and often nocturnal.
5. Panic Disorder with agoraphobia has been unlinked in the DSM-5™ and is now a separate diagnosis. Agoraphobia is associated by a fear of leaving home since the attacks are more likely to occur away from home in a crowded setting. The sufferer fears encountering a group of people, experiencing a panic attack, and feeling trapped without help.
6. Generalized anxiety disorder is a chronic disorder lasting no more than six months duration that has both disturbing physiological (tension) and cognitive aspects (worry) occurring on a day-to-day basis. This form of anxiety will usually last six months and frequently becomes a bothersome aspect of each day.

## Somatic Symptom and Related Disorders

Seven disorders comprise the classification of a somatic symptom and related disorder: somatic symptom, illness anxiety, conversion, psychological factors affecting other medical conditions, factitious, specified and unspecified somatic symptom and related disorders. These disorders often reflect a loss of physical functioning, symptoms not explained by a physical condition, absence of neurological damage, evidence suggesting that psychological factors are related to the symptoms, indifference to the disabling condition, and an inability to voluntarily control the symptoms (Rosenhan & Seligman, 1995).

Conversion disorder (alternate name-functional neurological symptom disorder) signs may be motor, sensory or other symptoms such as hysterical conversion is caused by psychological stress being converted to physical symptoms.

Somatic symptom disorder is a physical manifestation of unresolved emotional concerns. This disorder usually involves a series of unresolved medical complications including chronic pain, non-specific chest or intestinal l complaints, and symptoms that emanate from several organs or areas of the body. This disorder is insufficient without medical evidence (APA, 2013, p. 311).

## Dissociative Disorders

The dissociative disorders include dissociative identity disorder, dissociative amnesia, depersonalization/derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder (APA, 2013). Dissociative disorders are characterized by a disruption or discontinuity in memory, identity, emotion, perception, body representation, motor control, and behavior (p. 291). Rosenhan and Seligman (1995) defined a dissociative disorder as two or more disconnected mental processes, which co-exist or alternate with each other. Symptoms include

dissociation or split in consciousness, memory lapses and lost time, depersonalization, derealization, identity confusion, identity alteration, and multiple identities.

Dissociative amnesia can be localized amnesia, selective amnesia, and generalized amnesia. In rare instances it could be classified with dissociative fugue (APA, 2013, p. 208).

Dissociative identity disorder, previously called multiple personality (MPD), is characterized by two or more personalities, each of which can take full control at different times while expressing different and contradictory emotions and behaviors.

## Schizophrenia Spectrum and other Psychotic Disorders

This category includes schizotypal (personality) disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia disorder, substance/medication-induced psychotic disorder, psychotic disorder due to another medical condition, catatonia associated with another mental disorder, catatonia disorder due to another medical condition, unspecified catatonia, other specified/ unspecified schizophrenia spectrum and other psychotic disorders (APA 2013). Schizophrenia subtypes were eliminated in the DSM-5™.

Schizoaffective disorder is a disorder that is uninterrupted in which there is a major mood episode (major depressive or manic). This disorder exhibits delusions or hallucinations that last for two or more weeks in the absence of a major mood episode.

Schizophrenia disorder, for a significant amount of time has two or more of the following; delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and negative symptoms (APA, 2013, p. 99). Schizophrenia last for at least six months and at least one month of active –phase symptoms (p. 89). Schizophrenia is more primarily of thought, which may include a secondary disturbance of mood. An individual suffering from schizophrenia has a psychosis manifested by impaired reality testing, difficulty focusing attention, and problems with concept formation. Frequently, delusions (false beliefs) and hallucinations (disturbed or delusional sensory perceptions) are present.

# OBJECTIVE 3G: Addiction

The study of addiction is extensive but for the purpose of this study manual gambling (non-substance- related disorder), eating disorders, sexual, and substance-related and addictive disorders are mentioned. Each of these addictions has a pattern of progression, preoccupation, perceived loss of control, and negative long-term consequences (Walters, 1999). CACREP Objective G identifies necessary preparation areas when working with clients presenting with addiction and addictive behaviors.

## Substance-Related Disorders

Alcoholism is considered a disease. The same is considered true of addiction although not all agree (Peele, Brosky, & Arnold, 1992). The American Medical Association characterizes this disease as primary, progressive, chronic, potentially fatal, and symptomatic (Royce, 1989). Americans consume over 60% of the world's production of illegal drugs, 450,000 people die from the negative effects of alcohol and nicotine each year, and 5-10 million Americans abuse prescription medications (Washton & Boundy, 1989). America is an addicted society that suffers from a "quick fix" mentality and is in pursuit of mood-altering experiences. The keys to recovery, both individually and as a society, are to change the belief system, the approach to problem-solving, and the methods of getting social, physical, emotional, and spiritual needs met (Washton & Boundy, 1989).

Two classifications exist in the DSM-5™ for substance-related disorders, substance-use disorders (SUDS) and substance-induced disorders (intoxication and withdrawal). Substance abuse and dependency was combined into one disorder, substance use and added craving as a symptom. For the most part there are three levels, substance use, substance intoxication, and substance withdrawal. These disorders combine abuse of and dependency continuum for nonprescription or prescription drugs, alcohol, inhalants, chemicals, or toxic substances. Contained within the DSM-5™ (APA, 2013) are 11 classes of drugs with abuse potential: alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine, and sedatives/hypnotics/ anxiolytics.

Substance-use disorders include a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use substances (APA, 2013). Substance-induced disorders include intoxication, withdrawal, and other substance/medication-induced mental disorders (e.g., substance-induced psychotic disorder, substance-induced depressive disorder).

Fisher and Harrison (as cited in Hogan, Gabrielson, Luna, & Grothas, 2003, p. 4) define substance use disorder as "the continued use of alcohol or other drugs in spite of negative consequences." One of the most common terms in the substance abuse field is addiction. According to Fisher and Harrison addiction is a "compulsion and craving regardless of the negative or adverse consequences" (as cited in Hogan, et al., p. 69). Dependence is a repeated pattern of self-administration resulting in tolerance, withdrawal, and compulsive drug-taking behavior. Fisher and Harrison (as cited in Hogan, et al., p. 4) indicate that addiction/ dependence is the "compulsive use of alcohol or other drugs regardless of the consequences." Substance misuse is often accompanied by or coexists with anxiety, compulsive gambling disorder (removed from impulse disorder in the DSM-5™), mood disorder, personality disorders, and psychotic disorders (van Wormer & Davis, 2003).

Terms often used are denial, relapse, recovery, enabling, and co-dependency. As with other crises or trauma, there are a number of myths associated with addiction.

## Alcoholism

The alcohol user is one who regularly drinks excessively with the intention of getting "high" or drunk (Burnett, 1979). The alcoholic addict, on the other hand, has a compulsion to drink more and more

once drinking has begun. With the addict, there is a loss of control. Although not all abusers become addicts, the counselor should be aware of the early signs of addiction when dealing with abusers. No one knows exactly at what point an abuser will cross the line into addiction. The counselor should also keep in mind that a maximum of 10% of alcohol users become addicts (Burnett, 1979).

Psychologically, alcohol abuse often results from a need to experience power. Physiologically, alcohol creates an illusion of power in the abuser. The alcoholic seeks a magical and immediate sense of power from alcohol as opposed to acquiring legitimate social power through goal-directed behaviors (Burnett, 1979).

An addiction occurs when the alcoholic or drug addict becomes obsessive, compulsive, and unable to control drinking, despite its adverse consequences (Washton & Boundy, 1989). The addiction has psychological and physiological components. Alcoholism must be viewed holistically as a psychosomatic social disease with interpersonal and intrapsychic components as well as somatic components that could lead to death (Burnett, 1979).

High doses of alcohol cause low blood pressure, slowed motor reflexes, loss of body heat, diminished sexual performance, loss of balance, and mental confusion. Alcohol is a depressant and affects the central nervous system (Abadinsky, 1996). Addicts experience muscle relaxation, disinhibitions, lessened anxiety, impaired judgment, and impaired motor coordination as well as other physiological reactions. Sweating, tremors, altered perception, psychosis, fear, and auditory hallucination often accompany withdrawal from alcohol.

Alcohol-associated issues tend to be violence in domestic (perpetrators usually men) violence toward women, rape, child abuse, homicide, fires and burns, and business and industry losses (Peterson, Nisenholz & Robinson, 2003). Some terms to be aware of in alcohol or the substance field are: Alcoholics Anonymous (AA), blackouts, tolerance, withdrawal, alcohol abuse, alcohol dependence, Fetal Alcohol Syndrome (FAS), The Twelve Steps, relapse, and comorbidity.

## Recovery and Relapse

Recovery programs can be divided into two approaches to treatment. Early treatment programs focused on denial as prominent and the Twelve Step Plan program. Recent programs focus on Strength approaches and view denial as healthy. One such model, Harm Reduction, is designed to alleviate the social, legal, and medical problems associated with the unmanageable aspects of addiction. The harm-reduction emphasis is to limit the harm that may result from infectious diseases, violence, criminal activity, and early death. At the same time the approach does not necessarily attempt to cure the addiction (Nadelmann, McNeely, & Drucker, 1997). Another strength-based approach by Rapp (1998) suggests that there are six components to recovery. These are:

1. identity as a human being
2. need for personal control or choice
3. need for achievement
4. need for purpose

5. need for hope
6. presence of at least one key person

Gorski (1989) described a stage model of recovery. These stages in order are transition followed by stabilization, middle recovery, late recovery, and maintenance.

The Prochaska, DiClemente and Norcross (1992) model is a stage change. The stages are precontemplation, contemplation, preparation, action, and maintenance.

The 12-Step Model is probably the best-known approach to recovery.

Definitions for relapse may differ according to models for prevention and therapy. However, relapse is a return to harmful use of the addictive preoccupation (substance, gambling, sexual etc.). Weingardt and Marlatt (1999) state that negative emotions such as anger, anxiety, depression, and boredom accompany or promote the return to the addiction.

## Models

The causes of substance use and addiction are explained through the moral, psychological, family, disease, biological, sociocultural and multi-causal models (Fisher & Harrison, 2013; Capuzzi & Stauffer, 2012). A brief statement for each model will be shared as follows:

Moral model: Puts forth the idea that addiction is not biologically determined, rather individuals inherently know right and wrong and mostly offers punishment as the consequence.

Psychological model: A mind-emotions concept where people crave alcohol and other mind altering drugs.

Cognitive-behavioral model: This model suggests that pleasure is at the source and motivation and reinforcers constitute involvement with substances.

Psychodynamic model: An ego deficiency, inadequate parenting, attachment disorders, hostility, and homosexuality (Capuzzi & Stauffer, 2012).

Family model: Family members are important in assisting the client to become sober.

Disease model: A model where the disease is progressive along with symptoms for each stage (prodromal, middle, crucial, chronic).

Biological model: A predisposition of dependence on drugs (medical model).

Sociocultural model: Based on sociocultural systems and understanding the social phenomena that surrounds the substance use.

Harm reduction model: The underlying assumptions for harm reduction are: a) alternative to the moral/criminal and disease model, b) abstinence is ideal but accepts alternative for reduced harm effects of use, not use itself, c) grass roots advocacy and not federally driven, d) meeting the person

where they are, and e) a compassionate pragmatic approach-focus is daily living and not moralistic idealism (Marlatt & Witkiewitz, 2002).

Multi-causal model: A combination of the many models of addiction. Two examples are the Syndrome model (Shaffer et al., 2004) and Integral model (Amodia, Cano & Eliason, 2005). The Syndrome model includes addictions of eating, gambling, sexual behaviors, shopping, and substance abuse. This model includes three shared experiences that have intersecting variables (experiences and consequences, psychosocial antecedents, and neurobiological antecedents).

### Assessment and Treatment

There are several approaches to assessing for addiction to include strength-based characteristics, other disorders, prior treatment, red flags, motivation for change, type of addictive preference (s), family involvement as well as participation in substances, spirituality, coping skills and peer relationships. Assessment for screening and diagnosis can include standardized instruments such as the Substance Abuse Subtle Screening Inventory (SASSI-3), Michigan Alcoholism Screen Test (MAST), and The Cage. The MMPI-2 has three scales of importance; MacAndrew Alcoholism Scale-Revised (MAC-R), Addiction Potential Scale (APS) and Addiction Acknowledgment Scale (AAS).

Evidence-based practices are the treatments of choice. The National Registry of Evidence-based Programs and Practices (NREPP; http://www.nrepp.samhsa.gove) listed 96 intervention programs for abuse prevention and treatment. Cognitive-behavioral, contingency management, solution-focused and interventions programs have been cited several times. Interventions have not been found to be helpful. Harm reduction (Marlatt, 1998) has a strong emphasis on prevention with an outcome of reducing the harmful effects of the addiction and/or substance. Emphasis is more on the harmful effect than the actual substance. One example of the harm reduction concept was the needle exchange program that offered clean syringes during the increase of HIV/AIDS.

## Guidelines for Counseling

Discover whether the client is in control of his or her drinking by taking a drinking history in a nonjudgmental manner. Get specific, objective information.

1. Once the client has decided he or she is an alcoholic (which may require several progressively confronting interviews including family members, employers, etc.), refer the client to AA or a hospital alcoholism treatment center.
2. Refer the family to Al-Anon and/or Al-Ateen.
3. Once sobriety is established through 6-12 months of membership in AA, individual counseling may resume with the goal of understanding the underlying issues of alcoholism. It is imperative that the client maintains active participation in AA simultaneously. Burnett (1979) maintains that counseling will not be effective until abstinence is achieved. At the same time, however, as Washton and Boundy (1989) point out, the drug itself is not the whole problem. Therefore, getting off the drug is not the whole solution.

4. The goal of counseling is to help the client shift from a passive-dependent approach to a more active, problem-solving, self-reliant, goal-oriented approach. The counselor should help alcoholics to own the split-off, rejected parts of themselves that they've masked through drinking. Assertiveness training may be particularly helpful for the recovering alcoholic as he or she learns to achieve power through instrumental behaviors (Burnett, 1979). The key is to build a healthier, nonaddictive lifestyle (Washton & Boundy, 1989).
5. The recovery process must be holistic and multidisciplinary, involving family counseling, psychotherapy, medical supervision, a spiritual program, and personal development of non-chemical coping skills. The goal is recovery through understanding, and healing the internal need for a mood-changing chemical (Washton & Boundy, 1989).

## Addictive Drugs (other than alcohol) (Burnett, 1979)

Any drug that results in the development of a tolerance effect and withdrawal symptoms is considered addictive. The Drug Awareness Warning Network reported, in a 2011 survey, the illicit drugs identified in emergency room episodes were in rank order cocaine and marijuana followed by heroin, marijuana, amphetamines, methamphetamine, MDMA, GHB, Flunitrazepam, Ketamine, LSD, and PCP (DAWM, 2011).

The drugs with the highest dependence potential are heroin, crack cocaine, morphine, and opium (DAWN, 2011; Ray & Kisir, 2002).

Stimulants are often referred to as uppers and include many drugs. Addicts who use stimulants experience a feeling of less fatigue, increased alertness, and mood elevation. Behaviors associated with stimulant withdrawal tend to be a drug craving, irritability, depression, anxiety, apathy, and attempts or thoughts of suicide. Some drugs included under stimulants are:

1. nicotine
2. amphetamines or methamphetamines ("uppers" or "speed")
3. cocaine/crack (produces the same effect as amphetamines, but for a shorter duration of time)

Other substances often abused: glue, stimulants (caffeine, nicotine), LSD, PCP, ecstasy, peyote, hallucinogens, marijuana, mescaline.

Depressants are often called downers. Alcohol is the most widely used depressant. Barbiturates constitute another depressant group.

## Models for Addiction

Several models for addiction have been developed. Some of these models are: temperance, model, spiritual, sociocultural, social learning, cognitive, biological, psychological, dispositional disease, general systems, public health, and biopsychosocial (Peterson, Nisenholz, & Robinson, 2003).

## Guidelines for Counselors - (See guidelines above for alcoholism. There is a great deal of overlap)

1. Since drugs provide an escape from feelings of low self-esteem, depression, anxiety, etc., the counselor should help bring about changes in the client's experience that will result in more rewards (i.e., new pastimes, new structure, more meaningful identity). The goal is a lifestyle change in which a sober experience becomes more rewarding than the drugged experience (Burnett, 1979).
2. Help the client develop coping mechanisms that will help alleviate anxiety, depression, boredom, etc., without the use of drugs. Show the client how to gain control over his or her environment through personal efforts or through learning to tolerate the frustration of uncontrollable events.
3. Help the client learn to take responsibility for his or her own feelings so that there is less need to escape reality.
4. Marshall all resources to support the clients efforts. Utilize peer counseling, 12-step programs, support groups, family therapy, community programs, etc.
5. Encourage the development of trusting relationships in which legitimate dependency needs may be met.

Hogan, et al. (2003) suggest that certain factors point toward involvement in drugs. Counselors should be cognizant of the risk factors associated with substance use. Risk factors in the community, family, school, and within the individual are noticeable signs of possible involvement in drugs. Risk factors for the community are availability, favorable attitudes toward drug use, and mobility. Family risk factors include family history of substance abuse, delinquency, violence, teen pregnancy, family conflict, parental attitudes, and involvement in drug use. School risk factors are antisocial behavior, academic failure, and lack of commitment to school. Individual risk factors are alienation, rebelliousness, friends who are involved in problem behavior, and favorable attitudes toward problem behavior.

**Question 3-27:**
The treatment of choice for substance use addicts is:

a. peer counseling and support groups.
b. a 12-step program such as AA.
c. family and individual therapy simultaneously.
d. to wait until a support system is developed.

Answer: b. a 12-step program such as A.A. Most addicts readily respond to treatment programs, which include AA meetings.

**Question 3-28:**
What treatment would be recommended if a counselor was practicing harm reduction with a client experiencing an alcohol use disorder:

a. Adlerian and supportive therapy
b. CBT and Solution-focused
c. Psychodynamic and Object Relations
d. Person-centered and Reality Choice theory

Answer: b. CBT and Solution-focused. CBT and Solution-focused therapy is brief with a low threshold.

# OBJECTIVE 3H: Optimal Development

Theories for facilitating optimal development and wellness over the life span include those theories that will enhance the likelihood of achieving satisfaction into adulthood. Life span development is about change and to have an optimal development, one is to be able to part with some order of development and assume new roles, become cognizant of critical timing issues during the life-span, and be aware of cause-and-effect relationships (Sigelman & Shaffer, 1991). Theories describing optimal development would include creating a successful life style of play, school, and in work. Theories of personality and well-being, work and financial stability, achievement, generativity, empowering relationships, meaning in life, coping strategies to meet the stressors in life, mindfulness, and self-compassion all contribute to optimal development.

## Wellness

Myers, Sweeney and Witmer (2000) define wellness as "a way of life oriented toward optimal health and well-being in which body, mind, and sprit are integrated by the individual to live more fully within the human and natural community" (p. 253). Seligman (2002), Snyder and Lopez (2001) identified characteristics of what constitutes well-being. From these contributions Sweeney and Witmer (1991) developed a Wheel of Wellness model. Later Myers, Sweeney and Witmer (2000) revised the original model of self-direction to include 12 subtasks and five major life tasks that are correlated with healthy living, quality of life, and longevity. The components of the Wheel of Wellness are sense of work, nutrition, sense of humor, problem solving & creativity, exercise, self-care, realistic beliefs, emotional awareness & coping, sense of worth, sense of control, gender identity, and cultural identity. Life tasks are spiritual, self-direction, work and leisure, friendship, and love.

Reese and Myers suggested that most models of wellness have omitted the descriptive benefits of nature, environment, and natural community. The ecoWellness model references supportive literature to illustrate how individuals connect with nature and receive benefit from the restorative positive effects in psychological, physical, and emotional well-being. There are three domains to access the eco model, nature (green spaces), environmental identity (special relationship with nature), and transcendence (deep feelings of connectedness). Salovey, Rothman, Detweiler and Steward (2000) make a further connection in studying the emotional states with physical health. Clients in distress often refer to somatic ailments and mood. Emotional experiences have been linked to changes in physical health which have an effect on the immune system. A multitude of research exists regarding the positive and negative effects of client emotions as it relates to illness and the immune system. It

appears that for those individuals exercising a positive set of emotions there is informational value in learning about the risk factors associated with negative emotions. In addition mood does affect people's vulnerability to conditions for deteriorating consequences. Further evidence is available that identifies a direct link between emotional states and psychological resilience. Social support, or lack thereof, may affect health. Salovey, Rothman, et al. (2000) provide a contrast for social support with the buffering hypothesis and direct effect hypothesis stating support that social relationships promote health and well-being regardless of the stress level. Social support may lessen the degree of stress in a challenging physical, psychological and environmental situation.

Newsome and Gladding (2014) recommend a plan for counselors to initiate and carry out for a wellness-oriented lifestyle. The plan calls for a review in the areas of physical self-care (sleep, nutrition, exercise), cognitive self-care (evaluating and monitoring and negative and irrational stress inducing cognitions), and emotional and spiritual self-care (empathic, sensitive, humane, people oriented and committed).

Review the Professional Orientation and Ethical Practice Unit for a fuller explanation for wellness.

# Unit 3 – Terms

APGAR RATING:
Newborn assessment of heart rate, respiration, muscle-tone, response to stimulation, and skin color. This assessment is taken at birth and repeated five minutes later. Babies who score 4 or lower on a 0-10 scale are identified as high risk and require intervention and medical assistance.

CANON BARD:
Physical and emotional responses occur simultaneously. At the time the feared object is seen, the hypothalamus is triggered so both the emotional and physical response occur simultaneously (McMahon & McMahon, 1986).

CENTRATION:
The ability to concentrate on one thing at a time. A concept Piaget found to exist in the Preoperational Stage. A child is able to focus upon only one element of an action or thought; e.g. only one car when viewing cars and different models.

CLANG ASSOCIATIONS:
Rhyming words that are strung together but make no sense.

COHORT EFFECT:
The effect of being born at a particular time and growing up in a particular historical context (Siegelman & Shaffer, 1995, p. 16).

DEMBERS IDEATIONAL ADDICTION:
The brain feeds on and cannot live without a constant input of ideas to keep it operative. The brain absorbs and locks in on certain completely dominant ideas or beliefs and is consumed with them, never to let them go.

DEVELOPMENTAL NORM:
The average age of mastery for specific developments such as locomotion, puberty, speaking, learning volume, and other unique aspects of human growth.

EQUILIBRATION:
A term coined by Piaget for when a schema becomes more mature.

FIELD THEORY:
Max Wertheimer, Wolfgang Kohler, and Kurt Koffka (psychology) put forth the idea that behavior is a function of the person and the environment. The individual experiences conflict such as two positive or negative valences, or a positive and negative valence.

HARLOW, HARRY:
In Harlow's study of infant monkeys, it was found the monkey preferred a cloth mother to a wire mother that feeds. Contact comfort is when reassurance is received from pleasant stimulation.

HIERARCHICAL:
Maslow's hierarchy of needs, a theory of motivation. He proposed a hierarchy of needs where the needs at the bottom levels must be met before the needs of the upper levels are desired. The stages from the bottom up are the following: physiological, safety, belonging, self-esteem, and self-actualization.

IMPRINTING:
Critical periods exist during which the imprinting can take place, when the newborn recognizes something (object) as its mother.

INTERNAL-EXTERNAL LOCUS OF CONTROL:
Julian Rotter put forth the idea that man is controlled by internal or external standards. If the individual feels he/she controls his/her own destiny, he/she is internally controlled. If the individual feels that others control his/her life then he/she is externally controlled.

JAMES-LANGE:
Emotional response comes after physical response. See a bright bolt of lightning and hear loud thunder; respond internally (heartbeat, contracted stomach, etc.); finally because our body is so excited, we feel emotion of fear reaction first, emotion second (McMahon & McMahon, 1986).

LAMAZE METHOD:
A method developed by two obstetricians, Grantly Dick-Read and Fermand Lamaze, to teach women how to associate childbirth with pleasant feelings. This is a process of learning exercises of breathing and pushing methods along with relaxation techniques.

LEARNING:
Learning is defined differently by different theories. Social learning is explained through conditioning and observations involving mechanical and/or conscious decisions. A general definition of learning "is any change, which results from experience" (Siegelman & Shaffer, 1995, p. 4). This change can be a

modification in a person's behavior. Experiences bring about relatively permanent changes in thoughts, feelings, or behavior (Siegelman & Shaffer, 1995, p. 4).

MAINSTREAMING:
A term describing how developmentally delayed youngsters have been integrated into the regular classrooms, as opposed to separate learning environments. PL 94-142 requires appropriate education for all children.

MATURATION:
A biological unfolding of the individual according to a plan contained in the genes, or the hereditary material passed from parents to children at conception (Siegelman & Shaffer, 1995, p. 3).

MATURITY:
A mature individual is a realistic individual with a thoughtful sense of values and an underlying meaning to life that is maintained with integrity. The individual has achieved a state of harmony between self and social groups.

MCCLELLAND, DAVID:
A motivation theorist who put forth the idea that people are driven by a desire to achieve (Nach), to be recognized (Naffil), or to be successful (Nsu).

NEUROSCIENCE:
Heinrich, Gevensleben, and Strehl (2007) define neuroscience and neurofeedback as monitoring and changing brain wave patterns that lead to other changes in behavior, a sense of and ability to self-regulate.

ONTOGENESIS:
The course of development.

OPPONENT PROCESS THEORY:
When one set of activities goes too far in one direction the brain opposes and goes in the opposite direction; balancing-homeostasis (McMahon & McMahon, 1986). This is similar to the body's reaction to several cups of coffee a day. Because caffeine speeds up the body, the body reacts by slowing down so there will be a balance. If the coffee drinking is stopped, it takes the body a few days to speed back up to the normal level.

RAPID EYE MOVEMENT (REM):
Rapid eye movement is a state of active, irregular sleep. As a baby matures less sleep time is REM and more is non-REM.

RITES OF PASSAGE:
Most societies have developed rituals through which a child transcends to adulthood. The transitions for a young person to become an adult are referred to as rites of passage.

SCHACHTER COGNITIVE THEORY:
Emotional responses involve physiological excitement, but the person feeling it cognitively labels the emotion felt. We feel whatever we call it (McMahon & McMahon, 1986).

SCHEMA:
A schema is an organized pattern of thought or action which is used to understand experiences. Piaget viewed schemas as cognitive structures (Siegelman & Shaffer, 1995).

## Questions

**Question 3-29:**
Larry, a student in the tenth grade, stated that he had a conflict. He has to make a decision between going out for basketball or wrestling. He likes both sports and is equally good at them. This is an example of what type of conflict?

a. approach-approach
b. attribution
c. autonomy versus dependence
d. bipolar disparity

Answer: a. approach-approach

**Question 3-30:**
Sharon is a law-abiding person who is known to rely on approval from others. According to Kohlberg's Sharon would be operating on what stage?

a. preconventional
b. conventional
c. postconventional
d. formal operative

Answer: a. preconventional

**Question 3-31:**
According to Jerome Bruner, the enactive mode of language development is:

a. highly complex and symbolic manipulation.
b. where thought processes are represented by physical acts.
c. where one views an object in obvious sense without considering its possible uses.
d. the process of holding a visual image in immediate memory.

Answer: b. where thought processes are represented by physical acts.

**Question 3-32:**
Erik Erikson has proposed a stage for middle age that has been modified by Roger Gould and Robert Peck. These authors are in agreement that a basic conflict is to be resolved at this stage. The conflict is:

a. intimacy vs. isolation.

b. initiative vs. guilt.

c. industry vs. inferiority.

d. generativity vs. stagnation.

Answer: d. generativity vs. stagnation.

**Question 3-33:**
A teacher believes the best way to reinforce learning is to provide a reward after every third response for which a student gives a correct answer. This is an example of which reinforcement schedule?

a. fixed interval

b. variable interval

c. fixed ratio

d. variable ratio

Answer: a. fixed interval

**Question 3-34:**
In 1952, Hans Eysenck reported that nonpsychotic adults recovered without any treatment at all. This was because of:

a. empathy.

b. the placebo effect.

c. anticipation of cure.

d. spontaneous remission.

Answer: c. anticipation of cure.

**Question 3-35:**
Piaget's process of building one step of intellectual growth into another during maturation is called?

a. schemata.

b. reification.

c. equilibration.

d. conservation.

Answer: c. equilibration.

# Unit 3 - References

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# UNIT 4 - Career Development

## Goals and Objectives

Counseling individuals for career development throughout the life span requires knowledge of the world of work, techniques of assessment, vocational theory, special programs, and occupational resources. Counselors who assist clients with career exploration as well as decision-making must put lifestyle and career development theory to practice. It would be helpful to become familiar with the following information:

1. six to eight prominent vocational theories
2. major resource materials
3. commonly utilized assessment devices (interest, values, and aptitude)
4. career issues for all age groups
5. special needs for a diverse population.

The sample questions in this unit are designed to elicit recall of specific facts as well as to test the application of information for specific concerns at different age levels. The materials included in this

unit are not intended to be a thorough presentation of the subject matter. Rather, the topics introduced should be viewed in light of how familiar you are with the entire area of career counseling. If you are more knowledgeable than the brief presentation in this manual, continue on to the next unit. There are approximately 25-26 questions devoted to career development content of which 21 count toward your final score for Career Development.

# CACREP Objectives

CACREP 2009 objectives for Career Development are abbreviated. It is recommended that for a full review of the objectives download the standards from www.cacrep.org. Example questions follow the listed objectives.

The objectives are abbreviated and full standards are on-line at www.carep.org

A. career developmental theories and decision making models
B. career, avocational, educational, occupational and labor marked information resources
C. career development program planning, organization, implementation, administration and evaluation
D. interrelationships among and between work, family, and other life roles/multicultural
E. career and educational planning, follow-up and evaluation
F. assessment processes, techniques and decision-making
G. career counseling processes, techniques and resources

**Question 4-1: (Objective A.)**
The concept of career maturity is of primary importance to the theory of:

a. decision-making.
b. structural-interactive.
c. career development assessment and counseling.
d. trait-factor.

Answer: c. career development assessment and counseling. Career development assessment and counseling, C-DAC, is the final name change for Donald Super's theory previously identified as life span-life space.

**Question 4-2: (Objective B.)**
State labor departments use which world of work classification system?

a. Holland Occupational Classification
b. Standard Occupational Classification
c. Dictionary of Occupational Titles
d. Standard Industrial Classification

Answer: c. Dictionary of Occupational Titles

**Question 4-3: (Objective C.)**
One of several steps in designing and implementing a career development program is to write measurable objectives. Writing measurable objectives is important because:

a. the objectives set up the target population for services.
b. these are the means for the creation of a budget.
c. they are purposeful in hiring the correct counselor for the correct position.
d. the objectives determine the content and evaluation of the services.

Answer: d. the objectives determine the content and evaluation of the services.

**Question 4-4: (Objective D.)**
A technique that will assist a career counselor in understanding the relationship between family background, cultural prescriptions and career planning is the:

a. Psycho-drama.
b. Genogram.
c. Johari Window.
d. Karpman Triangle.

Answer: b. Genogram.

**Question 4-5: (Objective E.)**
Career assistance in the early history of the field of counseling and guidance was focused on job placement. At the present time placement is:

a. to focus on a singular placement.
b. a match with commerce, industry, and professions based on training in college.
c. based on a developmental perspective.
d. based on economic need.

Answer: c. based on a developmental perspective.

**Question 4-6: (Objective E.)**
The National Occupational Information Coordinating Committee was formed in 1976 to provide:

a. state career information systems.
b. up-to-date job listings in each state.
c. assistance for displaced workers.
d. store user information.

Answer: a. state career information systems.

**Question 4-7: (Objective F.)**
What instrument would Structural Interactive Theory employ to assess for congruence in a person-environment fit?

a. Kuder Preference Inventory
b. Holland Occupational Code
c. Strong Interest Inventory sten.
d. stanine.

Answer: c. Strong Interest Inventory sten.

**Question 4-8: (Objective G.)**
Cyber counselors and cyber clients are confronted with issues not as likely or apparent as in face-to-face counseling. One of these issues has to do with:

a. training.
b. a secure environment.
c. payment.
d. homework.

Answer: b. a secure environment

**Question 4-9: (Objective G.)**
An ethical dilemma might likely occur when counselors use the Internet to:

a. deliver occupational information.
b. provide on-line databases for purposes of occupational options.
c. provide on-line searches.
d. provide counseling on-line.

Answer: d. provide counseling on-line.

Harris-Bowlsbey-Dikel, and Sampson (1998) provide four guidelines in which the Internet can be utilized to provide career services to clients. Ethical issues are evident for each of the four. Qualification of Website providers must be stated on the site. False e-mails are not tolerated. Appropriate uses and limitations of the Website are to be stated.

# Terms

The following list of terms is provided to promote vocabulary knowledge. Brief definitions are provided at the end of the chapter.

Avocation Burnout

Career awareness
Career guidance
Career lattice
Career maturity
Career pattern study
CASVE cycle
Congruency
Consistency
Crystallization
Counseling
Differential Aptitude Test
Differentiation
Disability
DISCOVER
DOT
Dual-Career
Handicap
Holland's HOC
Interest
Leisure
MAPS
NOICC
Obsolescence
Occupational
Outlook Handbook
Occupational
stress
O*Net
P x E Fit Cyclical
RAISEC
Role Salience
Rust Out
Shadowing
Standard Occupational
Classification
Transition
Unemployment
Work

# Introduction

There is one reference to career development in the 2014 Code of Ethics. The reference is for counselor educators to provide students an awareness of career advising for job opportunities (F.8.b.). Many of the constructs such as respect, relationship, informed consent, client rights, releases, confidentiality, assessment, record keeping, technology, Internet counseling, electronic transmissions, employment, social media, research, competence, supervision, diversity and cultural specifics, instrumentation pertinent for guidance, counseling and psychotherapy are the same for each of the eight units in this study manual.

A review of the lifestyle and career research reveals that currently there is a resurgent interest in viewing individuals in relation to ongoing human development. Increasingly, there has been an awareness of the importance of focusing on people's development throughout the life span. Pryor described career development as "a series of continuous decisions about career choices" (as cited in Patton & McMahon, 1999, p. 4). The Manhattan Study conducted in the 1950s rated some 1,500 New Yorkers on psychological health; less than one-fifth were rated "well," while one-fourth were rated as "impaired" (Valliant, 1977). The Northcutt Studies in the early 70s indicated that 40% of the American adult population is coping inadequately with typical life problems (Knowles, 1977). The 1980s

witnessed Americans in one or more phases of career transition. The 1990s have emphasized work preparation for life may need to be in several skill areas. It is clear that workers are likely to retrain and work in several different jobs throughout their life span. The 1990s witnessed workers of all ages searching for positions in employment as worker layoffs in the form of institutional downsizing, rightsizing; 'involuntary separations', forced management, reshaping, reduction in force, repositioning, and reengineering, along with the normal released numbers of skilled and experienced workers into the unemployment pool. These individuals as well as high school and college graduates are seeking jobs, information on occupational fields, analysis of career possibilities, list of training programs, job-skill training, and counseling.

One outcome of the reports summarized above has been a resurgent interest in research regarding all aspects of work in the individual's developmental cycle. The major contributions of a few researchers are organized below for review.

George Vaillant (1977) in studying 300 Harvard graduates concluded that no single event greatly influenced the process of midlife adjustment. Long-term relationships and recurrent events in adult development are of greater importance than isolated traumatic events.

Daniel Levinson's (1978) in The Seasons of A Man's Life concluded that the term life cycle is better adapted to the course of one's development and is composed of four overlapping cycles: Childhood (0-20), Early Adulthood (17-45), Middle Adulthood (40-65), Adulthood (60+).

Gail Sheehy (1976) described adult development in Passages. Passages are the transitional periods and the difficult times for adults. Sheehy's Life Stages are: Pulling up roots 18-22, Trying twenties 22-29, Catching thirty 30, Rooting and Extending 30s, Deadline decade 34-45, Renewal and Resignation (mid 40s).

Robert Gould (1978) in Transformations: Growth and Change in Adult Life suggests the basic recurring developmental task is to rid oneself of major false assumptions in order to reach maturity. Gould's theory is composed of six periods covering the ages of 16-60. Each individual progresses through tasks during a particular time period. Gould's periods, task and myths are:

| Period | Task | Myth |
|---|---|---|
| 16-22 | Leaving parents' world to parents | Always belong |
| 22-28 | I'm nobody's baby | Doing things same way as parents |
| 28-34 | Opening up to what's inside | Life is simple and controllable |
| 34-45 | Mid-life | No evil or death in world |
| 45-53 | "Die is cast" (sympathy & affection) | We are whoever we are |
| 53-60 | Later middle & old age | |

# The History of Vocational Guidance: An Overview

Brewer (1942), in describing the development of guidance, listed democratic ideals, labor divisions, technological growth, and the development of vocational education as major factors. The history of vocational guidance in the United States prior to and during the early 1900s was molded by individual efforts during the Social Reform Movement. Individuals such as Eli Weaver, G. Stanley Hall, Hugo Munsterberg, John Dewey, Jesse Davis, and Frank Parsons gave rise to a movement that reflected upon human rights, worker dignity, choice, work, work performance, skill development, and satisfaction. Recognizing influential individuals is important; however, few names have been answers to questions for the NCE. Names have been included in this manual to reflect their important contributions and major movements to the field.

1890: JAMES McKEEN CATTELL: Published an article called "Mind." Cattell was the first to use the term "mental test." He studied under Wilhelm Wundt and Francis Galton and laid the groundwork for testing in the United States. He was interested in differences and believed that these differences should be studied systematically.

1896: LIGHTNER WITNER: Opened first psychological clinic. He was interested in learning disabilities. A student, Morris Viteles, developed the "clinical approach" in vocational and moral guidance.

1907: JESSE DAVIS: Grand Rapids, Michigan. He was a counselor for the 11th grade and conducted class period on "vocational and moral guidance."

1908: CLIFFORD BEERS: Mental Health. Wrote the book, *A Mind that Found Itself.*

1909: FRANK PARSONS: Wrote a noteworthy book, Choosing a Vocation. The Minnesota Employment Stabilization Research Institute (1930) recognized his work. He established Vocations Bureau in Boston and advocated a three-step procedure for guidance culminating in true reasoning. He is credited as the Father of Guidance.

1910: BOSTON: First National Conference on Vocational Guidance.

1911: Vocational Guidance Newsletter: First American Journal devoted to vocational guidance. It was the predecessor to 1951 APGA journal called Personnel and Guidance Journal.

1912: HUGO MUNSTERBERG: Was schooled in Germany and later employed at Harvard University. He applied experimental psychology to the study of vocational choice and worker performance. A major contribution was his development of methods for determining aptitudes and characteristics of men who were successfully employed.

1913: NVGA: At the third National Conference on Vocational Guidance the National Vocational Guidance Association was established. It was the forerunner to APGA.

1917: Several psychologists were appointed to government positions to determine if psychology could assist in the war effort (Bingham, Yerkes, Otis, Scott, Thorndike, etc.). Testing instruments such as the Otis IQ and the Army Alpha/Beta were developed.

1918: JAMES BURT MINER: Developed the first interest questionnaire at Carnegie Institute of Technology. Bruce Moore conducted research with graduate engineers and Karl Cowdery applied a differential weighting system to interest item responses.

1925: HARRY KITSON: He was a pioneer in the training of counselors for vocational counseling, which became a specialized field.

1927: E. K. Strong's Vocational Interest Blank (SVIB) appeared in 1927.

1931: DONALD PATTERSON: Directed the Minnesota Employment Stabilization Research Institute and studied factors in unemployment. Thousands of vocational diagnoses were made from aptitude batteries, interviews, and occupational ability patterns (OAP).

1938: HARRY JAEGER: Created the Occupational Information and Guidance Service Bureau.

1939: CLARK HULL: Published work on aptitude testing. He saw counseling as capable of predicting vocational success. He proposed a machine would eventually yield differential occupational predictions from aptitude test data.

1939: DOT: Dictionary of Occupational Titles published. A two-volume series prepared by the job analysis and information section of the U.S. Employment Service. The DOT defined 18,000 occupations. The two volumes, at a later time, were condensed into one volume and many more occupations were included.

1940: AGCT: Army General Classification Test. The armed forces developed a test to establish the classification and military assignment for several million recruits.

1942: CARL ROGERS: Published Counseling and Psychotherapy. His contributions created a movement away from testing and directive counseling (guidance) toward a client-centered approach to counseling in career development and the field of counseling.

1951: DONALD SUPER: Launched a pilot study called Career Pattern Study to test his career theory. He was one of the first vocational theorists to research his theory. His writings and theory freed people from a single-at-a-point choice in making a vocational choice.

1969: JOHN CRITES: Presented first objective taxonomy for the classification of problems in career decision-making. Career choice was defined in terms of aptitude, interest, and choice data. He advocated Comprehensive Career Counseling.

1970: Emphasis changed to career education (kindergarten to adulthood) and included:

1. career awareness
2. career exploration
3. value clarification
4. decision-making skills
5. career orientation

6. career preparation

Forerunners for Professionalism: APGA developed professional standards and NVGA set up procedures for credentialing of career counselors

# Guidance: Career and Life Span

## Work and Work Characteristics

Work has always been a major activity in the daily life of man. Historically, from a food gatherer to a knowledge provider the work role has changed to meet the existing needs. Changes in work roles along with the innovations and expansion in technology have necessitated an increased need for multiple skill developments to do that work. As the worker has focused more on skill development an interpersonal distance has been created between the worker and the work arena. Behaviors such as longevity in work, worker and company loyalties, hostility in the workplace, and commitment appear frequently in the guidance and counseling hour. This has created a need for assistance in bridging the gap between the worker and the employer. This assistance during the early years came in the form of guidance.

Individuals, young and old, often lack direction in locating a job, lack career exploration skills, and do not have the ability to assess potential career options. Career counseling is a process involving exploratory skills, values, development, needs assessment, goal identification, and the necessary skills to secure a job (interviewing skills, job specifics).

A variety of developments gave rise to the concept and formation of guidance in the United States. Some of these influential movements are:

1. philanthropy and humanitarian
2. religion
3. mental hygiene
4. social change
5. individualism
6. federal support
7. client-centered therapy

"Traditionally, work has an economic, psychological, and social perspective regarding the purpose and meaning of work. These categories are not mutually exclusive, and very few individuals would just work for one purpose. For most people, critical questions relate to identifying a career path and determining how they climb the career ladder. How do they acquire the skills needed to progress in a chosen career field?" (Drummond & Ryan, 1995, p. 40)

Herr and Cramer (1992, 1996) provide numerous definitions and purposes of work from an economic, psychological, and social perspective. Economic purposes tend to reflect a gratification of wants, acquisition of assets, security, liquid assets for investment and purchase of goods and services, success, and leisure. Social reasons tend to be for friendship, social status, feelings of being valued, relationships, sense of being needed, and responsibility. Psychological purposes are for self-esteem, identity, dependability, competence, self-efficacy, and commitment. Generally, work can satisfy psychological needs and many career theorists believe that career choice reflects our self-concept and that we develop our personal identity through a career choice (Drummond & Ryan, 1995).

The meaning of work changes as it is integratively derived from the work ethic of the time. To understand worker satisfaction and dissatisfaction, one has to take into account the prevailing worker ethic, economics, technology, mobility, social class, ethnic background, and psychological factors. For the present, although dated, worker satisfaction is related to the level of prestige, autonomy, work group cohesiveness, job challenge, working conditions, wages, job security, and upward mobility, variety of tasks and management sensitivity and involvement. The meaning of work has also changed as society has undergone a transition from goods to services to knowledge producing.

Seemingly, the majority of people who work are satisfied with their choice of careers. However, small percentages of people remain dissatisfied with work experiences or have patterns that lead to failure. Neff (1977) described work pathology in terms of type. These types reflect individuals who lack work motivation, experience anxiety or fear at work, display hostility or aggression, and, finally, reflect a dependence on others. For the most part, Neff's typology reflects that people who have difficulties in making appropriate career choices lack socialized work values, react to demands of productivity, experience relationship issues with peer workers, have trouble pleasing authority figures, and lack knowledge about themselves as workers. Neff (1977) lists some reasons for dismissal and work adjustment.

| **DISMISSAL** | **ADJUSTMENT** |
|---|---|
| 1. carelessness | 1. punctuality |
| 2. laziness | 2. honesty |
| 3. absence/tardiness | 3. reliability |
| 4. disloyalty | 4. dependability |
| 5. distraction | 5. initiative |
| 6. too little/much ambition | 6. cooperation |

Individuals, young and old, often lack direction in locating a job, lack career exploration skills, and do not have the ability to assess potential career options. Career counseling is a process involving exploratory skills, values, development, needs assessment, goal identification, and the necessary skills to secure a job (interviewing skills, job specifics).

# Variables to Consider in Career Guidance

Presently, career counselors generally explore the value and function of work in an individual's life. Theory and research have "produced a consensus that assessment for career choice should include an understanding of the client's interests, abilities, and values" (Yost & Corbishley, 1987, p. 57). Also emphasized in work-related preferences are personality, temperament, career maturity, and work environment. Furthermore, when counseling for career issues it is important to consider the client's values as they relate to family and leisure (Yost & Corbishley, 1987).

## American Work Ethic

The United States worker ethic has undergone a number of changes. Some of these are: Protestant ethic, craft ethic, entrepreneurial ethic, career ethic, and finally self-fulfillment ethic. Maccoby and Terzi (1981) identify the motivation to work behaviors for each work ethic as:

1. Protestant ethics—labor as a religious imperative, for the greater glory of God, a moral obligation, work is first.
2. Craft ethics—social obligation benefited the individual, as self-sufficiency and a desire for control of work standards—independence from entrepreneurs.
3. Entrepreneurial ethics—came about during mass production, machines, free enterprise, and risk-taking.
4. Career ethics—self-employment decreased, moving up the ladder, being loyal to the employer/business.
5. Self-fulfillment ethic—orientation toward greater concerns for self-fulfillment, personal growth, enjoyment of work, and a life of leisure.

## Stress at Work

Zunker (1986, 2002) compiled a list of stress sources for workers. These stress resources were derived from the research of numerous researchers.

1. Conditions of work—pace of work, hours, etc.
2. Work itself—repetitious, over loaded, uninteresting
3. Shift work—bodily function/family disturbances
4. Supervision—close/no supervision, unclear job demands
5. Wage and promotion—low pay
6. Role ambiguity—lack of clarity
7. Career development stressors—lack of job security, attainment, obsolescence
8. Group stressors—no group cohesiveness or identity
9. Organizational climate—impersonally structured

10. Organizational structure—bureaucratic/ autocratic

## Motivation

Several theories attempt to explain what motivates individuals to work. Three of these theorists are:

1. Maslow: Need theory—individuals work to satisfy needs
2. Herzberg: Two Factor theory based on motivators and hygiene
    a. Motivators—recognition, achievement, responsibilities and work
    b. Hygienes—negative perceptions of company, extrinsic to job
3. McClelland: People work for one of three basic needs.
    a. NACH Need for achievement, intrinsic rewards, success as measured against some internalized standard of excellence
    b. NAFF Need for affiliation, close interpersonal relationship and friendship
    c. NPOW Need for power, direct control or influence over others

## Burnout

Herbert Freidenberger (1974) was the first to use the term burnout in relationship to work behavior. There is no conclusive evidence to suggest that burnout is a result of stress or a part of the developmental aspect of career theory. The term is derived from psychiatric patients who were burned out physically, emotionally, spiritually, interpersonally, and behaviorally to the point of exhaustion (Paine, 1982). Burnout is an "internal psychological experience involving feelings, attitudes, motives, and expectations" (Maslach, 1982, p. 29).

Definitions for "Burnout"

1. Freidenberger (1974) applies the term to career behavior as a depletion of an individual's physical and mental resources. The etiology of burnout is an excessive striving to attain an unrealistic goal imposed by oneself or by the values of society.
2. Cherniss (1980) describes burnout as a process in which a previously committed professional disengages from his/her work in response to stress and strain experienced on the job. In the helping profession, burnout occurs in three stages:
    a. demands of a job (imbalance between resources and demands)
    b. strain due to emotional response to anxiety and tension
    c. cope defensively by changing attitude to job commitment
3. Maslach (1978) views burnout as a loss of concern for people with whom one is working. It is characterized by an emotional exhaustion in which the professional no longer has positive feelings, respect or empathy for clients.

4. Howard (1975) describes burnout in relation to individuals who are underemployed and who are in occupations that do not make full use of their education and training, or who do not have enough pressure and challenge on the job.

The two types of stressors that contribute to burnout are psychosocial and biogenic. Levels of burnout are trait, state, and activity (Forney, Wallace-Schutzman, & Wiggers, 1982). An individual is nonfunctional when burnout is at the trait level. Burnout is situational or periodic if at state, and at the activity level when routine. The levels are progressively more severe as you move from activity to trait. Edelwich and Brodsky (1982) outline a four-stage burnout as:

1. Enthusiasm—high hopes and unrealistic expectations
2. Stagnation—when personal, financial, and career needs are not met
3. Frustration—questions effectiveness, one's value, and impact of self and efforts as obstacles appear
4. Apathy—indifferent to the situation and resists efforts of intervention

In summary, burnout is thought to develop in phases, is cumulative, and is a reaction to occupational stress. Individuals who have experienced burnout report negative work experiences and negative outcomes. If burnout is not treated, it is likely to result in a crisis and has been known in severe cases to cause depression and abuse in the form of alcoholism.

## Work Classification Systems

Several classifications systems exist that organize and categorize work according to characteristics of the work, work setting, tasks, personality, etc. Herr and Cramer (1996) outline classification systems by industry, socioeconomic group, occupation, interests, field and level, field, level, enterprise, income, type of work, educational prerequisites, occupational duties, life span, rewards, and age. A few examples are provided in recognition of how they are utilized in a variety of resource materials (DOT), interest inventories, and in reporting federal and state departmental labor statistics.

1. Standard Occupational Classification (SOC). This system has 21 divisions, 14 major groups, minor groups, and unit groups. This system is often used for research.
2. U.S. Office of Education (USOE Clusters). This system has 66 work groups, 15 occupational clusters, and 348 subgroups.
3. Holland Occupational Classification System (HOC). This system utilizes six stereotypes to classify occupations. Realistic, Investigative, Artistic, Social, Enterprising, and Conventional (RIASEC).
4. Standard Industrial Classification System (SICS). This is the federal government's system that has 11 broad divisions that are broken down into 84 categories.
5. Anne Roe's Two-Dimensional Classification. Field (8) and Level (6). Field is divided into four person and four non-person occupational orientations, while Levels are based upon responsibility, education, and prestige.

6. Occupational Aptitude Patterns (OAP). This system is based upon the General Aptitude Battery and pertains to physical relations, maintaining bureaucratic order, dealing with social and economic relations, and performing work.
7. Status Classifications. Some classification systems are based on the status of the occupation. Status is determined by the perceived prestige that is based on the amount of money, level of power, type of work, degree of responsibility for social welfare, amount of education, and other indices. This system is called National Opinion Research Center Scale of Occupational Prestige (NORC; Herr & Cramer, 1996).

## Unemployment

Job loss tends to follow a process of shock or disbelief to adaptation. Schlossberg and Leibowitz (1980) developed a five-stage process composed of disbelief, sense of betrayal, confusion, anger, and resolution. A number of factors are important in assessing the psychological severity of the job loss (trauma to expected job loss), whether a primary wage earner or otherwise, family support systems, and the ability to resolve a crisis.

The unemployment scheme presented by Kroll (1976) may be dated; however, it does provide a framework for viewing those who are not working.

1. Seasonal: Includes occupational work associated with climatic conditions such as tourism, food production, construction, etc.
2. Cyclical: Fluctuates with fiscal and monetary policy. Often controlled by consumer demands.
3. Frictional: Time between completion of schooling/job and next involvement.
4. Structural: Where differences exist between skills of those seeking jobs and what skills are required

**Question 4-10:**
The goals of occupational exploration and career planning are most characteristic of which developmental group?

a. elementary students
b. junior-high-school students
c. senior-high-school students
d. post-secondary students

Answer: c. senior-high-school students. Goals for senior-high-school students tend to be those of self-knowledge, educational and occupational exploration, and career planning.

# OBJECTIVE 4A: Vocational Theories: An Introduction

Each vocational theory, irrespective of its assorted classifications and definitions, is concerned with the decision process and subsequent adjustment to the world of work. The job determinants which reinforce a good decision and on-the-job adjustment are reported to be: self-reinforcement, environmental and organizational reinforcement, and altruism (Shubsachs, Rounds, Dawis, & Lofquist, 1978), and safety, altruism, comfort, achievement, aggrandizement, and autonomy (Lofquist, & Dawis, 1978).

Work adjustment theory focuses upon the person developing a relationship with a work environment. This correspondence occurs when the worker and the environment are co-responsive to each other. Correspondence is in constant change as individuals and environment change. Lofquist and Dawis (1978) describe one aspect of their theory of work adjustment as the individual possessing a personality style. These styles are:

1. Activeness: act on their environment to increase correspondence
2. Reactiveness: change work personality to increase correspondence
3. Celerity: speed with which the person acts to increase correspondence (quickly/slowly)
4. Flexibility: tolerance for "discorrespondence"

## Classifications and Definitions

Since the early 1960s there has been an effort to classify and predict how individuals will select a satisfying job and career.

Trait-and-Factor or Actuarial: Emphasis is placed on personal traits and how they match job traits.

1. Frank Parson
2. E. G. Williamson

Decision Theory: A process by which the individual uses concepts to choose a vocational alternative that offers the best result.

1. H. B. Gelatt
2. Hershenson and Roth
3. Martin Katz (SIGI)
4. Tiedeman, Tiedeman and O'Hara

Psychological Emphases: Emphasis is with one's psychological makeup and how the interaction affects choice (motivation, self-esteem, needs).

1. Anne Roe
2. John Holland

3. Robert Hoppock

Developmental Emphases: These theories reflect a longer time period for development and career choice.

1. E. Ginzberg
2. Donald Super
3. Tiedeman and O'Hara
4. Robert Havighurst

Psychodynamic: Occupational choice is influenced by the separation from the family as the child develops a self-identity. Emphasis is upon unconscious motivation and in meeting emotional needs. Nachman, Segal, and Bordin

Humanist: Adolescent's work as a fundamental component of the self-actualization process of fulfilling one's potentialities in life.

1. Carl Rogers
2. Donald Patterson

Cognitive: The first real work experiences change our entire way of thinking about ourselves and the world of work. Social Learning Theory

Behavioral: The meaning of rewards as a method of achieving goals and satisfying needs undergoes conditioning during this period. Emphasis is on anxiety and diagnosis. The principles of learning theory are utilized to explain career behavior.

1. John Krumboltz
2. Carl Thorensen
3. Albert Bandura

Sociological Emphases: Sociological factors, such as one's social group and social structure, exert an influence on vocational development and choice.

1. Miller and Form
2. Status Attainment Theory
3. Wisconsin Model
4. Economic Theory
5. Dualist Theory
6. Tournament Theory

These designations for categorizing theories may appear to be different depending upon the writer. Some author-theorist such as John Holland could appear under the psychological framework and yet

appear under a personality framework. Yet, newer formations relative to career theory are emerging such as systems theory and constructivism.

Theories in career development have added some newer theories and can be explored if one has achieved competence in the above theories. Some of these are a cognitive information processing approach (Peterson, Sampson, & Reardon, 1991), career guidance from a social cognitive perspective (Lent, Brown, & Hackett, 1996), values-based, holistic model of career and life-role choices and satisfaction (Brown, 1996), and contextual (Brown, Brooks, & Associates, 1996).

In addition to new and different vocational theories emerging there are also different approaches to career counseling. One such is Cochran's Narrative Career Counseling (Cochran, 1997). A current trend in vocational theory and counseling is to integrate different theories and models for life planning. Hansen (2000) has one such approach called the Integrative Approach to Life Planning. A second way to understand and align theories along a matrix of active-inactive to structured-unstructured was developed by Reardon, Lenz, Sampson, and Peterson (2000). As these two sets of opposites intersect four quadrants are evident. They classify theories falling into the active-unstructured (Super, CIP, Krumboltz, 1979), inactive-unstructured (Tiedeman), inactive-structured (Roe, Parsons), and active-structured (Holland).

# Vocational Theories

## Trait-and-Factor

### FRANK PARSONS

Pope and Sveinsdottir (2005) researched the personal and occupational life of Frank Parsons and noted that Parsons worked in at least nine occupational jobs. Frank Parsons was the first to outline the process involved in choosing a career. His efforts initiated the vocational guidance movement (Gladding, 1992, 1996). Parsons was active during the times of the Social Reform Movement and Settlement Houses. Parsons was a trained engineer, mill worker, teacher, dean, lawyer, as well as a volunteer who worked with immigrants and young people seeking jobs. Parsons utilized "True Reasoning" in vocational guidance. He advocated a three-step model:

1. Assessment: a clear understanding of your aptitudes, abilities, resources, and limitations
2. Occupational requirement and conditions of success: (dis)advantages, compensation, opportunities, and prospects
3. Decision-making: true reasoning of the above two

Parsons' three-step model was based on psychometric methods by which aptitudes, interests, and various other characteristics could be measured. Parsons appreciated the contributions of psychometric techniques but recognized that instruments in existence were not very sophisticated. He relied upon the case study of social work to secure information about the person. A second influence combined his second and third stages, that is, providing occupational information and counseling through a direct, advice-giving approach. He wrote *Choosing a Vocation* and included material from

the work of Hugo Munsterberg, who was developing tests for measuring the abilities of men in various jobs. By 1939, three lines of thinking regarding vocational guidance emerged:

1. The importance of personality dynamics in vocational choice and adjustment. This was in conjunction with the rising interest in psychotherapy.
2. A developmental view of human growth.
3. A concern for the meaning of work.

Parsons counseled for "character analysis." He paid careful attention to physical attributes, non-verbal behaviors, and the ability to speak. He believed in giving homework as a part of educating the individual about oneself and the world of work. Frank Parsons is considered the father of vocational guidance.

## E. G. WILLIAMSON

The Trait-and-Factor Theory assumes that man has a variety of capacities that form an organizational pattern. These capacities can be identified through instrumentation. Individuals such as Hugo Munsterberg (human adjustment), Frederick Taylor (time and motion studies for standardizing work units), and Paterson and Elliott (standardized mechanical aptitudes tests) made sizable contributions, which became a part of Trait-and-Factor Theory. The actual theory was developed during work with dislocated men and women during the time of the Great Depression. Many of these individuals came for assistance to the Minneapolis-St. Paul Occupational Analysis Clinic.

The model is atheoretical, other than the concept of individual differences, and it relies upon an empirical base of definition and statistically predictable variables. The theory is atomistic and analytical. The trait-and-factor foundation is built upon differential diagnosis, that is, a process of ferreting out assets and liabilities in order to make a prognosis or prediction for future jobs. This theory was considered to be durable. It evolved from early studies of individual differences and psychometric techniques and emphasized self-understanding, realistic planning, and decision-making skills. The process is considered to be rationalistic and represents a cognitive model.

1. Synthesis: collate and summarize by means of case study and test profiles
2. Diagnosis: describe outstanding character problems, comparing profiles with education and occupational ability profiles and determining causes of problems. Williamson developed a method for counseling individuals, and at the same time developed four categories for diagnosing:
    a. No Choice: The client is unable to state a choice.
    b. Uncertain Choice: The client has chosen a career and can verbalize the title but expresses doubt.
    c. Discrepancy between interest and aptitude/ abilities and fields. Three discrepancies:
        1) interest more than aptitude
        2) interest less than ability
        3) interests and abilities the same but in different fields.

    d. Unwise choice: Disagreement between abilities and interests and requirements of the occupation
3. Prognosis: judging consequences and probabilities of adjustment
4. Counseling: advising a client what to do to effect desired adjustment
    a. Analysis:
        1) collect data about attitudes
        2) interests
        3) family background knowledge
        4) educational progress
        5) aptitudes
5. Follow-up: repeat above steps

Relationship: is one of teacher/student

Stages:

1. Listen to the client—Rapport
2. Test interpretation
3. Dissemination of occupational information

Techniques: Williamson advocated five techniques for interviewing.

1. Establishing rapport
2. Cultivating self—understanding
3. Advising—planning a program of action
4. Carrying out the plan
5. Referral

Occupational Information: Serves three functions

1. Informational
2. Readjustive—reality testing for choice
3. Motivational: involve the client

This was considered a successful model until about 1950, when it faded to the work of Carl Rogers and social learning approaches.

Criticisms: Disfavor arose from several sources such as:

1. According to Weinrach (1979) this theory suggested that people are rational beings. It was questioned because it relied heavily on the cognitive side to the exclusion of affective processes.

2. The belief that occupational choice is a single event and that a specific type of person is in each specific type job and that there is a single goal. This single concept idea changed with the work of Donald Super, John Holland and P x E Fit (Herr & Cramer, 1992).
3. The theory was largely unreliable. The agreement in diagnosing was very low, rarely above 50%, and the categories were not independent and exclusive. More categories are available.
4. Thorndike and Hagen (1959) followed career patterns of 10,000 people who took tests in the armed forces (World War II). Results suggested that tests taken 12 years earlier did not accurately predict occupational placement.
5. That everyone had a single career goal was questioned.
6. There was not expert agreement that career decisions are based primarily on measured abilities.

Trait-and-Factor Theory began to change and recently has evolved into a person interaction environmental fit (P x E) where each influences the other. The theory moves beyond matching for congruence to the idea of DYNAMIC RECIPROCITY. Dynamic Reciprocity reinforces the idea that the individual shapes the environment in which he/she works and that environment shapes the person working in that environment. This concept has been used to develop theories of vocational choice and adjustment. John Holland is a well-known P x E theorist. Dawis and Lofquist in their Theory of Work Adjustment (TWA) use different dimensions to describe structure of the work personality and the work environment. TWA advocates a correspondence between work abilities and work ability requirements as predictive of worker competence.

**Question 4-11:**
Frank Parsons' three-step model of career counseling relied heavily on:

a. psychometrics for analysis.
b. goal-setting.
c. the self-actualization process.
d. character analysis.

Answer: d. character analysis. Parsons relied heavily upon the case study process of social work to secure information regarding the true character of a person. This information enabled Parsons to gain a clear understanding of an individual's aptitudes and abilities. Parsons recognized that psychometric techniques in existence were not sophisticated; he therefore relied on "character analysis."

## P x E Fit

The P x E Fit system developed by Dawis, Dohm, Lofquist, Chartrand, and Drue (1987) describes the person-environment interaction of Work Adjustment (TWA) theory dimensions, levels of work abilities, and values. The components of each are:

1. Ability Dimension:
    a. Perceptual—perception and interpretation of stimuli

b. Cognitive—storing, processing, and transforming
c. Motor—manual, dexterity

2. Values and Occupational Reinforcers:
    a. Internal—achievement, autonomy, status
    b. Social—altruism
    c. Environment—comfortable and safe work conditions
3. Levels:
    a. High
    b. Moderate
    c. Insignificant

## Stages of P x E Fit:

1. Diagnostic Appraisal: Clients seek an appraisal because
    a. career indecision
    b. they desire confirmation for a tentative career choice
    c. hope to improve their work satisfaction

    The counselor will:
    a. differentiate the presenting problem
    b. set priorities among goals
    c. assess current resources and stressors
2. Counseling Process: The process is to facilitate career decision-making, planning, and adjusting through the acquisition of problem-solving skills (Rounds & Tracey, 1990).
    a. Information Processing:
        1) encoding—perceive information and appraise its meaning
        2) goal setting—establish concrete, realistic goals and organize them in sequence
        3) develop plan and alternate solutions, multiple avenues and considerations of pattern matching consequences
        4) acting—implementation
3. Counseling Outcomes:
    a. client—stated goals
    b. process being learned through counseling
4. Approaches to Counseling:
    a. counselor style-supportive
    b. directive teacher style

## Decision Theorists

The key ingredient of decision theory is the process of decision-making. A career goal of decision theory is to choose a career or occupation that will maximize gains and minimize loses. The decision is based upon what the individual decides is of primary value to him/her. For some, it may be money while for others it may be prestige, security, or a social climate. Decision theory advocates alternatives that are available and an essential aspect of the process for decision-making.

### H. G. GELATT

Gelatt's first work was with Clarke and Levine in which they developed a decision-making scheme for career development. This model suggests that an individual need both a prediction and a valuing system to make a decision. Gelatt advocates a prescription model in which intuition is valued. The process includes a purpose, identifying choices, predicting possible outcomes, and estimating probable results. Relooping or the step of investigatory decision for reentry is important when indecision exists (Gelatt, 1962). A decision is based upon information. The more information a person has, the clearer are the risks involved. Gelatt does not indicate that this will reduce the risk, rather it will delineate the magnitude of the risk. Positive uncertainty is to discover new connections between an old view and a new insight and to provide for the framework that will allow the client to interact with change and ambiguity. In addition, this process will assist the client in accepting uncertainty and inconsistencies, and to use his/her nonrational and intuitive side of thinking (Herr & Cramer, 1996).

Stages:

1. Information about alternative action
2. Information about possible outcomes
3. Information about probabilities linking actions to outcomes
4. Information about preferences for the various outcomes (Herr & Cramer, 1996).

Decide:

Data, Evaluation, Counseling, In, Decision-Making, Effectiveness.

In summary, Gelatt states that "decision-making is a process of arranging and rearranging information into a choice or actions" (as cited in Herr & Cramer, 1996, p. 190). Gelatt advocates the use of subjective data in the uncertainty of making a choice.

### MILLER-TIEDMAN, TIEDMAN, and O'HARA - (Decision Theorists with a developmental emphasis)

Miller-Tiedeman and Tiedeman trace the history of the present decision theory to Tiedeman and O'Hara's study of Super's self-concept theory. Rejecting aspects of that theory they elected to utilize Erikson's theory of ego development as the cornerstone for making decisions. Their theory is one of how people decide, not what they decide. Since 1971 the theory has shifted to life is-career that is

guided by inner knowledge. This framework includes living in the moment, beyond a lifetime, living by inner guidance, and life is as it has always been (Miller-Tiedeman & Tiedeman, 1990). An essential difference in this model and the previous one is the use of literature outside of the career field such as decision-making, self-organizing theory, and quantum mechanics.

## Decision-Making

The major principle of this theory is the linkage of personality and individual responsibility.

## Theory

Tiedeman and O'Hara's theory is based on the constructs of ego personality. Career development is the process of creating a vocational identity through differentiation and integration of the personality as one encounters the work in living (Tiedeman & O'Hara, 1963). The developing self becomes more differentiated and comprehensive. This development includes situational, social, and biological factors. Decision-making involves anticipation (formulation of a choice), implementation, and adjustment. Tiedeman and O'Hara studied the relationship between aptitude, interest, social class, and values (the Ginzberg model) and the development of a vocational self-concept (Super). This ego self is viewed as an entity which is always expanding or contracting at choice points when critical decisions are made after past discontinuity.

The process is one of shared impact between the self-concept of a person and the environmental expectations. The personality is formed by the individual's perception of career choices and by the norms and values of those individuals within those occupations. Therefore, the person's self-concept and career concepts mature as the person processes small decisions.

Ego Identity is a process of:

1. successively more refined and complex differentiations of the person's attitude toward oneself and his/her environment.
2. searching for integration at more and more comprehensive levels of identity and acceptance of the new self.
3. differentiation and integration occurring in relation to persons, things, and ideas.

## Components of Decision-Making

Osipow (1983) listed three components for career decision-making:

1. Ego identity is a continuous differentiation based on experience.
2. Differentiation is based upon problem-solving.
3. It is a rational differentiation (higher level of differentiation).

Therefore, self-development is EGO EVOLVING. This theory parallels Erikson's eight-stage orientation. One reaches differentiation and integration.

Process:

1. disorganized thinking about occupational field
2. evaluative process
3. decision (preliminary)
4. refractory period (expresses doubt)
5. induction into groups
6. integration (resolves conflicts of individuality)

Differentation happens by considering a choice. It is a matter of separating experiences, whereas integration is structuring the experiences into a more comprehensive whole. Tiedeman indicates that some people do not see these choice points, while others desire sameness and constancy, or miss the opportunities to process. This process is one of acting on choice points to differentiate and integrate in order to create larger wholes of themselves.

## Decision Process

1. Anticipation or Preoccupation:
    a. Exploration (awareness)
    b. Crystallization
    c. Choice (felt being)
    d. Clarification

At first the person has disorganized thinking about an occupational field. This is followed by a clearer distinction among fields by considering information. The person begins to make judgments regarding the advantages, disadvantages, and relative values. This process brings about some preliminary decision making and is followed by a refractory period, a time when the person expresses doubt.

2. Implementation or Accommodation:
    a. Induction (self participates)
    b. Reformation (abandons self for group purpose)
    c. Reintegration (group and self)

The individual is inducted into a group where he/she identifies closely with the purposes of the group. Later the person questions these purposes and may try to change the group. This is followed by integration, a process whereby the person resolves the conflicts of individuality with the group's demands and is able to integrate the two. A balance is achieved when the environment is changed to fit oneself, and changing oneself fits the environment. Self-evaluation is necessary to develop competence. Each decision calls for a new series of differentiation and integration.

Miller-Tiedeman and Tiedeman (1990) believed that to advance in one's field the person needs to be able to define reality. They defined two kinds of reality: personal and common. Knowing the difference between the two will allow the person a choice, thus allowing the person to be proactive rather than reactive.

1. Personally authoritative reality is an act, thought, behavior, or direction the individual feels is right for him/her and endorse one's own feelings.
2. Common reality is what others say is right for you.

Miller-Tiedeman and Tiedeman (1990) utilize a cube to illustrate their model of decision-making. Three levels interact with each other and form a series of 27 possible combinations of acting on a problem.

1. The first is the problem condition composed of:
    a. problem forming
    b. problem solving
    c. solution using
2. The second is psychological states of:
    a. accommodation
    b. clarification
    c. exploration
3. The third is self-comprehension composed of:
    a. doing with awareness
    b. doing
    c. learning about

Their pyramidal model of decision-making comprehension is made up of four levels:

Level 1: Learning about the problem (forming)
- a. define problem
- b. exploration
- c. collect information
- d. crystallization
- e. choice

Level 2: Problem-solving (doing)
- a. initiating, beginning to act

Level 3: Solution using (doing)
- a. carrying out

Level 4: Solution reviewing (doing with awareness)

a. think about

Miller-Tiedeman and Tiedeman, in developing their life-is-career, introduced "I" power into personal decision-making. "I" power is to internalize the process and make the career and process of career development as one. They developed a model primarily for adolescents to accomplish this "I" power. Their model has three units based upon Romey's Inquiry Techniques. This entails assessing the core functioning of one's ego functioning, value development, and decision-making processes.

This gives the learner a choice to unite the ego and values through a comprehension of his/her decision-making capacity. "I" power is to advance his/her ego differentiation and integration to levels beyond the conscientious stage. Miller-Tiedeman and Tiedeman utilized three theorists in their collaboration model for personal development. These are:

1. Loevinger, Wessler, and Redmore's model of ego development
2. Grave's values development model
3. Miller-Tiedeman and Niemi's Decision-making strategies

The client's problem may be of the following types:

1. A lack of awareness regarding one's personal reality
2. One's personal reality is overwhelmed by the common reality
3. One's decision-making style is ineffective
4. One's ego identity is not fully developed in the areas of autonomy and acceptance of responsibility for directing one's own life
5. Lack of awareness of, or skill in, using a decision-making process

Information Systems for Vocational Systems (ISVS) is the computer software program for this theory.

In summary, this theory advocates a "from within to without" perspective.

**Question 4-12:**
Which of the following is not a component of Trait and Factor Theory?

a. decision-making skills
b. understanding the process of career choice
c. self-awareness
d. testing

Answer: b. understanding the process of career choice

## The Developmental Career Theorists

### GINZBERG, GINSBURG, AXELRAD, and HERMA (economist, psychiatrist, sociologist, and psychologist)

This group was the first to approach a theory of occupational choice from a developmental standpoint. They reviewed the "accident theory" and "impulse theory" and found both of them incomplete. The "accident theory" rests on the idea of chance and external factors without the internal factors. The "impulse" theory stresses the internal factors to the exclusion of the external. As a result, these writers chose to develop a theory that was developmental. They believed that to develop this theory they needed to understand as the person matures how a decision is made. In addition, they needed to understand how the person reacts to the internal and external forces as he/she manipulates the sequences of a decision. They researched males from middle-upper-class urban, Protestant or Catholic families (6th grade to graduate school). They believed this process occurred during a six to 10-year period of time beginning at age 11 and ending at age 17. The process was lifelong, open-ended, and moved through stages. In counseling an individual, assessment was critical in determining the process of decision-making. They developed a set of questions that covered the person, reality, and key people. The person questions revolved around interests, goals, values, and time perspectives. Reality questions involved the social and economic influences of the family, from desired income to marriage. Key people or significant others were individuals who exerted pressure or had influence in the involved choice.

Key Points:

1. They believed there were four variables important in vocational choice (Osipow, 1983):
    a. reality factors
    b. emotional factors
    c. educational process
    d. individual values
2. Choice was an irreversible process of periods and a series of compromises (later changed).
3. Theory was developed from developmental psychology.
4. Vocational choice occurs during adolescent period.
5. Norm group was white boys/Anglo-Saxon/ upper-and middle-class Protestant/Catholic.
6. Periods: Fantasy (0-11), Tentative (11-17), Realistic (17-20 to young adult)
    a. FANTASY: Play gradually becomes work-oriented and reflects initial preferences for certain kinds of activities (before age 11)
        1) change from play to work orientation (function to pleasure)
        2) frustrated by sense of inadequacy and impotency
        3) ignore reality, abilities, potentials, and time perspective (Osipow, 1983).
    b. TENTATIVE: 4 stages (11-17):Tentative choices.

1) Interest (11-12)
2) Capacity (abilities 13-14)
3) Value (clearer perceptions of occupational styles 15-16)
4) Transition choices to responsibility (17)

Behaviors:

1) need to identify a career direction/likes-dislikes, intrinsic enjoyment
2) father's identification (interest stage)
3) evaluate ability to perform well in area of interest (capacity stage)
4) service to society, different lifestyle, giving to others, begin to look for a way to use skills (value stage)
5) need to make immediate, concrete, and realistic decisions (transition stage)

c. REALISTIC: Choices are made. A compromise between reality and personal factors
1) Exploration: college entrance, narrows career choice to two or three possibilities but in a stage of ambivalence and indecisiveness
2) Crystallization: commitment to a specific career field
3) Specification: selects a job or professional training (takes steps to implement)

Behaviors:

1) narrows goal and vocational flexibility, increased ambiguity
2) selection of a path from alternatives (exploration stage)
3) clear idea of what to avoid, decisions are firm and commitment grows (crystallization stage)
4) specification (specification stage)

7. Two basic personality types:
a. Work-oriented
b. Pleasure-oriented

## DONALD SUPER: Life Span-Life Space

Super was intent on the idea of stages and tasks for a life span approach; however, he saw serious shortcomings in the works of Ginsburg, Ginzberg, Axelrad, and Herma. He published his first work in 1953. He proposed that people strive to implement their self-concept by selecting to enter the occupation that seems most likely to permit them self-expression. As one matures, the self-concept becomes stable. External conditions determine how the self-concept is implemented. He made a distinction between the psychology of occupations and the psychology of careers. Differential psychology suggests that an individual and a career are matched. Developmental psychology suggests that career development adheres to the general principles of human development. Super united the two streams of thought and saw SELF-CONCEPT as leading to SELF-PERCEPTS and then to

secondary PERCEPTS. These percepts start off as raw sensations and later become ordered and related to one another. These ordered percepts through maturity become more complex and abstract, which then become the self-concept. He saw the vocational self-concept as only one of several self-concepts a person has throughout development.

Super's theory continued to evolve and is identified as a SEGMENTAL THEORY. This is a loosely but yet unified set of theories dealing with specific segments of career development. The theory is composed of principles from many contributions and is held together by learning theory and self-concept. Two streams of thought heavily influenced Super's original work:

1. Carl Rogers and Self-Concept Theory and Bordin's Projection of Self-Concept in stereotype.
2. Developmental Psychology: Charlotte Buehler and her distinct stages with life tasks which vary according to stage.

By 1974 additional influences had an impact on Super's evolving theory. Some of these are (Super, 1990):

1. Differential Psychology: work and occupation
    a. intelligence and aptitude testing
    b. interest inventories
2. Developmental Psychology:
    a. how people developed these abilities and interests
    b. life stages and developmental tasks
    c. interaction of the individual and environment
3. Occupational Sociology:
    a. mobility
    b. environmental influences
4. Personality Theory:
    a. self-concept and personal construct theories
5. Vocational Adjustment

## Propositions

Super's propositions began at 10 in number and, as the theory evolved, grew to 12 and finally to 14. The following statements are condensed from the 14 listed in Super (1990).

1. People differ in abilities, personality, needs, values, interests, traits, and self-concept.
2. People have the qualifications for many occupations.
3. Every occupation requires a pattern of characteristics and also requires tolerance for a wide array of people and occupational variance.

4. Self-concept changes with time and work along with time and experiences. It becomes more stable from adolescence to maturity.
5. A series of life stages (maxicycle) represents change of growth, exploration, establishment, maintenance, and decline. Each stage has subdivisions.
6. The pattern is influenced by the parental socioeconomic level, mental ability, education, skills, personal characteristics, and career maturity.
7. Success in coping with demands depends upon READINESS. Maturity is defined by being able to cope with stages/tasks of previous stage.
8. Self-concept is a hypothetical construct and is operationally defined.
9. Development of life stages can be guided through maturity, personal characteristics, and reality testing coinciding with developing self-concept.
10. Career development is developing an occupational self-concept and implementing it into an occupation.
11. The synthesizing occurs through role-playing and receiving feedback.
12. Work and life satisfaction depend upon suitable outlets for one's personal characteristics.
13. The degree of satisfaction is proportional to the degree of self-concept implementation.
14. Work and occupation provide the focus for personality organization and yet for others it is peripheral, incidental, or non-existent.

The process of change is a MAXICYCLE. Any given life-career stage depends on the readiness to cope. A maxicycle is a progression through the stages during one's lifetime (birth, growth, exploration, establishment, maintenance, decline, and death).

A MINICYCLE is a process of going through the same stages; however this occurs from stage to stage. Therefore, a person would more than likely conduct a minimum of six minicycles during a maxicycle.

CAREER PATTERN is determined by the parent's socioeconomic level, mental ability, education, skills, personality characteristics, and career maturity. A current pattern is established when a person combines his/her life roles which are comprised of a lifestyle, life space, and life cycle.

CAREER MATURITY: At any given age an individual with the constellation of developed (at that stage of development) physical, psychological, and social characteristics is able to cope with the demands of the previous stage and tasks. This includes both cognitive and affective responses.

Super believed the process of maturity development begins with curiosity (exploratory behaviors) and leads to key dimensions (autonomy) and eventually to problem-solving.

SELF-CONCEPT: For the most part this is similar to Holland's. That is, occupational choice is viewed as the choice of a role and setting in which the person is able to conduct a comfortable and satisfying fit. These choice points usually occur at the time a person takes on new roles or discards old ones. It is at these times a person is most vulnerable to indecision and in need of a cyclical counselor. Self-concept

becomes an attempt to implement a self-concept and the notion of translating one's idea of oneself into occupational terms. This has become a dual focus on the self and a situation.

The meta dimensions of a self-concept are (Super, 1990):

1. self-esteem
2. stability
3. clarity
4. abstraction
5. refinement
6. certainty

Four major elements of his approach are:

1. Vocational development: One of several human growth dimensions. Examples are: ego, intellectual, moral, which can be broken down into stages. Each stage has its own distinct characteristics.
2. Vocational maturity: For each age this is pinpointed that the individual is able to cope with the specific tasks.
3. Translating the self-concept into a vocational self-concept is a reflection of the occupational self-concept.
4. Career pattern: This evolves as the person becomes aware of the information and personal meanings attached to the information.

## Stages

Growth Stage: 0-14, self-concept-identification with important people. Needs, fantasies, interests, capacities, social participation. and reality testing:

1. Fantasy substage: 4-10, role playing
2. Interest substage:11-12, likes role playing
3. Capacity substage:13-14, abilities are Prominent

Exploration Stage: self-examination and exploration (15-24):

1. Tentative substage:15-17, tentative choices
2. Transition substage:18-21, enters world of work, implements self-concept in school
3. Trial substage: 22-24, beginning job

Establishment Stage: 22-44, permanent place

1. Trial substage:25-30, change may be made
2. Stabilization substage:31-44, develop a secure place

Maintenance Stage: 45-64, building

Decline Stage: 65-plus, mental and physical decline

1. Declaration substage: 65-70, part-time job

Tasks: Society presents the individual with time and age-appropriate behaviors to be accomplished. These are biological, educational, and vocational in nature.

Readiness: Readiness is determined by one's cognitive and affective development. The Career Development Inventory (CDI) tests this concept through two affective components of career planning and career exploration/curiosity and three cognitive components. The cognitive components are: knowledge of career decisions, nature of careers, and knowledge of the field of work.

Role Saliency: The constellation of positions occupied and roles a person has played.

Transition: It is a time when a person is between two states of greater stability, a period of flux, vacillation and discontinuity of function, and purpose with respect to work (Jepsen, 1991).

Career Decisions: Super sees this as a series of mini-decisions in which curiosity is essential. Super started out trying to understand the predicting sequence. His first attempt to understand this was through the Career Pattern Study in which he studied maturity.

Career Pattern Study: A study conducted in the 1950s of 138 eighth-and 142 ninth-grade boys from Memorial and Middletown Junior High Schools. The dimensions of vocational maturity studied involved orientation to vocational choice, information and planning, consistency of preferences, crystallization of traits, and wisdom of vocational preferences. His findings revealed a lack of readiness to decide on a specific direction or occupation.

Realism: The degree to which there is agreement between ability and preference, interest and preference, interests and fantasy preference, level of interest and preference, and the socioeconomic accessibility.

Super attempted in 1974 to illustrate his theory through the Life-Career Rainbow. This was a description of life space and life span, however it was not clear. His latest effort at this illustration is the Archway Model.

Archway Model: A graphic presentation of the archway appears in Super (1990). The base of the model includes the biological makeup of the person. The ends represent the person (psychological characteristics) and society (economic resources, structure, and institutions). The arch represents the stages of the self-concept and self. All segments of the arch are held together through learning theory and social learning theory.

Process: The development of self-concept is a progression through exploration to planfulness at each stage and tasks. This process, which is interactive, is illustrated in the Archway. The latitudinal dimension is role saliency, while the longitudinal dimension is based on traits and career maturity.

Techniques and Instruments: Career Maturity Inventory (CMI), Career Development Inventory (CDI), and Salience Inventory

Counseling Applied

Cyclical Counseling: Cycling and recycling of developmental tasks through life span.

1. Appraising what life stage the individual is presently residing. Analysis is based upon the Person-Environment Interactive Model.
2. Assess vocational maturity of the individual.
3. Assess the person's self-concept or role saliency.
4. Expand experiences to experiment and implement self-concept. Teach decision-making for career maturity.
5. Recycle through previous stages.

Language

1. Psychtalk: Language individual uses to think about self
2. Octalk: Both verbal and nonverbal expressions of occupational interests
3. Incorporation: Degree to which occupational selection an individual makes is congruent with self-concept

## JOHN CRITES (Maturity)

Vocational Development Project

As a member of the Career Pattern Study, John Crites developed a psychodynamic-oriented diagnostic system, Career Maturity Inventory, to use in career counseling. This was the first objective taxonomy for the classification of problems in career decision-making. Two scales of the instrument are completed and tested: attitude and competence. Comprehensive Career Counseling (Crites, 1981) contains elements from career development, life stages, organizational climate, and environmental influence. The basic premise is that all aspects of life functioning are interrelated.

Major Concepts:

1. Diagnosis

   Differentials—(using Crite's taxonomy) differential: What are the problems? (antecedents and contingencies)

   Dynamics—What are the causes of the problems?

   Decisional—How are the problems being addressed?
2. Process—establish collaborative relationship, communicate the parameters of the problem
3. Outcomes—career choice, acquisition of decision-making skills, and enhanced general adjustment

## Sociological Emphases

Sociologists take a different perspective when studying man and the world of work. Emphasis is placed upon institutions and the market forces that include formal and informal rules, and the supply and demand of workers and products. Tausky (1984) provides a list of topics most often involved in decisions regarding work. These are: status, occupational structure, labor unions, collective bargaining, power and authority, work-leisure, socialization at work, mobility, work groups, satisfaction, and rewards. Most of these topics fall within social structure, structural factors, and job structure.

### Social Learning Theory for Careers

The foundation for social learning theory's approach to career development stems from the work of Bandura, and classical behaviorism, and reinforcement theory (Bandura, 1986). Emphasis in the theory is given to the learning experiences of each person, rather than to the inherited qualities. In applying the theory a counselor will identify and assess the person and environmental events that shape decisions at critical times (choice points). These learning experiences are of three types:

1. Instrumental: Reinforced behaviors are repeated while punished behaviors are avoided. The repeated ones become self-reinforcing.
2. Associative: Based on classical conditioning that is to associate past affective neutral stimulus with an emotional stimulus and the behavior will be strengthened.
3. Vicarious: Observing others.

Components/Beliefs: Mitchell and Krumboltz (1990) list four components to their career theory:

1. Inherited Traits: Individuals are born with special abilities and are further developed through interaction with the environment. These traits are gender, race, physical appearance, motor-intellectual abilities, and perceptual abilities.
2. Environmental Climates: Environmental conditions are not controlled by the individual. These environmental conditions have to do with the job market, training options, opportunities, social policies, family resources, role models, social climate, technological development, etc.
3. Learning: The choice of a career is influenced by the past learning experience.
    a. Associative—To observe relationships between situations and then to predict behavior.
    b. Instrumental—Act on the environment
4. Task Approach: The interaction of the above three (3) result in task approach skills.

Mitchell and Krumboltz (1990) believe the individual learns to apply under, a wide range of skills, attitudes involving work standards, work values, work habits, and perceptual habits that are modified by his/her experiences and feedback. The individual will perform observations and an assessment of himself/ herself by his/her own standards along with attitudes and skills of others. From the

interaction of the above four components certain consequences are forthcoming. Therefore, according to Mitchell and Krumboltz, (1990) these are:

1. Self-Observation Generalizations (S-O): These are self views the individual learns based upon his/her life experiences. Skills of Self-Observation include tasks, interests, and values
    a. S-O About Task Efficacy: the individual estimates what are the skills they have to do task.
    b. S-O About Interests: intermediate step which links original learning with choices and action. This is often a summary of past experiences.
    c. S-O About Personal Values: attitudes about the worth of an event or experience. These result from association and instrumental learning.
2. Task-Approach Skills: work habits, mental sets, perceptual and thought processes, and problem orientation. These skills enable one to:
    a. determine when an important decision is needed
    b. define the problem
    c. assess personal values, interests, and skills
    d. generate wide variety of alternatives
    e. seek information about alternatives
    f. organize and initiate the correct sequences of decision-making
3. World-View Generalization: observations of environment and predictions for the future. These decision behaviors come from self-observation, generalizations, and the task-approach skills.

Counseling: It is critical to teach self-observation and how to synthesize. A counselor or teacher attempts to teach how the environment influences preferences, when to analyze the conditions and how to change them when it is appropriate. This is often conducted through simulation kits. Social learning theory suggests that occupational preference is represented through self-observation generalizations about interests, values, and task-approach skills that arise because of various learning experiences. These are influenced through reinforcement.

Positive Influences: The individual will express a preference if he/she has been positively reinforced for involvement in that activity. It is further strengthened if done by a valued person.

Negative Influences: The individual is less likely to express a preference if he/she has been punished. In fact, he/she will more likely reject the activity. Examples are poor models, low grades.

There are several systems that reflect a behavioral approach. Cognitive restructuring schemes are appropriate.

Instrumentation:

1. Career Beliefs Inventory
2. Career Decision Anxiety Scale

3. Career Decision Inventory
4. Structured Assessment
5. Dysfunctional Thought Record
6. Vocational Exploratory Behavior Inventory

## Individual-Organizational Interaction

Hall (1990) describes Edgar Schein's view as a sociological perspective traced through a person's movement in an organization. Schematically, Schein illustrates with a cone the visualization of a three-dimensional interaction and movement as a person changes.

The three dimensions are:

1. vertically (up/down)
2. radially (in/out)
3. circumferentially (function)

Two major terms are: socialization and innovation.

1. Socialization—organization influences (changes) the person
2. Innovation—person influences the organization

Through the individual's life cycle his/her integrative approach reinforces three dimensions. These are (as cited in Zunker, 1986, 2002):

1. Biosocial - biological changes with social and personal tasks
2. Career - external and internal factors which are age- related stages
3. Family - interrelational aspects of financial support, intimate relationships, rearing children

Schein describes a life cycle of career development for organizations. These stages are (as cited in Zunker, 1986):

1. Entry—preliminary choice, dream anticipating socialization, facing realities
2. Socialization—reality of the organization, resistance to change, learning how to work, relating to a boss, develop identity
3. Mid-career tasks—career anchors, specializing

Career anchors are guides, constraints, stabilizers and assist in the interaction of the person's movements (changes) in a career" (Schein, 1978, p. 127).

1. self-perceived talents and abilities
2. self-perceived motives and needs
3. self-perceived attitudes and values

Hall (1990) lists five types of anchors:

1. autonomy—large organizations
2. creativity—entrepreneurial activity
3. functional competence—professional specialization
4. security—stable setting
5. general management—corporate ladder

Late career—mentor, balance, retiring

**Question 4-13:**
Donald Super defines career maturity as a readiness to deal with developmental life tasks. He organized a model of stages and substages for the counselor's use in career counseling. Which of the following did Super identify as a substage of Exploration?

a. fantasy
b. beginning stabilization
c. interest
d. crystallization

Answer: d. crystallization. Super identified three exploration substages of implementing, specifying, and crystallizing..

# Psychodynamic Emphasis

## Bordin's Psychodynamic Model

Edward Bordin's psychodynamic model of career counseling has its foundation in psychoanalytic theory with techniques from Trait and Factor and Client-Centered approaches (Crites, 1981). Bordin (1990) modified his early work with Nachman and Segal. Freud was uncertain about the importance of work. He viewed work as needed by society but it was a painful activity, something to be tolerated. His basic belief was that man was unreliable. The pleasure and reality principles of giving up the child was necessary to establish a responsible person. The first six years of life, instinctual gratification, and the defense mechanisms of sublimation and identification are important. Sublimation is the linkage between job satisfaction and psychosexual development, instinctual behavior, resolution of infantile conflicts and similar needs (Osipow, 1983). Osipow interprets Bordin's process as going back and forth between job analysis, personality traits, and childhood experiences. Jobs satisfy instinctual needs such as curiosity and the scientific field. Bordin's recent views support a match between intrinsic work requirements and the dynamics and structure of personality. The basic premise holds that one's personality in work and career is founded upon the role of play. Play is what binds a self-fulfilling vocation and the requirements of a job. Spontaneity is what distinguishes work from play.

Theoretical Assumptions

1. Career choice involves the client's internal needs (i.e., gratification, protection from anxiety).
2. Career choice is the result of a developmental process with influences beginning at birth and includes ego development and ego forms.

Major Concepts

1. Diagnosis must form the basis for choice of treatment. (Diagnose needs and conflicts.)
2. The process of career counseling involves -
    a. exploration and contract setting
    b. critical decision as to what facets will be addressed other than vocation; the fusion of work and play
    c. working for change through increased self-understanding career decisions for ideal fit between self and work
3. The outcomes of career counseling are:
    a. assist the client in career decision-making
    b. effective positive change in personality
4. Interview techniques are a combination of psychoanalytic, client-centered, and trait and factor.
5. Tests are used for client's self-exploration with the client serving as an active participant in selection.

Other Key Concepts

1. Spontaneity: Elements of self-expression and self-realization. A major force in differentiating work from play.
2. Compulsion: The internalization of external pressures. As an adult, this becomes conscience, duty, and expectations.
3. Work and Play: Fuse through compulsion and effort from one's developmental history. Fuse effort and spontaneity.
4. Early experiences with parents provide balance of pressures from other's authority.
5. As the individual searches for a fit between self and work a string of decisions follow~~s~~ which change work into a vocation.
6. Satisfaction comes from recognizing that every talent is needed in work.
7. Mapping occupations: the intrinsic work requirements provide the person a way of being that is constant with the dynamics and structure of his/her personality.

    Axis I:

    a. manipulative
    b. sensual
    c. anal
    d. genital

e. exploratory
f. flowing, quenching, exhibiting, rhythmic

Axis II: Degree of involvement

a. instrumental mode of action
b. objects
c. sexual mode (male/female)
d. directly experienced or modified

8. Hall (1990) points out the level of occupation is based upon the personality style of:
    a. Curiosity: sciences, law, psychiatry, clinical psychology, medicine, dentistry
    b. Precision: neatness, control, detail-law, accounting, engineering
    c. Power: physical power-athlete, writer, lawyer
    d. Expression: self-displaying, performing-teacher, lawyer, minister
9. The earliest years of life are the foundation for the development of a career.
10. Personal identity is constructed from features of one's mother and father.

Counseling Steps

1. Exploratory interview: Listen for wishes and views of client self-realization. Bordin (1990) lists three questions:
    a. "What of yourself are you seeking to realize?"
    b. "What is making the decision difficult?"
    c. "Just how are you thinking about yourself and your decision?" (p. 137)
2. Testing
3. Test interpretation
4. Planning

# Psychological Emphasis

## ANNE ROE

Anne Roe (1956) began her graduate training in 1926 at the University of Denver and received her Ph.D. in 1933 from Columbia University. A graduate student spurred her interest in careers as he enlisted her efforts to determine the meaning and accuracy in admissions testing for dental school. She worked as a clinical psychologist even though her training was in experimental psychology. While employed at Yale University she studied famous painters. The actual interviews became the most important part of her study. Until that time, she was interested in intelligence and projective techniques. In her early studies she used a five-category Taussig Scale to classify occupations. Later, she shifted to the Minnesota Classification of eight-groups. Shortly thereafter she wrote a three-year grant that was funded and extended her previous study of painters to include biologists, physicists,

and social scientists (64 total). Two sets of findings focused her attention on early family relations and the use of imagery. Roe's (1956) findings regarding early family relations reveal:

1. Biologists—Lack close ties, 7 of 20 lost parent at early age.
2. Physicists—Very few speak or give indication of closeness to fathers as children.
3. Physical Scientists—All respected fathers, yet many have rebelled and little evidence of closeness.
4. Psychologists and Anthropologists Rebelliousness to over-protectiveness and firm control. They remained angry and disrespectful of one or both parents.

Roe studied this group again in 1963 and found very little change. John Wiley and Sons, a book publisher, had previously encouraged her to write a book of her findings. In 1956 Psychology of Occupations was published. She consulted with Donald Super and Albert Thompson for advice. Donald Super told her about the Strong Vocational Interest Blank and the Kuder Vocational Interest Inventory. She did not consider the Census Classification because she felt the fields and levels were interchanged and mixed. She came up with an 8 x 8 classification with one category representing kind of work (interest factors) and the other on level of work performed (degree of personal autonomy and level of skill and training required). After sharing this 8 x 8 classification with Donald Super and a seminar group, she revised her plan to reflect an 8 x 6 scheme. The primary focus of this classification was arranged on the kinds of interpersonal interactions (Roe, 1956).

Marvin Siegelman helped her with the parent-child interactions. While at Harvard, she started collaborative work with David Tiedeman. There were few developed and refined personality theories at the time. She became interested in Maslow's description of personality theory. She believed that individuals are heavily influenced in selecting a career based upon their personality. The component parts have to do with the type of interaction with people and things, child-rearing practices, and a combination of genetic factors. The early home atmosphere is a vital factor in career choice. Her theory based upon Maslow's ideas of personality and the hierarchy of needs is formed around the interacting levels of needs of importance (Roe & Siegelman, 1972). It is important to have insight regarding the relationship between the individual's family background, rearing, and later occupational situations. Deficiencies during childhood may be compensated for through the work one has chosen. If one did not receive sufficient praise/rewards and respect from parents, one may elicit these through seeking jobs where this is abundant and available. The person turns to work for this gratification.

## Parent Behaviors

Anne Roe (1956) hypothesized that parental attitude is the critical determinant regarding outcome of career choice. Her theory centers on where the child is in the emotional scheme of the family. Peterson, Sampson, and Reardon (1991) provide descriptors to Roe's parenting styles. These descriptors are for the protective (child-centered), demanding (high expectations and strict obedience), rejecting (child inferior and unaccepted), neglecting (little attention, neither positive nor negative), casual (parents tend own needs first), and loving (set limits and guide). Roe (1979) interprets this structure using three dimensions:

1. Emotional Concentration:
    a. Overprotection: encourages dependency, restricts exploration, primary emotions with parents, slow to satisfy love and child's self-esteem, and is connected by dependency and conformity
    b. Overdemanding: perfection in performance, high achievement requests, love exchanged for conformity and achievement
2. Avoidance of Child:
    a. Emotional rejection: lack of gratification is intentional
    b. Neglect: gratification lacks but not intentional
3. Acceptance of Child:
    a. Casual acceptance: noninterference by default
    b. Loving acceptance: intentional encouragement of independence

Summary: Loving, overprotective parents usually find their children in service occupations. The type of home atmosphere influences vocational activities. Genetic structure and expenditure of psychic energy influences the occupational level.

Theory: Anne Roe offers her theory in the form of a relationship existing between specific childhood environments, need development, personality, and the job choice (as cited in Brown, Brooks & Associates, 1990). Genetically, each of us is born with psychological predispositions and a variety of physical strengths/weaknesses. These will interact with one's child-rearing practices and as a result a need hierarchy will develop. This is followed by a pursuit to meet those needs in a work environment.

## Interests

The direction of interest developmentally occurs through early satisfiers and dissatisfiers. These satisfiers and dissatisfiers provide direction to the selection of a field. Needs are routinely satisfied or frustrated. Forms in which drives first find satisfaction later are expressed as dominant drives. Those drives most often frustrated will later become dominant motivators. One of the earliest differentiations is the orientation of attention between person and nonperson occupations.

1. A child who is loved and approved of but who is not the focus of intense interpersonal relationships will focus his/her attention on objects in the environment. He/she may develop object-orientation (nonperson) of interest in mechanical and scientific fields.
2. If a child is involved in an intense interpersonal relationship (positive/ negative) he/she may concentrate upon this as a source of conflict. Dominance is not acceptable to him/her and he/she may find an occupation in service or in the business field. A submissive attitude may lead to a subordinate role in organizations.
3. A child who struggles against the interpersonal involvement may select a science field such as those Anne Roe studied who had an early loss of father.

4. A child who becomes focused upon him/herself and not others through over-concern or even special abilities may select the arts and entertainment field.

Groups: Anne Roe displays her groups with a circle. Groups form a relationship between early childhood development factors and occupational choice. The center of the circle differentiates between warm/cold atmospheres.

1. Loving, protecting, and demanding homes would lead to person-orientation in the child, and later to person-orientation in occupations.
2. Rejecting, neglecting, and casual homes would lead to non-person orientation.
3. If extreme protecting and extreme demanding the child experiences restricting conditions, and he/she might, in defense become nonperson-oriented.
4. Some individuals from rejecting atmospheres might become person-oriented in search of satisfaction.
5. Loving and casual homes might provide a sufficient amount of relatedness that other factors, such as abilities, would determine interpersonal directions more than personal needs (Roe & Siegelman, 1964; Tolbert, 1980).

## Propositions

Brown, Brooks, and Associates, (1990) provide a good understanding of Roe's five propositions. For this understanding, you are encouraged to seek this source and gain a full appreciation of each of the propositions. They are condensed here:

1. One's genetic inheritance sets the limits for potential development (intellectual and temperament).
2. One's general culture, specific experiences, and socioeconomic position in the family are important (race, sex, etc.).
3. A pattern of interests, attitudes, and personality variables is developed where the control is through individual experiences. This energy is involuntary and channeled in certain directions. Maslow's Hierarchy of Needs is used to interpret this direction.
4. The pattern of psychic energies, attention-directedness, is the major determiner of interests.
5. The motivation to reach a final goal is determined by the intensity of these needs, satisfied or frustrated.

PROCESS: Early orientation of an individual is related to later decisions.

1. Interview—Maslow's Hierarchy
2. Assessment—Family Attitudes—use of instruments
3. Counsel—Interpretation and use of the wheel

Level: The levels refer to the degree of responsibility, capacity, and skill.

Field: Interest/primary focus of occupation.

| Person-Oriented | Nonperson-Oriented |
|---|---|
| 1. service | 5. outdoor |
| 2. business contract | 6. science |
| 3. organization | 7. general culture |
| 4. technology | 8. arts/entertainment |

The first 4 levels are person oriented, while 5-8 are non-person oriented occupation.

JOHN HOLLAND

## Structural Interactive

John Holland's theory on careers has undergone five modifications. Much of his early work in counseling centered on the use of the Strong Vocational Interest Blank. He focused on the kind of work a person selects rather than the level of work. As mentioned in the P x E Fit, Trait-and Factor Theory, and Work Adjustment Theory, the core of Holland's theory rests upon the dynamic of an interaction between an individual's personality pattern with an environmental pattern. He believes that most difficulties in vocational decision-making fall into:

1. vocational identity
2. lack of job information
3. personal or environmental barriers

Vocational interests according to Holland are one component of personality yet work choices provide a description of the person's personality (Holland, 1985). John Holland was a vocational counselor and developed his theory from:

1. observations of broad classes of interests, traits, and behaviors
2. Darley's occupational stereotypes
3. Guilford's six types: mechanical, scientific, social welfare, clerical, business, and esthetic
4. types are analogies to Adler, Fromm, Jung, Sheldon, Spranger, Gordon and Welsh types
5. assessing environment came from Linton's idea that the force of the environment is transmitted through people. This helped with the development of the Environmental Assessment Test (EAT).
6. type development evolved from Staat's theory of social behaviorism

The principles and dynamics that underlie structural interaction are:

1. choice of vocation is an expression of personality

2. interest inventories are personality inventories
3. vocational stereotypes have reliable and important psychological and sociological meanings
4. members of a vocation have similar personalities and similar histories of personal development
5. individuals in vocational groups have similar personalities and will respond to situations and conflicts in similar ways
6. satisfaction depends upon the congruence between one's personality and the environment

## Propositions

John Holland (1985) proposes four primary working assumptions to his theory. The personality and environmental descriptions are based upon a typology.

## Primary Assumptions

Most individuals can be typed or classified as one of six personality types. These types are

1. realistic
2. investigative
3. artistic
4. social
5. enterprising
6. conventional

A type is a product of interaction of cultural and personal forces including:

1. peers
2. biological hereditary
3. parents
4. social class
5. culture
6. physical environment

From this interactive experience a person learns or develops a preference for a particular activity that becomes stronger with time. The development of these interests and competencies become a personal disposition of thinking, perceiving, and acting in particular ways. There are a possible 720 combinations of the six types (RIASEC).

There are six environments. They are the same types as personality types:

1. realistic

2. investigative
3. artistic
4. social
5. enterprising
6. conventional

These types hang together (people of this type) and create an environment.

Occupational choice begins at an early age as a person (with a predisposition) begins a search for an environment (like type) which will allow him/her to express himself/herself fully. That is, to express his/her attitudes, skills, values, accomplishments, and abilities.

Thus, a person's behavior is then determined by this interaction of personality and environment.

## Secondary Assumptions (Concepts)

Holland (1985) has several important concepts to bridge the theory to interpretation of the typologies. These are:

1. CONSISTENCY: This is the degree of relatedness between subtypes as they are arranged on the hexagonal model. If subtypes are adjacent to one another, they are more alike (similar) in characteristic (traits) and tend to blend with one another. Relatedness (adjacent)is described by Holland as high, medium and low. High has adjacent codes (such as RI on the hexagon), while medium has one subtype between the two adjacent codes (such as RSI), while low has two or more subtypes between the two adjacent codes (such as RSEI). Assessment always begins with the first code of one's stereotype. Consistency can be described for both personality and environment propositions.
2. CONGRUENCY: This concept relates to the fit concept of locating a person of a specific personality type in a similar environmental type. If the type is identical to the work environment, there is congruency. This supports Holland's premise whereby the person will be allowed to express his/her talents and personhood. A personality code of RI is congruent to an environmental code of RI.
3. DIFFERENTIATION: This term defines how well defined the type is for the person. A person can be a pure type or similar to several types. A well-differentiated type indicates a person is capable of deciding his/her preferences as opposed to being confused about his/her choices.
4. IDENTITY: This is an estimate of the clarity and stability of a personality or environmental identity. How clear and stable is this picture of one's goals, interests, abilities, etc.
5. CALCULUS: This is a measure of the distance between types or environments and is inversely proportional to the theoretical relationship (Holland, 1985).

## Type Definitions

Holland (1985) describes three codes as a subtype, although a person is a listing of all six in descending order. Constructs such as congruence and consistency are often interpreted to only two codes. A brief description will be provided for easy recognition, but you are encouraged to read John Holland's book for a thorough understanding of each type. A few adjectives will be selected from pages 19-23 of Holland (1985).

REALISTIC: asocial, conforming, natural, persistent, hard-headed inflexible, frank, tools, genuine manipulation of objects, machines

INVESTIGATIVE: analytical, independent, rational, cautious, reserved, critical, curious, introspective, physical, biological or social sciences

ARTISTIC: imaginative, intuitive, emotional, expressive, impulsive, open, idealistic, unsystematized activities

SOCIAL: cooperative, generous, helpful, warm, empathic, persuasive, idealistic, patient, teaching

ENTERPRISING: adventurous, ambitious, energetic, seeking, extroverted, optimistic, talkative, manipulation of others

CONVENTIONAL: conforming, inhibited, persistent, thrifty, defensive, obedient, orderly, methodical, systematic, precise and use data

## Process

The counseling process is to interview, assess, and interpret for a fit. Holland's theory is less structured and didactic than trait-and-factor theory.

Techniques/Instruments: The following inventories yield the Holland code:

1. Strong Interest Inventory (SIT)
2. Career Assessment Interest Inventory (CAI)
3. Self Directed Search (SDS)
4. 16 PF
5. Environmental Assessment Technique (EAT)
6. Vocational Exploration and Insight Kit (VEIK)
7. My Vocation Situation (MVS)
8. SCA-CV, a computerized package including MVS, congruence, level, consistency degree, identity, and differentiation.

## Research and Limitations

Over 450 articles have been published on the research of the five revisions. In general, there is little to no support for consistency and differentiation. The most support is with congruency and identity (Weinrach & Srebalus, 1990). It is a closed system (six types) and concerns rest with a bias of being sexist. There is little to no support or foundation for how types are developed.

### Composite Theory

### ROBERT HOPPOCK

Hoppock's theory is best known as a need theory with heavy emphasis upon occupational information. His basic view is that individuals select occupations to meet their needs. In order to make a decision, he advocates that environmental information is critical. His theoretical foundation is built upon ten (10) propositions.

**Question 4-14:**
John Holland's classification system (HOC) is used to stereotype individuals, occupations, and environments according to a code. Which of the following three letters illustrates the highest level of consistency?

a. RSE
b. RSC
c. SEC
d. IEC

Answer: c. SEC. Use the hexagon to determine order (adjacency)

**Question 4-15:**
Who incorporated Maslow's eight levels of needs into a two-level approach to understanding career selection?

a. Donald Super
b. Donald Patterson
c. Edward Bordin
d. Anne Roe

Answer: d. Anne Roe. Anne Roe utilized Maslow's hierarchy of needs in developing her theory on personality and career choice.

**Question 4-16:**
Tiedeman and O'Hara believed that individuals process through seven steps in career development and decision-making. According to these decision-making career theorists an individual who begins to

see patterns, connections, or can order relevant information about a career decision would be at which step of this process?

a. exploration
b. crystallization
c. choice
d. clarification

Answer: b. crystallization

**Question 4-17:**
An individual assessed by the Strong Interest Inventory as high on the personality stereotype I (Investigative), would best fit in which work environment?

a. business
b. political
c. scientific
d. conventional

Answer: c. scientific

## Career Theories for Women

While there is no established theory of career development for women, there has been some recent theory construction. It would be helpful to understand societal trends, career patterns for women, sex role stereotyping, sex role socialization, self-concept development of women, women in the work force, and obstacles to women's development.

Fitzgerald and Betz (1983, 1994) and Fitzgerald and Weitzman (1992) cite several factors that affect career choice for women. Some of these are:

1. societal sex—role stereotypes-different life roles and personality characteristics
2. occupational sex stereotypes—normative view of male and female occupation appropriateness
3. socioeconomic status—SES and educational level
4. race—black women, for example, have been more disadvantaged than white
5. environment—family background, marriage, children, role models, education, and career counseling
6. aptitude interests, personality

## Barriers to Career Development for Women

Barriers are plentiful when looking for discrepancies between men and women as well as racial and ethnic inequalities. Some of the more common examples revolve around attitudes of men and some women in nontraditional jobs, sexual harassment, compensation, role conflict and role overload, and the management of dual career issues.

Gray (1980) and Fitzgerald and Weitzman (1992) reported a number of studies that pointed out practical and psychological problems encountered by women and feminist women who sought dual-careers. Specifically these studies isolated some of the following:

1. the husband's job was considered the primary one
2. the husband's self-esteem was threatened
3. attitudes of neighbors, colleagues, and parents
4. views of married professionals
5. incompatibility of qualities of wife-mother and mother-worker
6. conflicts between wife, mother, career, and home roles.

While some of the above concerns are more accepted today, they remain as issues for counseling. Brooks (1990) points out those existing theories are inadequate. Career theories have evolved from the initial research that was based upon white, middle class men. It has also been hypothesized that the variables that determine careers for men are different for women. A majority of women are in "pink collar" traditionally female jobs (Howe, 1977).

EARLY THEORISTS: Super, Ginzberg and Zytowski gave brief attention to career development for women. Briefly, their categories reflected:

Super (Fitzgerald & Betz, 1983)

1. stable homemaking—marry after high school and no work experience
2. conventional—work outside of home until marriage
3. double track—combine work and home duties
4. stable working—work through life span
5. interrupted—return to work soon after the children are raised
6. unstable—repeated cycle of home and work
7. multiple trail—unstable work history

Ginzberg (1966) Three Life Styles

1. traditional—homemaker oriented
2. transitional—more emphasis upon home than job
3. innovative—equal emphasis to job and home

Zytowski (1969) Three Patterns

1. mild vocational
2. moderate vocational
3. unusual vocational

Brooks (1990) offers a brief introduction to three recent and different approaches to career development for women. A summary of that work follows:

## Hackett and Betz's Self-Efficacy Theory

Hackett and Betz (1981) believe that women have lower expectations of themselves than men when it comes to careers. As a result, they utilize the Self-Efficacy Theory developed by Bandura (1977) to explain their behavior. In summary, the theory suggests that individuals avoid those tasks they feel they are unable to perform successfully and gravitate to those they believe they can do. Thus, the theory is concerned about the belief's a person has in his/her ability to perform a feat. This will then determine:

1. if behavior will be initiated
2. degree of effort expended
3. how long this will be maintained
4. how they handle obstacles

Bandura (1977) indicates that self-efficacy varies on three dimensions:

1. Level: the degree of difficulty of the task an individual feels capable of performing
2. Strength: the confidence a person has in his/her estimation
3. Generality: the range of situations in which a person feels effective

## Gottfredson's Model of Occupational Aspirations

A summary of Gottfredson's (1983) propositions are as follows:

1. occupations are differentiated along sex-type, level of work, and field of work
2. people select jobs based upon his/her self-concept and how much energy he/ she wants to put forth
3. the elements of a self-concept are: gender, social class, intelligence, interests, values, and abilities
4. these elements are developed during four stages of cognitive development:
    a. Orientation to size and power —being an adult (3-5)
    b. Orientation to sex role —gender self-concept (6-8)
    c. Orientation to social evaluation—social class and intelligence (9-13)

    d. Orientation to internal unique self —reinforcement, values, traits, attitudes, and interests (14+)

5. As a person progresses through these stages, he/she accepts and rejects occupations according to suitableness. Gottfredson calls this the Zone of Acceptable. He/she will:
    a. first, reject occupations unsuitable for gender.
    b. second, reject occupations unsuitable for social class and ability level.
    c. third, reject occupations unsuitable for personal interests and values.
6. Job self compatibility and accessibility to jobs become job preferences. This presents the obstacles and opportunities.
7. Jobs are not always available, therefore a compromise is necessary. In so doing women:
    a. first sacrifice interests
    b. second sacrifice prestige
    c. third sacrifice sex type

## Astin's Need-Based Sociopsychological Model

Astin's theory reflects a career-choice process for women and has four constructs (Astin, 1984):

1. Motivations: All humans will expend energy to satisfy three needs:
    a. survival
    b. pleasure
    c. contribution
2. Expectations: Expectations are based upon:
    a. kind of work that will satisfy needs
    b. type of work that is accessible
    c. if the person is capable of performing the work
3. Sex-role socialization: A person is rewarded and reinforced for gender-differentiated behavior. The person internalizes social norms and values regarding appropriate self-role.
4. Structure of opportunity: Social changes alter the opportunity and interaction with the sex-role socialization process and the opportunity.

## Narrative Counseling

Cochran (1997) developed a seven "episodes" model for narrative counseling. The seven episodes are elaborating a career problem, composing a life history, founding a future narrative, enacting a role, constructing reality, changing a life structure, and enacting a role. This process is for the client to tell a story of his/her past and future and eventually crystallize a decision.

Social and Economic Approaches

1. Accident Theory-external factors affect such as chance factors and to benefit from accident theory the individual relies on self-efficacy.
2. Status Attainment Theory-the role that achievement and social status influences occupational choice. A graphing process referred to as path analysis and the family receives a great deal of attention.
3. Human Capital Theory-the focus of this theory is the individual's attention and energies given to education and training with the outcome earnings.
4. Dual-economy Theory-the focus of this theory was two-fold and takes the perspective that employers view the work world from a monopolistic or oligopolistic market. The dual or two-fold was composed of a primary and second market with primary paying higher rewards and second less.

# OBJECTIVE 4B: Information Resources

CACREP Objective 4.B. Information systems for career, avocational, educational, occupational and labor market.

Resources are of vital importance when counselling for career, avocational, educational, and occupational and market information. Some of these resources will be listed as a guide for further reviews. The labor market amounts to a process of gathering data for the supply and demand of individuals who want and are able to work and to the demand for workers.

1. Americans with Disabilities Act of 1990 (ADA). This act covers many aspects regarding the work role and diverse populations. Title III includes public accommodations (auxiliary aids and physical barriers), employment (hiring/promotion, unable to ask if a person has a disability). Individuals may be exposed to a double or triple minority status in a job search. When this is true for an individual ADA is to be consulted for client fairness.
2. FERPA and HIPAA. Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act are explained in the Professional Orientation and Ethical Practice unit.
3. Bureau of Labor Statistics (2013) publications include monthly labor review, national longitudinal surveys, news, occupations outlook handbook, occupational outlook quarterly, magazines and journals, chartbooks, bulletins and reports, catalog of publications, research papers, contacts and help. http://www.bls.gov/news.elease/empsit.t06.htm

Niles and Harris-Bowlsbey (2013) suggest that counselors have three obligations in recommending and dispensing of data for career counseling. The first is to select high-quality print materials, computer-based systems, and web sites, second is to make available in a user friendly manner, and the third is to aid the client to process and make meaningful use of the information. The National Career Development Association (NCDA) provides guidelines for the career counselor (ncda.org).

Information systems such as computer resources are pertinent to career, avocational, educational and labor market needs. The development of computer resources in career guidance and counseling has made it possible for individuals to have easy access to an enormous amount of career information. Because of the vast development of computer software in this area, career counselors are able to more effectively serve clients because the retrieval of career and educational information is now manageable (Drummond & Ryan, 1995).

While obvious advantages exist in utilizing computer resources, Drummond and Ryan (1995) point out that not every counselor or client is enamored with the computer. Some feel that computer programs are dehumanizing to the counseling process and that the computer is sometimes used inappropriately as a poor substitute for one-on-one counseling. Another factor to consider is the issue of maintaining confidentiality when computer applications are used in conjunction with counseling. Possible problems could arise if consideration is not provided in how to secure confidential information in computerized systems. The majority of computer software programs are designed to offer multiple databases, labor, and market information. Even though several of the programs indicate the components are derived from one of the vocational theory developers, these programs are not theory-based, do not provide all elements of an assessment, and do not store a user. The fact that they do not store the information is one way to avoid issues of confidentiality with user information.

Drummond and Ryan (1995) and Niles and Bowlsbey (2002) provide a comparison of the pros and cons of computerized career guidance systems. A few of these advantages and disadvantages are summarized below.

### Advantages

1. clients gain increased knowledge about themselves
2. clients develop more specific career plans as a result of using computerized career resources
3. clients learn more about career exploration resources
4. clients find the systems helpful, understandable, and enjoyable
5. the systems deliver the same services to all clients and are not subject to conscious or unconscious biases of the counselor
6. computers can administer test and inventory along with interpretation
7. database searches can be conducted
8. crosswalking - that is, moving from one database to another
9. access to the information from a variety of sources
10. monitoring progress of user
11. delivering instruction
12. linking resources

### Disadvantages

1. computer resources may be expensive

2. counselor intervention is needed to provide reinforcement, clarification, and support for career or life style decisions
3. career counseling risks becoming mechanistic and dehumanizing
4. user anxiety with technology
5. using interpretation without counselor involvement (ethics code for validity of results)

## Computer Resources

Several computer packages are available for career exploration and guidance. Most vocational theories have an applied computer program. Some examples are as follows:

1. ISVD: Information Systems for Vocational Decisions. Tiedeman and O'Hara-Harvard system is based on a decision model. The counselor is an interpreter utilizing files educational, military data, and vocational opportunities.
2. ECES: Educational and Career Exploration Systems was developed by ABEAM. Minor, Super, Myers.
3. CVIS: Computerized Vocational Information System is a career guidance system providing counselor-administrator support with the capability of local development for computer assisted instruction. The CVIS is based on Anne Roe's classification.
4. SIGI and SIGI-PLUS: System of Interactive Guidance and Information (ETS)—is based on the Trait-and-Factor Theory and includes steps to assess values, locate information, make comparisons, provide a prediction, establish a plan, and to develop a strategy. SIGI has five subsystems while SIGI-PLUS has nine. This system was developed by Katz (1993).
5. DISCOVER: This system was developed by the American College Testing Program and includes self-information, strategies for identifying occupations, up-to-date occupational information and search capability for educational institutions.
6. GIS: Guidance Information System contains four information files and is based on the Trait-and-Factor Theory.
7. COCIS: Colorado Career Information System
8. CHOICES: An interview based on Trait-and-Factor Theory and provides both information and guidance functions.
9. INQUIRY: Inquiry has five components composed of a query, educational: information, occupational information, self-information, and guidance functions for the counselor-client interaction.
10. VEIK: Vocational Exploration and Insight Kit. This is not a computer package rather a kit developed by John Holland for data gathering.
11. 11. NOICC: National Occupational Information Coordinating Committee. The NOICC is a federal interagency committee regarding occupational and market information. The NOICC interfaces with State Occupational Information Coordinating Committees (SOICC). This combined

system offers the Occupational Information Systems (OIS), Career Information Delivery Systems (CIDS), The National Career Development Guidelines, NOICC's Improved Career Decision Making (ICDM), and the Career Development Portfolio (Teacher's Guide to U.S. Department of Education, 2000, Archives).

## Education Career Guidance

An effective career guidance program throughout the school years and later life can be implemented using Havighurst's developmental stages. The stages have an established continuity and transition approach. The focus of the theory identifies specific tasks encountered during different time periods. Tasks and time periods are: early infancy, 6-12, 12-18, 18-30, 30-60, and 60+.

There will be some overlap when equating Havighurst's developmental stages with age ranges to grade level for the elementary, middle school and high school years. Developmental tasks according to Havighurst (1972) for the middle childhood students are to:

1. achieve new and more sophisticated relations with peers
2. achieve emotional independence from parents and other adults
3. set vocational goals
4. prepare for marriage and family life
5. develop skills for civic competence
6. acquire a set of values and an ethical system as a guide to behaviors

The goal is to set realistic goals and make plans for achieving these goals.

Career guidance involves all activities that seek to disseminate information about present and future vocational interests (Gladding, 1996). Many school- based guidance programs are based upon the National Occupational Information Coordinating Committee (NOICC) competencies and indicators (1998, 2002). These competencies are based on self-knowledge, educational and occupational information, and career planning. Career Guidance: Elementary Years. The focus during these years is on developmental experiences in order to:

1. become aware of choices
2. anticipate and plan for choices
3. take into consideration own personal characteristics
4. foster self-awareness and to utilize the school experience to explore and prepare for the future

Niles and Harris-Bowlsbey (2013) suggest that elementary counselors utilize the standards established by the American School Counseling Association (ASCA). Standard A: Self-knowledge indicates that students will acquire the skills to investigate the world-of-work in relation to knowledge of self and to make informed career decisions. Standard A Skills: Students will acquire skills to investigate the world-of-work in relation to knowledge of self and to make informed career decisions. Standard A: Feelings- Students will acquire skills to investigate the world-of-work in relation to knowledge of self and to

make informed career decisions. Specific Standard A includes interesting activities, skills I have, Feelings, Comic Strips, What is a Friend?, The Problem Bucket, Workers I Know, Women and Men at Work, Future Skills, Picture This, ABC List of Occupations, School and Work, Leaders and Followers, School: The Good and the Bad, and Changes.

ASCA's competencies and indicators domains include academic, career, and personal/social development. Standard A will be highlighted to serve as an example except for career development. Standard A for academic indicates students will acquire the attitudes, knowledge and skills that contribute to effective learning in school and across the life span. Within this domain are competency and indicator tasks. The competency for academic development is to improve academic self-concept, acquire skills for improving learning, and achieve school success.

Standard A for career development indicates that students will acquire the skills to investigate the world of work in relation to knowledge of self and to make informed career decisions. Within Standard A the competencies are to develop career awareness and 10 indices, develop employment readiness and nine indices (ASCA National Standards for Students, 2004).

Standard B for career development indicates that students will employ strategies to achieve future career goals with success and satisfaction. Within Standard B the competencies are acquire career information and eight indices, identity career goals and five indices.

Standard C for career development indicates that students will understand the relationship between personal qualities, education, training and the world of work. Within Standard C the competencies are to acquire knowledge to achieve career goals with seven indices and to apply skills to achieve career goals with four indices.

Standard D is personal/social development whereby the student acquires the knowledge, attitudes and interpersonal skills to help them understand and respect self and others.

Focusing on these topics is to emphasize the importance of a developing self-concept, how to effectively interact with others, personal responsibility, relationship between work and learning, benefits of educational achievements, work habits, societal needs, decision-making, different occupations, changing female roles, and career planning (Zunker, 1998).

## Counselor's Role

The counselor's role in the elementary years is one of counseling, coordinating, and consulting. Bailey and Stadt (1973) suggest that the early years are composed of awareness experiences while grades 4-6 are of accommodation. In summary, the awareness concepts revolve around self, occupational roles, individual responsibility, decision-making skills, cooperative social behaviors, and respect for others and their work. Accommodation tasks are developments of concepts related to self, world of work, planning one's time, application of decision-making skills, social relationship, and work attitudes and values.

## Critical Development

Miller (cited in Herr & Cramer, 1996) indicates that the critical development in the formative years is self-awareness. Thus, career guidance is to foster a "child's awareness of self, feelings of autonomy and control, need for planful behavior, and desire for exploration" (p. 350).

### Career Guidance: Junior High School

The focus during this time period is upon exploration and planning. The counselors will emphasize the acquisition of knowledge and skills for this exploration and planning. Students are encouraged to understand the consequences of their choices in curriculum and courses. Students are preparing to enter into decisions regarding the selection of their career options. The students are in transition physically, educationally, and socially.

Havighurst's (1972) developmental stages include:

1. achieving new and more mature relationships with peers of both sexes
2. achieving a masculine or feminine role in society
3. accepting one's physique and using the body effectively
4. achieving emotional independence from parents and other adults
5. preparing for marriage and family life
6. preparing for an economic career
7. acquiring a set of values and an ethical system as a guide to behavior
8. desiring and achieving socially responsible behavior

The American School Counseling Association standards for high school for career development for 1, 2, and 3 are as follows:

1. Counselor's Role: Lefstein and Lipsitz (as cited in Herr & Cramer, 1996) indicate that the counselor should be critically aware of the developmental needs of this age group when conducting career guidance. They suggest the needs of this age group are: diversity, self-exploration, meaningful participation, positive interaction with peers and adults, physical activity, and competence and achievement.
2. Career Goals: Wilson (1986) indicates that the junior high school student should be skilled in decision-making skills, coping with transitions (home, school, and community), relating personal interests to broad occupational areas, understanding communication skills, conflict management, and the limitation factors of bias and discrimination in the work world (as cited in Herr & Cramer, 1996). The focus of middle-school guidance is to continue the development of the elementary focus and to expand upon the skills to develop and understand career information and interrelationship of life roles. The elementary years are a time to bring awareness to all of these areas; the middle-school years will focus on understanding the process.

3. Career Guidance for Senior High: This period in the vocational career development of high-school students revolves around selecting vocational training, admission to college, major field selection, full-time employment, option of military service, marriage, and apprenticeship training and involvement. The young person is about to separate from high school and is faced with the reality of independence. This independence is approached by how he/she looks at the alternatives and implications of his/her decisions.

The American School Counseling Association content standards for high school for career development are as follows: (American School Counselor Association, 2004):

Content standards guide in providing the foundation for the acquisition of skills, attitudes and knowledge enabling students to make a successful transition from school to the world of work and from job to job across the life career span. Standards are the same across elementary, middle school and high school with the exception of the indices. For high school students the indices are to:

1. develop skills to locate, evaluate and interpret information.
2. learn about the variety of traditional and nontraditional occupations
3. develop an awareness of personal abilities, skills, interests, and motivations
4. learn how to interact and work cooperatively in teams
5. learn to make decisions
6. learn how to set goals
7. understand the importance of planning
8. pursue and develop competency in areas of interest
9. develop avocational interest
10. learn to balance work and leisure time
11. acquire employability skills such as working on a team, problem solving, and organizational skills
12. apply job readiness skills to seek employment opportunities
13. demonstrate knowledge about the changing workplace
14. learn about rights and responsibilities of employers and employees
15. learn to respect individual uniqueness in the workplace
16. learn how to write a resume'
17. develop a positive attitude toward work and learning
18. understand the importance of responsibility, dependability, punctuality, integrity, and effort in the workplace
19. utilize time and task management skills

Standard Five outlines competencies and indices for employing strategies to achieve future success and satisfaction. Standard Six outlines an understanding of the relationship between personal

qualities, education and training, and the world of work (American School Counselor Association, 2004).

Perrone (1973) conducted values research with senior-high-school students. The students regarded values of security, affiliation, and independence as the most important. Boys valued a good income while girls valued helping others, working with people, and having time for one's family.

Goals for Senior High: Goals for senior-high students tend to be those of self-knowledge, educational and occupational exploration, and career planning. In summary, these goals include, but are not limited to, the development of interpersonal skills in interacting with others, a positive self-concept, positive attitudes toward work, skills in understanding, career information, decision-making skills, as well as many others (NOICC, 1989). NOICC focus is to expand upon the guidance competencies and indicators for elementary and secondary youth but also to expand into the areas of evaluating and interpreting career information in light of themselves, seeking, obtaining, maintaining jobs, and continuous changes in male/female roles (Zunker, 1998). Whereas elementary years are to become aware, and middle-school years are to understand, the senior-high years are a time to evaluate and interpret career development.

Career Guidance: Adult Development Career guidance in higher education and for adults is comprehensive. That is, individuals are counseled for the selection of a major field of study, self-assessment, understanding the world of work, decision-making, access to the world of work, and specific needs of special populations (Herr & Cramer, 1996).

Individuals change jobs for a variety of reasons. Career writers in the 1970s focused on crises and predisposing factors as each related to job change. Levinson (1983) and Vaitenas and Weiner (1983) also discussed several reasons for career changes (as cited in Osipow, 1983):

1. Levinson (1983) found middle-aged men change jobs due to:
    a. anxiety over aging and death
    b. questioning about basis of their lives
    c. need for affirmation of self by society through success in career
2. Vaitenas and Weiner (as cited in Osipow, 1983) found several other reasons for career changes:
    a. interest incongruity with occupation
    b. lack of consistency and differentiation of interests
    c. fear of failure
    d. emotional problems
3. The unfulfilled worker is searching for autonomy, challenge, and meaning in work. He/she tends to experience:
    a. a change in needs and restructuring of goals
    b. reorganized disparity between current work content and formulated goals
    c. recognized disparity between self-perceived abilities and utilization of current work

d. feelings of isolation

e. feelings of lack of accomplishment

The individual who is unemployed because he/she was the victim of being displaced, re-engineered, rightsizing, downsizing, and a reduced work force remains interested in his/her skill and work areas but is in need of employment services.

Hopson and Adams (1977) developed a model for adult transitions. This model is composed of seven stages and the stages focus on crises of adults in transition. These stages are immobilization, minimization, self-doubt, letting go, testing out, search for meaning, and internalization. Sharf (2002) points out that not all adults, especially women and culturally diverse populations in transition, are in a crisis and therefore do not fit this model. Sharf suggests that two issues are important for counselors working with adults in transition. The first is the counselor's own experiences with his/her own past transitions. The second concern is counseling when the counselor is in transition.

**Question 4-18:**

A librarian at a community college has been successful in acquiring funds for the installation of a computerized career guidance program. After researching the different systems the library board along with several administrators agreed that SIGI PLUS and DISCOVER would be the most appropriate systems for purchase. Which statement below cannot be considered a true statement describing these systems?

a. DISCOVER is a system that combines career guidance and search strategies to provide users with knowledge about self-in-relation to occupational and educational knowledge. SIGI PLUS is an individualized career guidance program that teaches a user the process of career planning and decision-making strategies.

b. DISCOVER and SIGI PLUS are two of the most widely used computer-assisted career guidance systems in the United States.

c. DISCOVER and SIGI PLUS are best utilized by individuals without counselor intervention.

d. DISCOVER and SIGI PLUS are considered viable tools in the career decision-making process.

Answer: c. DISCOVER and SIGI PLUS are best utilized by individuals without counselor intervention. A major disadvantage of all computerized career guidance systems is that clients may often times not discuss findings with a counselor. As a result, there is a lack of clarification or support for decision-making when there is no counselor intervention.

## Summary

Popular computerized career guidance programs such as DISCOVER, SIGI, and CHOICES are now extensively used in career counseling programs. A review of the literature shows that individuals react positively to computerized career guidance systems and utilize such systems in expanding his/her knowledge of himself/herself and the world of work. Sampson (as cited in Hinkle, 1992) points out that individuals use computerized career guidance to assist in making career and educational plans and to make confident career decisions. Hinkle (1992) suggests the accountability of these computer-assisted

career guidance packages (CACG) must be thoroughly researched. "Computer-assisted career guidance is becoming widely accessible, cost-effective, and reasonably easy to use. Career counselors are increasingly implementing CACG in their practices, but accountability for its use remains limited" (Hinkle, 1992, p. 391). Career counselors choosing to utilize CACG systems should obtain the data necessary to consistently improve services, recognize potential areas in which computers cannot be used effectively, and recognize when the computer or the counselor may be more effective alone. Johnston, Buescher, and Heppner (1988) identified typical issues with wholesale use of CACG to be in the area of psychometrics, programming, technical service, and staffing.

## Avocational Career Guidance

Leisure is a component of vocational and avocational wellness. Leisure is often thought of in qualitative terms and as a state apart from work. It is a segment of time an individual devotes to the pursuit of certain aims found in the leisure process. Leisure defined by Reardon, Lenz, Sampson, and Peterson (2000) is "relatively self-determined activities and experiences that are available due to discretionary income, time, and social behavior; the activity may be physical, intellectual, volunteer, creative, or some combination of all four" (p. 65). Avocational Counseling Manual (Overs, Taylor, & Adkins, 1977) lists 725 different leisure activities classified in a three-level system. A later guide published in 1990, The Leisure Activities Finder, lists 760 leisure activities (Holmberg, Rosen, & Holland, 1990). Some advantages of leisure are the release of tension, attainment of a sense of freedom, feelings of pleasure, joy, satisfaction, or being creative or expressive of the self (Gunter & Gunter, 1980).

Leisure can serve several functions. Some of these are to help:

1. people learn how to play their part in society
2. people to achieve societal aims
3. society to keep together

Societal classes utilize leisure in different ways. The upper middle classes use libraries, home diversions, and lectures; the lower classes utilize parks, playgrounds, churches, and museums.

Gunter and Gunter (1980) outlined a leisure model for counseling. Briefly stated, the four types of leisure are:

1. Pure: This is an individual choice and involvement. It can be temporary free fun, not necessarily involving work. It is usually spontaneous and not repetitive. It can be a day at Six Flags, reading a book, going to a play, etc.
2. Anomic: A person is not involved in an institutional work setting and has too much leisure. A person may dislike being unattached to an employer and have a sense of powerlessness. Coping difficulties.
3. Institutional: Leisure is a part of the institution. Examples are business and golf, racquetball, business meeting, travel, etc. This type may limit the use of leisure outside of the institution. The most negative form is for the workaholic.

4. Alienated: No pleasure from this leisure. It comes as a result of habit and no pleasure is derived.

Leisure counseling is a process of assisting another in identifying his/her leisure interests, attitudes, and needs at a particular time during life span.

## OBECTIVE 4C: Career Development Program Planning

Niles and Harris-Bowlsbey (2013, 2002) outline important features in establishing and designing a career development program. The steps included are to:

1. define the target population and characteristics (high school, college, corporation, etc.).
2. determine the needs of the identified population.
3. create measurable objectives to meet the needs.
4. determine how to deliver the career planning services.
5. determine the content of the program.
6. determine the cost of the program.
7. promote and explain services.
8. promote and deliver the full-blown program of services.
9. evaluate the program.
10. revise the program as needed.

How to determine and evaluate program needs easily could be two areas for the examination. These authors identify four ways to identify needs of a group. That is:

1. some information may already be available
2. a short questionnaire may be developed and administered and processed by a focus group
3. consultants may be hired
4. ask managers and administrators to identify problems that need solutions

If program objectives are written in a clear concise manner, the evaluation process will be much easier. The objectives are the content and evaluation of the services. Evaluation of services can include both quantitative and qualitative findings. Evaluative information can be secured through asking questions to those who use the service. A questionnaire can be developed, and a pre-post questionnaire administered after a seminar or individual session is good. An experimental design using a control group is recognizable information.

Hansen (1996) developed an Integrative Life Planning (ILP) model that included career development, life transitions, gender-role socialization, and social change. The overarching integrated nature of the process is processing and decision-making regarding the impact of decisions that reflect changes in lifestyle and relationships. Decisions affect responsibility sharing regarding finances, child care, home

environment, leadership roles, changes from traditional jobs to others not considered before and, along with these changes, subtle attitudes and prejudices (glass ceiling; Reskin & Pakavic, 1994).

# OBJECTIVE 4D: Multicultural

Culture is defined as "the set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each individual, communicated from one generation to the next" (Matsumoto, 1996, p. 6). Zunker (2002) paraphrases the work of Matsumoto in describing work-related values that the counselor is to determine when conducting career counseling with clients. These are:

1. power distance
2. uncertainty avoidance
3. individualism/collectivism
4. masculinity

Each of the dimensions above has been covered within other units of this manual with the exception of "uncertainty avoidance." Matsumoto's dimensions of uncertainty avoidance have to do with how different cultures deal with anxiety and stress.

Sue, Ivey, and Pederson (1996) provide some key points for counselors who offer career work with individuals of ethnic background. It is important to:

1. provide a balance in self-oriented help and self-in-relation help.
2. expand helping responses
3. understand cultural based roles
4. develop alternatives to conventional counseling roles.

Issues of discrimination and a lack of access to work opportunities for individuals and groups representing a minority, disability, disenfranchisement, gender, especially women, age, and special needs are plentiful. Broad areas in which these opportunities have lacked support is in opportunities to contribute and to receive a satisfactory fulfillment in work, education, politics, culture, social influence, skill development and non-discrimination practices (biases). Although there are commonalities (universal) that cross all oppressed individuals and groups, frequently the individual experiences them as both individual and group applied.

For some time attention has focused on the national censure bureau description of minority groupings of African Americans, Asian Americans, Hispanic Americans and Native Americans although issues in multicultural work-related issues cover an even much broader scope of individuals and groups and can be said to exist for all oppressed people. Although there are commonalities that cut across the four groupings there are individual specifics to be considered.

Cultural differences exist as noted in applying the concept of worldview to different groups such as individual or collectivism. Acculturation (beliefs, values and behaviors of the white dominant and

minority cultures) is not universal. Time orientation in terms of promptness is viewed from different perspectives within and outside of groups. From this perspective language, place of birth, generation level, socioeconomic status, ethnic identity and ethnic group contacts are areas for counseling when issues arise. Hall (1971) defined time as polychromic and monochromic. Another issue may be that space and privacy are culturally determined and oriented (Zunker, 2002). A concluding comment is that much non-acceptance and misunderstanding may center from an acceptable behavior in one cultural group and not so in another. Hofstede (1984) studied work-related values in 50 countries, 20 different languages and at seven different occupational levels and identified cultural differences to exist. The differences are power distance, uncertainty avoidance, individualism/collectivism, and masculinity.

Women are protected by Title VII of the Civil Rights Act of 1964 and Title IX of the Educational Amendment of 1972 that prohibit discrimination on the basis of gender in employment, payment for work, educational opportunities and equal opportunity.

Sue (1978, p. 293) recommends that to be a culturally effective counselor is to develop an:

1. ability to recognize which values and assumptions the counselor holds regarding desirability and undesirability of human behavior.
2. awareness of the genetic characteristics of counseling that cut across many schools of counseling theory.
3. understanding of the sociopolitical forces that have influenced the identity and perspective of culturally different.
4. ability to share the worldview without negating its legitimacy
5. approach of true eclecticism in counseling.

## OBJECTIVE 4D: Work-Family-Life Roles

Dual career is a term coined by Rapoport and Rapoport (1978) whereby both spouses are pursuing an active career and family life. Counselors often confront clients with multiple issues, which are considered to be internal and external sources of stress (Kater, 1985). Some examples of these stressors are:

Internal: Identity issues, role overload, child care, unequal sharing of household duties, work role competition, differing opinions of importance of work role

External: Rigid work schedules, patriarchal work values, career interruptions, and lack of support for nontraditional roles, mixed messages, lack of role models

Zunker (1998, 2002) identifies counseling issues during the counselor-client hour to be child care, role conflict, geographic moves, competition, personal factors, relationship factors, and family-oriented work policies.

Dual role occurs when one of the two partners assumes two roles, that of house-family-children and an occupational work outside the home. There is a lack of male perspective in most studies relating to the dual-career families. Some authors subscribe to the idea of an Identity Tension Line. This line identifies a point at which the individual feels uncomfortable in the sex-role socialization.

Family changes are ever changing as many families are experiencing the Wait Generation, young people waiting for jobs, difficulties with insurance, marriage, education financial debts, and changing careers. Many family issues remain from past generations such as single-parent, extended families, child care, poverty, and dual roles. Family relationships are often affected by expectations and intentions revolving around work and family. Surfacing issues can be role conflict, child care, geographic moves, competition within partners, personal factors (attitudes, values, biases, finances, divorce, disabilities, work loss, trauma, i.e.), relationship issues, and work related issues.

## OBJECTIVE 4E: Placement, Follow-Up, and Evaluation

Evaluating career guidance from an individual and program perspective utilizes the research designs relative to a formative or summative perspective. If the career program has a step like design it is easier to formulate a plan for follow-up and evaluation. Niles and Harris-Bowlsbey (2013) ten-step program is:

1. define the target population and its characteristics
2. determine the needs of the target population
3. write measurable objectives to meet needs,
4. determine how to deliver the career planning services
5. determine the content of the program
6. determine the cost of the program
7. begin to promote and explain the services
8. start promoting and delivering the full blown program of services
9. evaluate the program
10. revise the program as needed and reflected in the evaluation process

This programmatic outline is targeted at middle school, high school, college and university, corporations and job service offices. Working from a program design the evaluation can pursue a macro-micro approach, that is, from an agency, a group or an individual.

An evaluation should consider the feasibility of a formative or summative data gathering that lends itself for analysis. If the evaluation is for a program, assessment content and feedback can be secured from participants. A second step is to gather specific knowledge, skills, attitudes and behaviors of the individual or group. The data can be collected through feedback, questionnaires, and interviews or administering standardized instruments and structured interviews or observations. Follow-up studies can be a part of the over-all evaluation plan. The final step is to decide on the proper analysis of the data.

# OBJECTIVE 4F: Career Assessment

In 1883, the United States Civil Service Commission used competitive examinations for job placement. Assessment is an informed technique often associated with interest inventories. The first assessments were of the type conducted by Frank Parsons and were modeled after the social intake interview. He was interested in instrumentation, however at the time these instruments were not refined. A good assessment will stimulate, broaden, and provide a focus to career exploration, encourage an exploration of self in relation to a career, and provide the necessary information to assist in conducting a choice.

Career assessment takes into account information from the family development (career tree), socio-economic levels, education, aspirations, work ethic, skill level, resources, special skills, personality, interests, and aptitude. For this review, traditional measurements will be listed.

APTITUDE: Aptitudes measure specific skills, proficiencies or abilities as an index of measured skills. Aptitude measures provide an indication of cognitive strengths and weaknesses. The most commonly used batteries include:

1. GATB: General Aptitude Battery. This aptitude measure was developed by the U. S. Department of Labor and predicts job performance in 100 specific occupations (Gregory, 1996). From the GATB results an occupational analysis profile (OAP) is developed which is matched across occupations for a job fit.
2. DAT: Differential Aptitude Test is the most commonly utilized in the high school setting.
3. FACT: Flanagan Aptitude Classification Test was developed from the Flanagan studies.
4. ASVAB: Armed Services Vocational Aptitude Battery. The ASVAB is one of the most widely utilized instruments. The ASVAB results are used for screening recruits and placing them in different jobs and training slots.
5. SAT: Scholastic Aptitude Test is commonly used for college acceptance and competition probabilities are developed for best choice. The SAT is a very good measure of reasoning skills.
6. ACT: American College Entrance Examination. The ACT, similar to the SAT in purpose also includes an interest inventory based upon Holland's typology.

ACHIEVEMENT: Achievement tests assess present level of developed abilities.

INTEREST: Interest inventories measure patterns of similarity and for some, satisfaction. Four types of interests were identified by Super and Crites (1962) that can be assessed through testing, observation, and a personal interview (expressed, inventoried, manifested, and tested). A few inventories of this type and authors are:

1. Clark Hull: Minnesota Vocational Interest Inventory
2. E. K. Strong: Strong Vocational Interest Blank and Strong Interest Inventory
3. G. F. Kuder: Kuder preference, occupational, vocational
4. John Holland: SDS-Self Directed Search VPI-Vocational Preference Inventory

PERSONALITY: Certain personality inventories develop profiles to match the characteristics of a job setting to the personality of the individual. Some examples and authors are:

1. Myers-Briggs: Myers-Briggs Type Indicator
2. Raymond Cattell: 16 Personality Factor Questionnaire
3. A. Edwards: Edwards Personal Preference Schedule (EPPS). Based on 15 needs of Murray.

VALUES: Values inventories measure values associated with broader aspects of life style. Some inventories and authors are:

1. Allport-Vernon: Study of Values
2. Donald Super: Work Values Inventory

# OBJECTIVE 4G: Vocational and Career Resources

## Occupational Descriptions

1. O*Net is a database that was developed by the U.S. Department of Labor and is available at www.onetcenter.org. The O*Net has in excess of 1,100 occupations. This website has three assessment instruments, the O*Net Interest Profiler, the O*Net Ability Profiler, and the O*Net Work Importance Profiler.
2. Dictionary of Occupational Titles (DOT.) lists some 20,000+ titles. The original work of two (2) volumes outlined specific jobs and worker characteristics. The two volumes were reduced to one volume. Each job title is coded with a nine-digit number (U.S. Department of Labor, 1996-1997).
    a. position 1 occupational divisions
    b. position 2 one of 97 occupational divisions
    c. position 3 location of occupational group within occupational division

    The first three digits identify the particular occupational group: category, division, and occupational group.

    a. position 4 data relationship
    b. position 5 people relationship
    c. position 6 things relationship

    The second three digits immediately to the right of the decimal are worker functions. Positions four, five, and six refer to the relationship each job has to data, people, and things respectively and are referred to as worker function. As the digit approaches zero, the job role has a higher relationship (involvement) to that category. Higher indicates requiring more skill and involvement.

A numbering system exists for each category and reflects that involvement. An example such as 014.061-001 would indicate the person with a (0) in the tens digit would desire synthesizing-data, (6) in the hundreds digit would desire speaking-signaling-people, and (1) in the thousand digit would prefer precision working-things.

Positions g, h, i. (not shown) or position 7, 8, 9 further identities or differentiates a specific occupation from another by increasing the number by increasing a multiple of four if it has the same six digit number.

3. Occupational Outlook Handbook (OOH)—The OOH is published by the U.S. Department of Labor (2012) every two years and can be accessed through the Internet (www.bls/gov/oco). This handbook uses the same classification system as the DOT. It contains several pages of information and includes employment trends, working conditions, training, earnings, and projections for some 250 occupations (U.S. Department of Labor, 1996-1997). Even though there are a limited number of occupations within this reference book those 250 jobs account for approximately seven out of eight jobs in the economy (Neukrug, 1999).
4. Occupational Outlook Quarterly. This literature contains information on new occupations, the job, youth, women, veterans, minority group members, labor market, and training opportunities and is available at www.bls.gov/opub/ooq/ooqghome,htm (Drummond & Ryan, 1995).
5. Other work information sources:
    a. Occupational Briefs
    b. Post-Secondary Information (Examples)
    c. College Blue Book
    d. American Universities & Colleges
    e. Career Employment Opportunity Directory
    f. Directory of Career Training and Development
    g. Directory of Corporate Affiliations
    h. Moody's Manuals
    i. Standard and Poor's Register of Corporations
6. Vocational, Trade, and Technical Schools (Examples)
    a. Lovejoy's Career & Vocational
7. U.S. Employment Services (Job Service)
8. National Level
9. Services: Employment
    a. CETA: Comprehensive Employment and Training Act—disadvantaged individuals and rate of unemployment determines the award. CETA trains for basic skills, maturity and job specific skills (replaced by JTPA-1982).

b. WIN: Work Incentive Program assists individuals in families who are receiving aid to families with dependent children.
c. VIEW: Vital Information for Education and Work—Local Labor Market Information
d. JOB-FLO: U.S. Department of Labor Information about career fields and information on high demand occupations.

# Unit 4 - Terms

AVOCATION:
A casual occupation or diversion; a hobby (Chaplin, 1968).

BURNOUT:
Lowman (1993) considers burnout to be one of three patterns of over commitment. Over-commitment is defined as too intense of an identification with and involvement in the work role where psychological health is at risk. Ashforth and Lee (as cited in Lowman, 1993) indicate burnout is a three-dimensional construct composed of the psychological aspects of emotional exhaustion, depersonalization, and personal accomplishment. Leiter (as cited in Lowman, 1993) points out that not all experts agree emotional exhaustion is a factor in burnout but that it appears to be related more to family issues, depersonalization to family and work, and personal accomplishments to work.

CAREER AWARENESS:
The knowledge, values, preferences, and self-concept utilized in making a career choice.

CAREER GUIDANCE:
Career guidance is often used interchangeably with vocational guidance and counseling. Guidance has been associated more with schools than with private practice or community agencies work. Career guidance appears to be a lifestyle concept incorporating both work and leisure counseling. Career interventions, a recent term, is being utilized in order to avoid controversy between career guidance and career counseling. Some authors tend to refer to career counseling as more interpersonal adjustment counseling.

CAREER LATTICE:
Business and industry's term to describe the opportunities which include possible upward and horizontal mobility (lateral transfer), the possibilities of shifting from one career ladder to another (Herr & Cramer, 1996).

CAREER MATURITY:
Super's term for successful completion of the appropriate tasks for the stage that society presents to the person. A person is capable of maturity at each stage of the maxicycle.

CAREER PATTERN STUDY:
Donald Super's research efforts to validate his theory by following 100 men from the ninth grade to at least 35 years of age. His research was initially concerned with choice and maturity. Results from this study influenced changes in his theory. Maturity in adulthood as in adolescence is influenced by the

same five factors: planfulness (time perspective), exploration, information, decision-making, and reality orientation.

CASVE CYCLE:
Peterson, Sampson, and Reardon (as cited in Herr & Cramer, 1996) define a CASVE cycle as a process for utilizing information correctly. The letters represent communication (identifying a need), analysis (interrelating problem components), synthesis (creating likely alternatives), valuing (prioritizing alternatives), and execution (forming means-ends strategies).

CONGRUENCY:
John Holland defines congruency according to the fit concept between personality and a chosen work environment, comparing the assessed codes or stereotypes of the RIASEC model of personality and environment. A congruent pattern would be a RI (realistic-intellectual) personality working in or choosing a RI (realistic-intellectual) occupation.

CONSISTENCY:
Holland's concept for the degree of relatedness between subtypes. Consistency can be high, medium, or low depending upon the nearness of the codes (adjacency on the hexagon).

CRYSTALLIZATION:
The third tier of the Realistic Stage of Ginzberg and associates' theory. Crystallization is said to occur when commitment to a specific field is made. Super views this process as a task, involving the formation of a general vocational goal through one's awareness, interests, values, and planning.

CYCLICAL COUNSELING:
A term applied to the style of counseling when using the developmental approach theorized by Donald Super. Cyclical is Super's concept that a person entertains several minicycles during a life span of a maxicycle.

DIFFERENTIAL APTITUDE TEST (DAT):
This aptitude test is for educational and vocational guidance for grades eight through 12. The results are considered to be useful in vocational counseling and for the selection of employees. The test consists of eight tests, and a profile is provided.

DIFFERENTIATION:
Miller-Tiedeman and Tiedeman indicate that differentiation takes place when considering a choice and then separating experiences. The four steps of exploration, crystallization, choice, and clarification complete this process. John Holland described differentiation as to how well defined a person was with his/her likes and dislikes.

DISABILITY:
"A person with a disability is one who is usually considered to be different from a normal person—physically, physiologically, neurologically, or psychologically—because of an accident, disease, birth, or developmental problems" (Herr & Cramer, 1996, p. 294). A disability can be physical, emotional, intellectual, and/or sociocultural. Accepted terms today are "disabled person" and "people with disabilities."

DISCOVER:
One of many computer-assisted career guidance systems (CACGS) accessed through a computer program or network. Survey research reveals that DISCOVER is a frequently utilized system and does have a positive effect on self-efficacy and career planning for undergraduates (Fukuyama, Probert, Neimeyer, Nevill, & Metzler, 1988).

DOT:
The Dictionary of Occupational Titles contains information about 20,000 jobs. The first DOT appeared in 1939. The current volume is used for classifying job applicants, classifying job orders, matching workers to orders, and assisting special groups. An occupational code number is assigned to each occupation according to a nine digit numbering system. The first three numbers refer to the category, division, and group of the occupation. The second three numbers refer to the relationship the job has to data, people, and things, while the last three digits refer to the alphabetical order of the titles.

DUAL-CAREER FAMILIES:
Both spouses are pursuing and committed to an active career and family life. For the most part, this term has been reserved for those in professional, technical, or managerial positions (Wilcox-Matthew & Minor, 1989).

HANDICAP:
Having less than normal ability or having an anatomical or functional defect that makes it difficult for one to compete with peers (Chaplin, 1968). The Americans with Disabilities Act (ADA) of 1990 provides for essential and non-essential job functions and makes provisions for what and when certain questions may be addressed to a disabled person in an employment interview. In addition it provides for nondiscriminatory practices in job application procedures, hiring, firing, advancement, compensation, fringe benefits, job training, and other conditions (ADA, 1991).

HOLLAND'S OCCUPATIONAL CLASSIFICATION (HOC):
This classification is an alphabetical listing of occupations by code that are related to the various major permutations of Holland's codes. This coding system allows users to search out related occupations as possible alternatives.

INTERESTS:
The definition of interests has been linked to four methods of obtaining this type of information. These four are expressed, manifested, tested, and inventoried interests. An expressed interest is a verbal statement of an object, activity, task, or occupation. A manifested interest is an involvement in an activity or occupation. A tested interest is an objective assessment of information. Finally, an inventoried interest is usually derived from a questionnaire or inventory such as the Strong Interest Inventory.

LEISURE:
A state of being. Gunter and Gunter (1980) identified four types of leisure: pure, anomic, institutional, and alienated. The connection between work and leisure is an arena for leisure counseling with the goal of attaining life satisfaction. There appears to be a relationship between social competence and the type of chosen leisure.

MAPS:
A classification scheme for occupational structure. The World of Work Map by ACT and the Occupational Aptitude Patterns Map by GATB are two examples. Mapping is a concept utilized in Bordin's Psychoanalytic Theory that is composed of satisfiers and the degree of involvement.

NOICC:
The National Occupational Information Coordinating Committee provides for counselor's current, valid, localized, integrated, and comprehensive career information. Congress established NOICC in 1976 for the purpose of developing, disseminating, and using occupational and labor market information (Herr & Cramer, 1996).

OBSOLESCENCE:
The degree to which organizational professionals lack up-to-date knowledge of skills necessary to maintain effective performance in either current or future work roles.

OCCUPATIONAL OUTLOOK HANDBOOK (OOH):
The OOH is published by the Bureau of Labor Statistics and contains detailed information on about 200-250 occupations. Information includes a description of working conditions, employment, training, qualifications, advancement, job outlook, earnings, and related occupations.

OCCUPATIONAL STRESS:
Occupational stress is when one's resources are less than the stressors. The process is one of perceiving a work stressor followed by a cognitive appraisal in which the person is confused about a response both psychologically and behaviorally. The last step is the introduction of coping behaviors.

O*NET:
Occupational Information Network (O*NET) replaces the DOT and can be accessed through the Internet (http://www.doleta.gov/programs/onet. and is also located with the Employment and Training Administration of the U.S. Department of Labor (http://online.onetcenter.org) (DOL, 2002). This source has a database for the DOT, OOH, and The Guide for Occupational Exploration. The database contains interest and work activities of employed workers in different occupations as well as information about knowledge-skills abilities. It is designed to replace the DOT because the DOT was last revised in 1991. The O*Net is to be an automatic replacement, and it is designed for the computer and updated as frequently as needed.

P x E FIT:
A dynamic reciprocity where the person (P) and the environment (E) interact and influence each other. The Theory of Work Adjustment recognized this correspondence between work abilities and work requirements as predictive of worker competence.

RIASEC:
John Holland's typology is ordered on a hexagon. The six types of realistic, intellectual, artistic, social, enterprising, and conventional are assessed for order and consistency is determined as codes lie adjacent to each other on the hexagon.

ROLE SALIENCY:
The positions and roles a person occupies or plays. Saliency is latitudinal with lifespace and represents the constellation of different positions an individual occupies.

RUST OUT:
A term referring to individuals who are underemployed and who are in positions that underutilized their skill and training. There is not enough pressure and challenge in their work. Their skill performance drops off and surface symptoms appear which are similar to burnout.

SHADOWING:
A career term for acquiring information on the job regarding different work settings. An individual will accompany a worker on his or her job. "Early Entry" is when children spend a day at work with their parent. Watts (as cited in Herr & Cramer, 1996) defines work shadowing as "schemes in which an observer follows a worker around for a period of time, observing the various tasks in which he or she engages, and doing so within the context of his or her total role" (p. 464). The principle element is observation of work roles.

STANDARD OCCUPATIONAL CLASSIFICATION (SOC):
This classification bridges the Census Classification and the DOT, and covers all occupations in which work is performed for pay. However, it does not cover volunteer work. This system is a four-level system of divisions, major groups, minor groups, and unit groups.

TRANSITION:
Super defined a transition when one is between two stages of greater stability; it is a period of flux or vacillation.

UNEMPLOYMENT:
A major social and economic issue that carries individual and societal costs. A term applied to a state in which an individual and/or group desires or needs to work and is unable for a variety of reasons to secure work.

WORK:
"Work is a way of life, and that adequate vocational and personal adjustment are most likely to result when both the nature of the work itself and the way of life that goes with it are congenial to the aptitudes, interests, and values of the person" (Roth, Hershenson, & Hillard, 1970, p. 203).

## Questions

**Question 4-19:**
You are an elementary counselor working with the teachers in your school on career guidance emphasizing vocational development of the life span. What would be important to emphasize in K-6?

a. an awareness of available choices and personal characteristics
b. the need for self-motivation for alertness to self-change
c. career exploration activities

d. the gap between education and work skills

Answer: a. an awareness of available choices and personal characteristics

**Question 4-20:**
A registered apprenticeship is a:

a. four-year commitment of working under mentorship.
b. program of study in learning one of the occupations listed in the Dictionary of Occupational Titles.
c. set number of hours of continuous employment and related classroom instruction.
d. program of support personnel building rapport and climate for in-service training.

Answer: a. four-year commitment of working under mentorship.

**Question 4-21:**
Which vocational theorist would indicate that a vocationally mature person will demonstrate achievement of developmental tasks?

a. Anne Roe
b. John Holland
c. Donald Super
d. John Hoppock

Answer: c. Donald Super

**Question 4-22:**
According to John Holland, a person who self-selects stereotype RIA would demonstrate which of the following concepts if he or she worked in a similar environment?

a. congruence
b. consistency
c. differentiation
d. confluence

Answer: c. differentiation

**Question 4-23:**
If you were assisting a student in grade 12 in looking for specific information about a particular job, which source would you select?

a. Dictionary of Occupational Titles (DOT)
b. Occupational Outlook Handbook (OOH)
c. Vital Information for Education and Work (VIEW)
d. Buros Mental Measurement Yearbook (MMY)

Answer: a. Dictionary of Occupational Titles (DOT)

**Question 4-24:**

In using the DOT classification system with a client who indicates he would like to be an optical engineer, the DOT code is 019.601-014. Which of the following would be accurate for an optical engineer?

a. high relationship to data and things and low relationship to people
b. high relationship to data and people and low relationship to things
c. low relationship to data and high relationship to people and things
d. low relationship to things and high relationship to data and people

Answer: c. low relationship to data and high relationship to people and things

# Unit 4 - References


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# UNIT 5 - Helping Relationships

## Introduction

The nature of  helping relationships accurately reflects the foundation of guidance and counseling. Guidance and counseling has evolved from an interdisciplinary framework including philosophy, educational foundations, health, psychology, sociology, and anthropology. Several theories attempt to explain the person in relationship to the self, others, and/or the environment. These explanations and understandings often suggest a developmental perspective that includes the following areas: vocational, physical-sexual, psychosocial, moral, affective, ego, personality, and learning. Several of these areas are covered elsewhere in this manual.

It is helpful to be familiar with the philosophical foundations that support the development of theory. It is also advisable to review the ACA Code of Ethics and Standards of Practice, especially Section A: The Counseling Relationship, Section C: Professional Responsibility, and Section D: Relationship With Other Professionals. Major theories are reviewed in this chapter. To become familiar with these theories, study the goals, techniques, counseling process, role of the counselor, dynamics, client behaviors, and outcome effectiveness. Compare and contrast the theories in terms of these facets. There are 41 content questions in this section; however, only 36 count toward your total.

# CACREP Objectives

CACREP 2009 objectives for helping relationship are not presented in full. Therefore, you may want to visit www.cacrep.org website for the full standard objectives. The 2009 objectives for helping relationships are paraphrased and follow:

A. counselor characteristics and behaviors that influence helping processes
B. essential interviewing and counseling skills
C. counseling theories and models to conceptualize interventions and research practice
D. systems perspective provides understanding of family and related interventions
E. orientation to wellness and prevention as desired counseling goals
F. understanding practicing consultation framework
G. crisis intervention and suicide prevention models, including the use of psychological first aid strategies

**Question 5-1: (Objective A.)**
To customize a therapy relationship, client characteristics are important. Clients who have little support from other people are likely to benefit from:

a. short-term, brief therapies.
b. lengthier psychotherapy creating social support.
c. lengthier psychotherapy and psychoactive medication.
4. shorter psychotherapy creating social support.

Answer: b. lengthier psychotherapy creating social support (Norcross, 2004)

**Question 5-2: (Objective B.)**
One way in which a counselor can assess client improvement is to:

a. ask the client.
b. ask family members.
c. administer a test.
d. compare specific behaviors with initial assessment of the same behaviors.

Answer: d. compare specific behaviors with initial assessment of the same behaviors.

**Question 5-3: (Objective B.)**
Evidence-based practices suggest that clients demonstrating low resistance tend to get better when there are signs of:

a. therapist directiveness and guidance.
b. self-control methods.

c. minimal therapist directiveness.

d. paradoxical interventions.

Answer: a. therapist directiveness and guidance (Norcross, 2004)

**Question 5-4: (Objective C.)**

Which of the following is not considered a criticism of family systems counseling?

a. intrusiveness

b. training of therapist

c. family case conceptualization

d. sexism

Answer: c. family case conceptualization (Day, 2004)

**Question 5-5: (Objective D.)**

Integrative psychotherapies focus on three approaches: theoretical integration, technical eclecticism, and common factors orientation. Select the correct choice for therapies or theorists for the above three in sequential order.

a. Prochaska, Lazarus, Wachtel

b. Lazarus, Wachtel, Prochaska

c. Prochaska, Wachtel, Lazarus

d. Wachtel, Lazarus, Prochaska

Answer: d. Wachtel, Lazarus, Prochaska (Day, 2004)

**Question5-6: (Objective E.)**

The Belmont report focused on principles for ethical decisions when conducting research in a counseling setting. The report addressed three of the priniciples. Which one is not included in the Belmont Principles?

a. justice

b. respect

c. beneficence

d. fairness

Answer: d. fairness

**Question 5-7: (Objective F.)**

Theoretically and clinically consultation is what type of relationship?

a. collateral

b. linear

c. casuality

d. triadic

Answer: d. triadic. Triadic-consultant, counselor, and consultee

**Question 5-8: (Objective G.)**
During the aftermath of a disaster and considering the survivor is safe there are psychological tasks to be performed by the first responder. Reports from several disaster follow-ups highlight for a responder which psychological task is considered to be the most important to survivors?

a. comforting and consoling a distressed person
b. providing goal orientation and support for specific reality-based tasks.
c. sharing the experience.
d. facilitating a beginning of some sense of mastery.

Answer: a. comfort and consoling a distressed person. The Disaster Health Response Handbook indicates comfort and consoling, protecting them from further harm, and ensuring basic needs are met, conversing compassion, and recognition for what they have been through (Raphael, 1993).

## Preview Questions

**Question 5-9:**
According to Erik Erikson, the conflict between industry vs. inferiority takes place at about what age?

a. retirement age
b. elementary-school age
c. young adulthood
d. adolescence
e. middle age

Answer: b. elementary-school age

**Question 5-10:**
Which of the following statements is not true according to the tenets of Adlerian therapy?

a. Social forces impact behavior more than biological forces.
b. A person's lifestyle changes throughout the life span as his or her goals change.
c. Consciousness, rather than unconscious, is the center of the personality.
d. Childhood experiences in themselves are not as important.
e. Feelings of inferiority can be a well spring of creativity.

Answer: b. A person's lifestyle changes throughout the life span as his or her goals change.

**Question 5-11:**
Which technique(s) is/are most often used in person-centered therapy?

a. active listening and reflection
b. questioning and probing
c. free association
d. paradoxical intention
e. dream analysis

Answer: a. active listening and reflection

**Question 5-12:**
Which of the following is not a goal of Gestalt therapy?

a. acceptance of personal responsibility
b. awareness of the "here and now"
c. movement from external to internal locus of control
d. dealing with unfinished business
e. insight into unconscious motivation

Answer: e. insight into unconscious motivation

**Question 5-13:**
A basic assumption of Rational-Emotional Behavior therapy is that humans:

a. think without emoting.
b. emote without thinking.
c. behave and then emote.
d. behave without thinking or emoting.
e. think, emote, and behave simultaneously.

Answer: e. think, emote, and behave simultaneously.

**Question 5-14:**
In Reality therapy, insight is regarded as:

a. necessary for behavior change to occur.
b. not necessary for behavior change to occur.
c. the end result of the teachings of the therapist.
d. something only the client can discover for himself or herself.
e. something that follows changed attitudes.

Answer: b. not necessary for behavior change to occur.

# Terms and People

Definitions and descriptions for these terms can be found at the conclusion of this chapter:

Abreaction
Bibliotherapy
Catharsis
Compensation
Control Theory
Eclecticism
Evidenced based Outcome Therapies
Figure/Ground
Iatrogenesis
Integrative Therapy
Masculine Protest
Narcissism
Negative Reinforcement
Phenomenology
Punishment
Self-monitoring
Solution-focused
Transference
Basic ID
Brief Therapy
Cognitive Restructuring
Constructivism
Counter-transference
Empowerment
Feminist Therapy
Hakomi Body-Centered Therapy
Impasse
Logotherapy
Morita Therapy
Narrative Therapy
Paraprofessional
Positive Reinforcement
Secondary Reinforcers
Social Learning Theory
Solution-Focused Brief Therapy
Unfinished Business

## OBJECTIVE 5A: Wellness and Prevention

Wozny (2012) devoted an article to promoting leisure wellness in counseling. The implications for this unit of study include wellness from a prevention approach for the counselor and the client. Of immense importance is the direct effect of emotional states on immunity and illness. The ACA (2014) Code of Ethics in Section F.8.c. emphasizes self-growth, an expected component of the counselor-in-training. In addition the code specifies remediation in terms of impairment (C.2.g.) and for personal concerns (F.8.d.)

Self-care in the form of assessment and implementation of effective strategies to maintain a healthy life style are encouraged. The result of not doing so increases the risk of fatigue, burnout and eventual impairment for the counselor. For clients the same exist, but also includes health issues, relationship conflicts, and personal psychological risks. Review unit one for definitions of serious and casual leisure perspective and resiliency. That same unit highlights Myers, Sweeney, and Witmer's (2000) wheel of wellness and suggestions for treatment planning. The concept underlying wellness is prevention and

alternative methods of intervention and remediation when working with clients. An overarching goal for clients is to move from a dependent position in life to one of independence. The charting for wellness includes an assessment and planning for spirituality, self-direction, sense of worth, realistic beliefs, emotional awareness, problem solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, cultural identity, work, leisure, friendship, and love. One or more of these categories is a part of a large majority of counseling cases.

Remely and Herlihy (2010) approach the topic of early prevention and prevention from a wellness perspective. The philosophical and practical belief system in responding to societal client needs by counselors is the belief in prevention oriented efforts to identify the risk factors, protective factors, and precursors of psychological issues. Counselors endorse the mental health beliefs in assisting clients through the client's emotional issues within the wellness model of mental health. The belief is that problems are developmental, prevention is superior to remediation interventions, and to empower clients to resolve their own problems (pp. 19-20). Prevention strategies are primary (awareness and teaching preventive techniques), secondary (intervene the issue or symptoms), and tertiary, reducing the effects (Gibson & Mitchell, 2008).

The Institute of Medicine (IOM) in 1994 on prevention focused on precursors of dysfunction and health risk factors and protective factors (Heller, 1996). The first task was to define prevention. The committee studied and defined prevention as interventions that occur before the initial onset of a clinically diagnosed disorder (Munoz, Mrazek, & Haggerty, 1996). The second step was to define intervention types to be universal preventive (entire population at risk), selective preventive (individuals or subgroup whose risk of developing a mental disorder is significant), and indicated preventive interventions (high risk).

Risk factors are characteristics, variables, or hazards, that if present, increase the likelihood of a disorder. Protective factors are those factors that will lessen or reduce a person's predisposition to a dysfunctional outcome (Rutter, 1985). The IOM commissioned five disorders for prevention study regarding the risk and protective factors. The disorders are conduct disorder, depressive disorder, alcohol abuse and dependence, schizophrenia, and Alzheimer's disease.

## OBJECTIVE 5B: Counselor Characteristics

The qualities of effective counselors have not been documented through research. Several researchers have attempted to link personal characteristics of the counselor with effective therapeutic relationship development. Research conducted by Najavits and Weiss (1994) and Najavits and Strupp (1994) found a significant association between strong interpersonal skills and counseling effectiveness. Capuzzi and Gross (2003) recognize the importance of health and wellness for the helper. They identified three models emphasizing elements of a healthy person. These models are personal characteristics, psychological health models, and multidimensional health and wellness models. Carl Rogers suggested that counselors should possess the core conditions as a part of who they are in relationship development. These core characteristics are: concreteness (specificity), congruency (genuineness), empathy (understanding), positive regard (accepting), immediacy, and respect. Other characteristics

have also been suggested such as self-awareness, open-mindedness, flexibility, objectivity, trustworthiness, personal integrity, and a sense of values. Whiston and Sexton (1993) reported that Horvath and Symonds found that the working alliance accounted for 30% to 45% of change and social-influence models were helpful. LaCrosse (1980) indicated that perceived expertness, attractiveness, and trustworthiness accounted for 35% of client change. Session length can also be a factor in that a 50% improvement rate was found at the end of eight sessions, 75% by the end of 2 sessions, and 85% of improvement by the end of the first year. (Howard, Kopta, Krasue, & Mann, 1972).

Meier and Davis (2001) refer to the healthy and well helpers as:

1. aware of personal issues
2. open to supervision
3. not hiding behind the use of too many tests
4. consulting when involved in ethical dilemmas.

A composite model of human effectiveness includes openness to and acceptance of experiences, awareness of values and beliefs, ability to develop warm and deep relationships, willingness to be seen by others as one actually is, willingness to accept personal responsibility for one's own behaviors, and development of realistic levels of aspirations (George & Cristiani, 1990).

Sometimes it is helpful to review reasons individuals who are experiencing distress avoid coming to counseling. Kushner and Sher (1989) indicate that less than one-third who are in distress seek mental health services. Vogel, Wester and Larson (2007) isolated eight factors through a literature review. Factors they found are social stigma, treatment fears, fear of emotion, anticipated utility and risk, social norms, self-disclosure, and self-esteem. These authors suggest that influence factors are prominent for the avoidance reactions. Less well documented are studies for other avoidance factors of sex and gender, race and ethnicity, setting and problem type, and age. For a more in-depth review of these factors reading the article will be helpful. Suggestions to address social factors may be to advocate on a larger social scale to reduce the negative perceptions that society holds toward mental health services. Helping clients to learn and identify ways to cope with the stigma is a possibility. The same can be said for treatment fears. To lessen this concern is to challenge the negative perceptions. The fear of experiencing a negative affect may be helped by educating clients about the personal control they have regarding disclosures and readiness for counseling or change. The use of motivational communication in discussing readiness for change can be a topic that helps to dispel what might be considered a forced choice for change. Conducting a cost-benefit analysis for counseling that is worked out jointly and is visible to the eye, written-out or placed on a working board can help in weighing options. Social advocacy in a group effort is a positive direction for meeting some of the avoidance factors due to social norms.

**Question 5-15:**

The literature indicates that greater than 50% of the clients who are likely to benefit from counseling avoid seeking mental health services. In many of those instances of individuals avoiding counseling this might be explained by:

a. approach/avoidance conflict
b. unexplained reasons
c. client's belief they can resolve the issue without counseling
d. there is a poor match between counselor and client especially with majority-minority

Answer: a. approach/avoidance conflict. Kushner and Sher (1989) explain the dilemma consisting of several avoidance behaviors.

## Effectiveness of Counseling

The ACA Code of Ethics (2014) remind counselors to continually make concerted efforts to improve in areas of client care and personal development. Specifically Section C.2.d. refers to monitoring effectiveness and efficacy through peer supervision and research. In addition with the advent of distance counseling Section H.4.d. (effectiveness of services) if it is deemed to be ineffective that face-to-face services are delivered. If face-to-face counseling is not possible then assisting the client in identifying a service is recommended.

There have been many studies related to the outcome of therapy. More information on efficacy studies is to be found in the professional counseling and ethical practice unit. Outcome research is the term most frequently applied to the investigation of the impact of counseling on clients, that is, on those practices and activities. Eysenck (1966) found that adults and children treated by professional counselors and therapists did not improve, on the average, any more than untreated people in control groups. True and Carhuff (1967) did find that counselors who displayed empathy, warmth, and genuineness did have clients who made positive changes. Eventually the Carkhuff communication model became a vehicle to train helpers to perform at high levels, consequently providing a model for human functioning. In another study, Mahoney and Arnkoff (as cited in Garfield & Bergin, 1986) found that contemporary approaches in psychotherapy are experienced by clients as ineffective and poorly generalized to "real life" situations. Furthermore, therapeutic gains were poorly maintained, there was poor cost efficiency, and ethical dilemmas frequently arose in which clients' rights and responsibilities were not respected.

Other studies have shown that traditional, insight-oriented psychotherapy is most successful with middle- and upper-middle class, or YAVIS (young, attractive, verbal, intelligent, and successful) clients. Traditional psychotherapy is indeed geared to middle-class values, philosophies, and abilities (i.e., verbal abilities). Therefore, it is not surprising that lower-class and otherwise disadvantaged clients who tend to be less verbal, less intellectual, and less psychologically sophisticated experience minimal benefits from psychotherapy. According to Goldstein (1981), 50 percent of psychotherapies involving lower-class clients tend to last only one or two sessions (premature termination). Furthermore, traditional psychotherapies were successful at obtaining a transfer of training in only 15-20% of the cases. In response to these findings, skills training programs were developed to address the needs of populations often not being met by traditional therapies. Research reveals that skills training results in transfer of training in 50% of the cases and is more cost-efficient than traditional therapies (Goldstein, 1981).

Nugent (1994), reporting on meta-analysis research, summarized studies of Smith, Glass, and Miller; Glass and Kliegel and Shapiro and Shapiro and found agreement that those clients who had therapy were better off than those who did not. Nugent went on to report on the research of Lambert, who indicated that not everyone improves in a satisfactory degree, nor are all therapies equal or one better than another. Kelly (1991) found in his research that no theoretical approach was better than another.

Current research that has been summarized by Lambert and Cattani-Thompson (1996) dating from 1920 to the present suggests that treated clients are better off than 50-80% of the clients who are considered the controls. Although there has been difficulty in conducting this type of research, Kadera, Lambert, and Andrews cite that 75% of clients reach some level of recovery after 26 weeks of psychotherapy and about 50% recover with as few as 8-10 sessions (as cited in Lambert & Cattani-Thompson, 1996). In evaluating the literature on outcome effectiveness, Corey (1986) cautions against drawing hasty conclusions. He points out that the question of effectiveness cannot be approached globally, due to the unique personality and situation concerns of each client. Therefore, outcome effectiveness must be evaluated in terms of what treatment, by whom, is most effective for which individual with what specific problem and under what circumstance.

Recovery variables are related to the client, common factors, and specific interventions. Lambert and Cattani-Thompson (1996) summarized some of the following variables from articles published by several researchers:

Client: Severity of disturbance, motivation, capacity to relate ego strength psychological mindedness, and ability to identify a focal problem.

Common Factors: Empathy, warmth, positive regard, working alliance, personality of the counselor, counselor helping them understand their problem, encouragement to face their problem, talk to an understanding person, and the counselor helping them to a greater self-understanding (Sloane, Staples, Cristol, Yorkston, and Whipple as cited in Lambert and Cattani-Thompson (1996).

Interventions: Phobic disorders are best served with behavioral techniques (accompanied by systematic exposure), panic disorders are best treated by a cognitive-behavioral approach, depression by cognitive-behavioral and/or interpersonal psychotherapy.

## Evidence-Based Practices – Therapy Relationship to Individual Client

Sexton (1999) isolates two broad domains in which counseling effectiveness has research support. The two specific areas are clinical models and the counselor. His conclusive statement is that there is no "best" theoretical approach. The research points in the direction of "common factors" that drive effective counseling. Lambert (1991) states that approximately 30% of outcome is attributable to common factors within therapies. Factors outside of therapy (40%), client expectations (15%), and specific psychological techniques (15%) make up the rest of the outcome, for effectiveness.

According to Sexton and Whiston (1994) common factors are: collaborative counseling relationship, learning (affective experiencing, corrective emotional experiences, and skill acquisition), and action (successful experiences, behavioral regulation, and mastery).

The counselor variables that affect best practices are skillfulness (competence), cognitive complexity (ability to think diversely), and an ability to relate (a match with the client). It is also crucial that counselors have the ability to assess the problem.

Grencavage and Norcross (1990) isolated 89 common factors across 50 different studies. The two most common were client expectations and a facilitative therapeutic relationship. Later research by Norcross (2004) in a meta-analysis found that tailoring therapy relationship to match the client needs and characteristics are more likely to achieve effective outcomes.

1. Client characteristics are resistance and impairment. Matching therapist directiveness to the client level of resistance improves therapy efficiency and outcome (80% of studies; Norcross, 2004, p.1).
    a. Clients with high resistance benefit from self-control methods, minimal therapist directiveness, and paradoxical interventions.
    b. Clients with low resistance benefit more from therapist directiveness and explicit guidance.
2. Impairment is the severity of the client's subjective distress and reduced functioning (Section F. 5.b.).
    a. Clients manifesting impairment in 2 or more areas of functioning are likely to benefit from treatment that is lengthier and from psychoactive medication.
    b. Clients who have little social support from other people are also likely to benefit from lengthier therapy and development of social support outside of therapy.
3. Coping style
    a. Internalizing clients tend to benefit from interpersonal and insight-oriented therapies.
    b. Externalizing clients tend to benefit from symptom-focused and skill-building therapies.
4. Stages of change (precontemplation, contemplation, preparation, action, and maintenance
    a. Cognitive-affective in the precontemplative and contemplative stages
    b. Behavioral in action and maintenance
5. Personality: Anaclitic (relatedness) / sociotropic and introjective (integrated identity)/ autonomous styles
    a. Anaclitic/sociotropic clients tend to benefit from therapies that offer closer interaction and personal interactions
    b. Introjective/autonomous clients tend to do better in therapies that offer separation and autonomy.
6. Expectations
7. Assimilation of problematic experiences
    a. Clients follow a regular developmental sequence in working through problematic experiences (eight stages).

## Models of Human Effectiveness

The wellness concept has continued to develop support from the time Karl Menninger used the term "Weller than Well" to the present term of positive wellness. The wellness concept includes health-related activities that are preventive and remedial (Gladding, 1996). There are several models representing human effectiveness. Individuals who live effectively in all aspects of their lives for the most part best illustrate higher levels of functioning. This concept of wellness would include physical exercise, eating natural health foods, mental exercises, social participation, meditating, and a variety of other life-enhancing experiences. Witmer and Sweeney (1992) include a list of five life tasks that have 11 dimensions of a healthy person. These five life tasks are: spirituality, self-regulation, work, friendship, and love. The following models are examples of individuals who would be functioning at high levels based upon the research of different authors.

## Maslow's Self-Actualizing Person

Abraham Maslow (1973) was one of the first American psychologists to become interested in the problem of high-level human functioning. Maslow approached his study of positive functioning with the assumption that man does indeed have an essential nature or set of genetically based tendencies. He viewed these tendencies as giving rise to needs that are on the surface good or neutral, rather than bad. Maslow conceptualized human development as the process through which the basic tendencies were actualized and full human potentialities fulfilled. He thus saw human personality as basically growing from within, rather than being shaped from without. Psychopathology, on the other hand, was seen largely as the result of frustrating or twisting man's essential nature from without.

Within the value system for human nature anything that contributes to the development of man's inner nature is good, while anything that disturbs, blocks, or denies that nature is bad or abnormal.

Maslow wrote a paper titled "The Need to Know and the Fear of Knowing," in which he outlined each of the intrinsic aspects of what he called B-values, or Values of Being. "Self-actualization is an experiencing fully, selflessly, with full concentration and total absorption" (p. 45). He viewed self-actualization as a process.

Maslow hypothesized the conditions for optimum development or actualization within a theory of Hierarchy of Needs. Briefly, Maslow classifies human needs into a series of increasingly "higher-level motivations," each of which emerges as soon as the next lower level need has been satisfied.

The hierarchy is:

1. physiological needs
2. safety needs
3. love needs
4. esteem needs
5. self-actualization needs

Since the higher order needs will emerge only when the lower ones have been reasonably well satisfied, Maslow pointed out that the best way to obscure the higher motivations of a person is to keep him or her chronically hungry, insecure, or unloved. If one is to view people in such a primitive need state, one would develop a warped picture of true human potentialities.

## Rogers' Fully Functioning Person

Carl Rogers has approached the construct of an effective human personality out of his own theoretical orientation and clinical experience. He conceptualized particularly the "fully functioning person" as the fully successful client in Client-Centered Therapy. Rogers has isolated and described three major characteristics of this hypothetical personality:

1. Be open to his or her experience. She or he would not be defensive or resistant to aspects of the environment that might produce change. All aspects of his or her environment would be available in the form of accurate, realistic perceptions. There would be no built-in barriers that shut out the possibility of fully experiencing their environment.
2. Live in an existential way. She or he would experience life in terms of an ongoing, "becoming" process. She or he would live in a fluid stream of experience, rather than in a rigid or stereotyped way. There would be an absence of tight organization or imposed structure.
3. Trust himself or herself. She or he would be willing to do what "feels right," and find his or her feelings to be a trustworthy guide to behavior. She or he would have a feeling of direction and consistency that flows out of himself or herself, rather than feeding in from the environment.

## Allport's Mature Personality

Gordon Allport (as cited in Hall & Lindzey, 1970), in attempting to describe the nature of psychological maturity, listed six major characteristics of the mature person. Allport's theory revolved around motivational variables, genetic factors, and ego concepts. Allport's list is:

1. Extension of Self: The mature person was able to extend his or her concept of self through feelings of caring and belonging to other individuals, institutions, and mankind itself. Through this process of self-extension, the welfare of others becomes as important as the welfare of self.

2. Warm Relating of Self to Others: The mature person was capable of intimacy and love. His or her interpersonal relationships were characterized by empathy and compassion rather than possessiveness and hostility.

3. Emotional Security: For the mature personality, emotional security arose out of acceptance of self. This security allows him or her to tolerate frustrations and to avoid overreaction to disturbing, but relatively inconsequential, situations. This security was reflected in self-control and the ability to defer gratification or adjust the inevitable.

4. Realistic Perceptions, Skills, and Assignments: The mature person was able to function efficiently in the areas of perception and cognition. He or she was capable of accurate and realistic intellectual behavior. He or she had problem-solving skills and techniques.
5. Self-objectification, insight, and humor: The mature person had realistic self-insight. He or she understood himself or herself, and had a sense of humor, and can put him or herself in perspective without distortion.
6. Unifying Philosophy of Life: "The mature personality had worked out some type of unifying approach to life that yielded consistency and meaning to their own behavior" (p. 277).

Allport described the mature personality as reaching out, relating warmly to another, and possessing an emotional security and acceptance of self. This person is active, effective, and value-oriented. He or she needs to possess humor and insight.

## OBJECTIVE 5C: Interviewing and Counseling Skills

Skills training is a method to address the needs of populations often not being met by traditional therapies. In general, skills training is superior to traditional approaches in learning generalization, learning maintenance, and cost efficiency (Goldstein, 1981). Many skills training approaches emphasize the assessment of strengths as well as weaknesses, thereby avoiding the pitfalls of the medical model of therapy, which tends to stigmatize clients by viewing behavior as an illness. Instead, behavior is viewed as a skill deficit that can be corrected through learning.

Psychological skills training models can be used to 1) train clients directly in more effective living (psychosocial coping skills) and/or 2) teach counselors effective ways to communicate with clients (interpersonal helping skills). The skills training approach is an integrative, psychoeducational model. That is, the trainer is the teacher of these skills through modeling, behavioral rehearsal, feedback, etc. (Larson, 1984). The goal is the demystification of the therapeutic process, the empowerment of the client, and the systematic transmission of identified skills to large numbers of helpers and helpees. The emphasis is on prevention, although the model is also effective in remediation. Some of the coping skills models reported by Larson (1984) are: Life Skills Education by Winthrop Adkins (1984) ; Structured Learning Therapy by Arthur Goldstein; Relationship Enhancement Therapy by Bernard Guerney; Listening and Focusing by Eugene Gendlin; Skilled Helping: Problem Management by; and Parent Effectiveness Training by Thomas Gordon. Following are descriptions of three models of the training programs in psychosocial coping skills and interpersonal helping skills (Larson, 1984).

# Coping Skills Models

## Microskills Counseling: Allen Ivey and Maryanne Galvin

Ivey and Galvin (1984) developed microskills based upon social learning theory. This model teaches specific interviewing skills called "microskills" so that beginning counselors can, within 45 hours of training, generate multiple appropriate responses to various stimuli. Ivey outlines the basic listening skills to include open and closed questions, encouragers, paraphrasing, reflection of feelings, and summarization (a-f). To these he adds nonverbal attending patterns of appropriate eye contact, body language, tone of voice, speech rate, physical space, and time. He believes these skills are attending skills and are most helpful in the early phase of counseling. To assist in insight and motivating clients to action, social influencing skills, confrontation, focusing, and self-disclosure skills are required.

Microskills hierarchy:

1. Attending behavior
2. Client observation skills
3. Open and closed questions
4. Encourage, paraphrase, summarize
5. Reflection of feeling
6. Reflection of meaning
7. Focusing
8. Influencing skills
9. Confrontation
10. Skill sequencing and structuring the interview
11. Skill integration

Social influencing skills are: intended to motivate the client to change; interpretation; directives; advice; self-disclosure; feedback; logical consequences; and summaries. Confrontation is defined as appropriate when the client reveals discrepancies between and or among thinking, feeling, and acting. Focusing refers to selective attending and is a technique in which the counselor makes the choice and directs attention and discussion to relevant client areas (problems). Ivey (1994) suggests the counselor is to first focus on the client and then to focus on the problem. When counseling from a multicultural theory, Ivey indicates focusing should achieve a balance between the individual, family, and multicultural issues. The final skill area is self-disclosure, a focus upon oneself (counselor). This personal sharing can deepen the relationship and provide the opportunity for insight.

Applications: professionals and paraprofessionals, patients, inpatients, parents, couples, children, public offenders.

## Interpersonal Process Recall (IPR)

Norman Kagan (1984), using a film-based model of video-or audio-taped interviews, has the counselor review all thoughts, feelings, goals, and sensations describing what he/she was experiencing at the time. Learning by discovery is a central aim of the model.

Phases of IPR:

1. Facilitating communication—learning skills of effective counselors
    a. Respond to clients with exploratory questions and behave so as to encourage the client to explore further.
    b. Listen intently and compassionately to the client.
    c. Focus on client's affect, dealing with client themes that are subtly communicated.
    d. Be frank, honest, and gentle.
2. Affect Simulation—overcome fears of interpersonal involvement
3. Counselor recall—video, stop tape where you recall feelings and thoughts, then elaborate
4. Inquirer training—student learns inquirer role of respectful probing
5. Client recall—client views tape and responds to inquirer regarding interview
6. Mutual recall—both counselor and client participate with inquirer
7. Transfer of learning

Applications: mental health workers, teachers, physicians, nurses, prison guards, military personnel

## Human Resources Development Model (HRDM)

Robert Carkhuff (1987) developed a listening and responding communication model based upon the work of Carl Rogers and B. F. Skinner. The central components of his skills model are the core conditions of helping. The following is an overview designed to elicit a working knowledge of the components of the model. Carl Rogers and Robert Carkhuff both rejected the notion of making mankind average, instead preferring that people grow. In addition, Rogers felt that Freudians distanced themselves from people and in turn Carkhuff felt that Rogers in his theory was still too distant from the client. Carkhuff felt that Rogers did not go past insight. The model is based upon the principles of client-centered humanistic therapy and operant conditioning. More specifically, stages 1 and 2 to include parts of 3 were client-centered while parts 3 and 4 were operant in theory.

The goals of client-centered counseling reflect the model as well. That is, an openness to experience; trusting in the organism; developing an internal locus of control; and a willingness of the client to be in the process.

The six necessary and sufficient conditions of therapeutic change are important for the HRDM. These are:

1. two people in psychological contact
2. one is incongruent
3. helper is in state of congruence
4. helper provides empathy
5. helper unconditionally yielding positive regard
6. all conditions above the minimal level and perceived by the client

The role of the communicator is to lead but not lead, that is, to go with the person on an emotional level, a critical zone. Learning how to focus upon the other person in the relationship is very important (Gendlin, 1984).

The core conditions were the main components of the communication, and Carkhuff believed they were most effective when applied at certain stages of the model. The core conditions, in order, were: respect, concreteness, empathy, genuineness, immediacy, self-disclosure, and confrontation. Respect, concreteness, empathy, and genuineness were most effective during stages one and two while immediacy, self-disclosure, and confrontation were most effective in stages three and four.

Skinner's reinforcement schedules were critical to the action stage of the model. In addition, reinforcement is dispensed:

1. as therapist attention during early stages
2. during exploration when the therapist gives accurate responses
3. during program development through a step/check format reinforcing successive approximations to the goal

The four stages of the model are:

1. Attending (helper attends) and helpee involves (involvement)
2. Responding (helper responds with content/ feeling /meaning) and helpee uses (exploration)
3. Personalizing (helper personalizes) and helpee understands (understanding)
4. Initiation (helper initiates) and helpee (acts)

# Core Conditions

The following seven core conditions are important variables of person-centered therapy and the Human Resources Development Model.

RESPECT: Respect is the counselor's attitudes and high regard for the worth of a person (unconditional positive regard). Respect is a state of prizing the individual regardless of the conditions and behaviors the client brings to the session and as well as his/her world view (Hackney & Cormier, 1996).

GENUINENESS: Genuineness is a reference of being real. This is a state of mind in which the counselor is open and honest in the relationship. Rogers saw genuineness in communication as a match

between what one says on the outside and how one feels and thinks on the inside. Egan (1994) describes the "genuine person being congruent, spontaneous, nondefensive, open to the experience, consistent, and comfortable with those behaviors which help people" (p. 55-56).

EMPATHY: Empathy is a state of being able to enter into and understand what the client is experiencing (thinking and feeling) and to convey this in such a way the client is able to sense this understanding. Listening -understanding-communicating and awareness-know-how-assertiveness is the process.

CONCRETENESS: Concreteness is the act of specificity. When an individual speaks in generalities or with vagueness, concreteness is required.

Example: Client: "I am a lousy parent."

This statement has as many meanings as said by different individuals. A request for specificity is to ask the client what he/she means by a lousy parent.

IMMEDIACY: The counselor brings covert, hidden material into the open as it occurs in the communication. The function of immediacy is to see what is happening between the counselor and client. The two types of immediacy are relationship and the here and now. "It seems that something I said has turned you off." "You seem to have become rather quiet in the last five minutes." The first statement is relationship and the latter is "here and now."

SELF-DISCLOSURE: An intentional decision to reveal self-information to the client. "When I was first married I had doubts as to whether or not I wanted to be married." According to Egan (1994) the function of self-disclosure is for modeling and developing a newer perspective. Caution should be exercised in using self-disclosure. It should be used minimally during early phases of counseling and the counselor's self-disclosure should not proceed into a role reversal.

CONFRONTATION: A technique that is used to increase client insight and to motivate him/her for change. Confrontation is used when there are discrepancies between actions-thoughts, feelings-thoughts, and feelings-actions. Confrontation should be used only when the relationship is strong enough to sustain this type of communication.

**Question 5-16:**
Which one of the counselor responses is an example of empathy?

Client: I am so tired of his nagging and telling me I am a selfish person. It makes me so upset when he compares me to women he says are more mature.

Counselor: You _____

a. don't know what to make of this statement. You are not those other women.
b. think he is so angry and comparing you to other women is unfair.
c. are distraught with how he views you in the negative.
d. cannot figure out how he can be so down on you.

Answer: c. are distraught with how he views you in the negative. An empathic response includes an accurate reflection of the feeling (distraught) and content (negative view). Rogers believed the core conditions are ATTITUDES, while Carkhuff believed they are SKILLS. Carkhuff believed Rogers' system was unidirectional, that is, the counselor was limited from being himself/herself and was not able to impact the client. In addition, he allowed clients to talk about their feelings rather than express them to the counselor.

The counselor provides encouragement, support, warmth, challenge, and confrontation in ways that empower the client to make changes consistent with the client's values and goals. Some theoretical orientations see the relationship between client and counselor as the essential process that produces change (Prochaska, 1979). This relationship, built on self-disclosing communications, can be conceptualized by the Johari Awareness Model. The Johari Awareness Model examines the dynamics of communication.

It divides communication regarding an individual into four quadrants involving knowledge of behavior, feelings, and motivation (Hanson, Stevic, & Warner, 1986).

Quadrant 1 is the open quadrant that contains material about the self that is known to both the client and the person with whom he/she interacts. The client openly communicates this material to the counselor.

Quadrant 2 is the blind quadrant that contains material about the self that is known by others but is not recognized by the person. This is information the counselor picks up that the client did not intend or realize he/she communicated.

Quadrant 3 is the hidden quadrant containing material about the self that the person is aware of but is not known to people with whom he/she interacts. The client is consciously aware of this information but does not share it.

Quadrant 4 is the unknown quadrant that contains material about the self that is out of the awareness of both the client and the counselor.

The process of counseling involves increasing the area of Quadrant 1, while decreasing the areas in the other three quadrants (Hansen, Stevic, & Warner, 1986).

The Johari Window is a picture of change process and another way to view the process. The ultimate purpose of counseling is to help the client achieve some kind of change that he/she will find satisfying (Eisenberg & Patterson, 1979). This change may involve changes in overt behavior, changes in thinking patterns and perceptions, and/or changes in affect such as increased self-esteem or decreased anxiety. Not all significant change is readily observable, it is often difficult to document, yet outcome effectiveness must be assessed. Counselors need to be able to assess clients in the process of growing into healthier and more fully functioning individuals (Eisenberg & Patterson, 1979).

In conclusion, the ultimate goal of the counseling process is for the client to internalize the change process. When this is achieved, he/she is ready to autonomously pursue his/her goals. Effective

communication is essential to effectively manage the process. Verbal and non-verbal communication will briefly be mentioned before addressing the sequential stages in the process.

# Communication

Communication is vital to the counseling. Regardless of the counselor's theoretical orientation, the counselor strives to effectively communicate, to understand the message, and in return be understood by the client. A few components of the verbal and nonverbal skills will be emphasized in the counseling process.

## Verbal

The counselor communicates via several skills found in most communication-skills-training programs. Some of these are:

1. Attending and understanding skills such as reflection, clarification, paraphrasing, interpretation, and summary. These skills are means to assure the client has the opportunity to know that he/she is conveying correctly what he/she wants to say and that the listener is accurately hearing it.
2. Need for more information and sharing skills, such as minimal encouragers, questioning, and the core conditions of immediacy and self-disclosure. Ivey (1994) in his micro-skills package indicates that minimal encouragers can be verbal and non-verbal. Some of these are "I see," "tell me more," "un-hum," tail end of the sentence, such as, "that means?" and any abbreviation which leaves the sender in the position that the listener does not have enough material yet to understand the gist of the message. Questioning skills are probes that tend to seek specific information. These can be in the form of direct or indirect questions. Closed questions, such as "Where did this take place?" "What year are we talking about?" yield specific answers, while open-ended questions tend to allow the person to bring about specificity. Examples of open-ended questions are "What sort of things brought you to this point?" and "How do you see yourself as a bad parent?" Open-ended questions allow the client to start where he/she wants and to share at the depth he/she is comfortable.

## Nonverbal

Nonverbal communication is that part of communication which is conveyed through expressions of the face, body posture, and physical movements. Paralanguage, kinesis, and proxemics, along with the verbal message, contribute to the understanding of a complete message.

1. Paralanguage is the study of extra-linguistic features of speech, voice tone, voice quality, and pacing (voice set). A complete study of voice tone would include the emotional significance, artificially produced tones, deception in tone, and the paralinguistic significance in a clinical setting (Weitz, 1979).

2. Proxemics is the use of space and the study of human factors. This includes territoriality, crowding, and cultural differences.
3. Kinesis is the "study of observable, isolable, and meaningful movement in interpersonal communication" (Leathers, 1976). Significant body movements tend to be the total head, face, neck, trunk, shoulder-arm-wrist-hand, and hip-joint-leg-ankle, foot. Each of the eight areas is divided into individual parts as well as integrated for understanding.

**Question 5-17:**
The study of nonverbal behavior that relates to the personal space in which an individual feels comfortable speaking to others is called:

a. paralanguage.
b. kinesis.
c. proxemics.
d. synergetic.

Answer: c. proxemics.

# Motivational Interview

According to Chanut, Brown, and Dongier (2005) the four basic principles of motivational interview (MI) are to express empathy, develop discrepancy, support self-efficacy, and roll with the resistance. This type of interview is designed to assess the ambivalence many clients come into treatment with regarding change and what it will cost them to make a change. Cost is defined as behaviors the client has to give up, encounter from others, and to manage self-discipline and accountability in order to change. Motivational interviewing is a popular form of interviewing in the addiction field (substances, diet, exercise, gambling, etc.) as well as other behavior problems. Motivational interviewing focuses on the goals of the client to increase internal motivation through exploring and resolving ambivalence about a change (Miller & Rollnick, 2002). Two important terms within motivational interviewing are ambivalence and resistance. One way to deal with resistance is rolling with resistance. Some examples of rolling with resistance is to state reasons to change and reasons not to change in the same sentence (double sided reflection) and state reasons to change so the client takes the opposite stance and hopefully makes a commitment to change.

Strategies for implementing motivational interview is through the utilization of (O) open-ended questions, (A) affirming the client's self-efficacy and support, (R) reflections, and (S) summaries (complex reflections, organize resolving ambivalence, promote change). The acronym is OARS.

Prochaska's six stages of readiness for change can be utilized to manage the ambivalence. The Motivational Interviewing Treatment Integrity (MITI) Code, an instrument in research developed by Moyers, Martin, Manuel, and Miller, codes the interview for competencies in pausing utterances, giving information and open/closed questions, reflections, affirming, emphasizing control, support, advising, confronting, directing, empathy, and spirit to name a number of the indices. Prochaska's six stages of

readiness for change are precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska, DiClemente, & Norcross, 1992).

**Question 5-18:**
Discrepancy is one of the four guiding principles for effective interviewing and treatment. The counselor attempts to develop discrepancy through?

a. increased cognitive-dissonance
b. confrontation
c. past behaviors
d. narratives

Answer: a. increased cognitive-dissonance. To increase cognitive-dissonance is to examine this discrepancy between the client's present behavior and core values.

**Question 5-19:**
Motivational interviewing rolls with resistance, that is, to not confront the client. A technique that MI interviewers use to roll with resistance and to avoid an argument is?

a. empathy.
b. support self-efficacy.
c. ignore the resistance.
d. reflective listening.

Answer: d. reflective listening. MI does not view resistance as a client characteristic rather as the health of the collaborative relationship and therapeutic rapport between the client and counselor.

**Question 5-20:**
All of the following are strategies to roll with resistance when the intervention suggested by the counselor is incompatible with the client's level of recognition except to:

a. avoid recommending change and advocate for the client to recommend change.
b. negotiate with the client to identify a first target to change among several targets.
c. recognize that motivation to change is permanent.
d. state reasons to change and not to change in the same sentence.

Answer: c. recognize that motivation to change is permanent. MI believes that motivation to change is not stable rather modifiable and in a stage of fluctuation.

In addition to motivational interviews, three additional types of communication methods to obtain important diagnostic information are unstructured, structured, and semi-structured. In most cases, either a structured or semi-structured interview is preferred. However, an unstructured interview can be very effective, because it requires a professional who is highly skilled in communication, confident, empathic, and able to create an atmosphere of trust wherein the client is most likely to share personal information and feelings.

## Example of Unstructured Interview to Elicit Behaviors

When the interviewer suspects a personality issue, say the client is behaving or expressing pathologically narcissistic and avoiding responsibility for a failed marriage, the counselor might ask open-ended questions about the client's family and other matters that are important to him, follow up with more specific questions, pay attention to the counselor's own "counter-transference feelings," and wait until there is an opportunity to gently confront.

Q. "Tell me about your relationship to your wife." (open-ended question)

A. "She's impossible to live with." (defensiveness: avoiding taking responsibility for his part of the problem)

Q. "Give me an example." (open-ended question)

A. "She refuses to fix meals, have sex, watch television programs I like and only does what she wants to do." (blame and projection)

Q. "Give me an example." (open-ended question)

A. "Yesterday I got home from work and she said she wasn't going to fix anything to eat."

Q. "Can you recall the conversation more specifically?" (focused question)

A. "I said, `I'm hungry.' And she gave me a smart-alec answer that I didn't like."

Q. "What did she say exactly?" (more focused question)

A. "`So you're hungry. What do you want me to do about it?'

Q. "How did you respond to that?" (focused question)

A. "Slapped her across the head."

Q. "Help me understand what made you feel so vulnerable that you had to retaliate and strike her?" (gentle confrontation)

A. "I didn't feel vulnerable to her. She can't hurt me."

Q. "What other feelings besides anger did you have?" (open-focused question)

A. "Besides anger, well frustrated, upset, taken advantage, disrespected to name a few."

At the other end of the continuum is the structured interview, which defines the questions to be asked (Vacc & Juhnke, 1997). It is very appropriate in certain circumstances to use a structured interview to assess specific issues, including those which would be relevant to racial and ethnic minorities (Hodges & Cools, 1990). When the interviewer uses a structured approach, it is important to be alert to the way he or she asks the questions. The wording of the questions will elicit a client's responses accordingly. When the interviewer asks specific questions, a client can often provide definitive answers. As an

illustration, Marshall (1994) recommends structured interview techniques to differentiate between social phobia and panic disorder. Clients suffering from panic disorder will predictably answer yes to questions such as: "Do you have anxiety attacks that cause rapid heart rate, shortness of breath, and tightness in your chest?" and "Do you feel anxious when you are in a crowd?" The same clients will usually answer no to one or both of these questions: "Do you feel anxious when you are alone?" "Do you feel anxious when in the company of one or two friends?" On the other hand, clients with social phobia will answer yes to this question: "Do you feel anxious when you have to speak, perform, or are the centers of attention?"

Lanyon and Goodson (1982) recommend semi-structured interviews for several reasons: they are more flexible than paper-and-pencil assessments, clarification of unclear answers or questions can take place, rapport can be established, and clients who are confused can relate more easily to the interviewer than to paper-and-pencil assessments. In all three types of interviews, the professional has to rely upon his or her observational, judgmental, and interpretational skills to elicit information surrounding the chief complaint, presenting illness, dates of onset, past history, family and personal history, and all significant etiological factors which contribute to understanding the client's symptoms. In all interviews it is of primary importance to focus on the chief complaint and present illness while determining if the client's symptoms are severe enough to cause dysfunction or incapacitation in social, interpersonal, occupational, or other areas of living. A good mental status examination also can help to make that determination. As the interview progresses, it is helpful for the interviewer to assess not only problem areas but also the client's lifestyle, self-appraisal, psychological coping styles, and religious and cultural factors. Most therapies and practices utilize a case conceptualization conducted by the counselor. Conceptualizing a case is developed from a number of data gathering interviews. Day (2004) considers conceptualization of a case as a theory of the person. Four methods or models to categorize or derive and organize information that explains past, current, and future behavior are the inverted pyramid (Schwitzer, 1996), analytical thinking, Stevens and Morris (1995), and Linchpin (Bergner, 1998). Specific case conceptualizations are available for individual therapies such as cognitive behavioral.

There are specific intake interviews and/or questions for specific therapies such as solution-focused. Examples of solution-focused questions are what brought you here, how can I help, the miracle question, relationship questions, exception questions, scaling questions, and is there anything else? Each of these may have several questions to accompany the first question for expansion. One example is the scaling question with four or five subquestions with responses ranked on a scale of 1-10 (where are you now? confidence scale, motivation scale, risk scale and resiliency scale).

# OBJECTIVE 5D: Philosophical Foundations of Counseling Theory

ACA Code of Ethics (2014) foundation is based on core values of the profession which include:

1. enhancing human development throughout the life span;

2. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts;
3. promoting social justice
4. safeguarding the integrity of the counselor-client relationship; and
5. practicing in a competent and ethical manner (ACA, 2014, p. 3).

# Definition of Theory

A theory is a model that is used to explain experiences for purposes of predicting future events or solutions. A theory, therefore, is a guide to explain events and is a framework for interpreting observations. It is a systematic framework from which inferences and hypotheses about plausible relationships between a series of events can be made (Peterson & Nisenholz, 1995; Steffler & Matheny, 1968).

## A theory:

1. synthesizes a particular body of knowledge.
2. provides a framework for making observations and understanding observations.
3. increases the understanding about a particular body of knowledge.
4. provides tools for making predictions, evaluating outcomes, and improving techniques.
5. encourages future research.

## Counseling theory:

1. is a framework for understanding and predicting human behavior.
2. is a set of concepts used to explain the concerns, actions, perceptions, emotions, and motivations of human beings.
3. is a guide of principles that counselors use as the basis for their interventions.
4. provides the reasons for what counselors do as well as helps to explain the counseling relationship.

Theories of personality are meant to answer a specific question such as why do human beings behave the way they do or when does behavior come about or even how does it come about. Cullari (2001) indicates that personality theory answers two questions, the first why we do what we do and the second when does human behavior develop. Theories explain human behavior. Psychotherapists study personality theory until they find one that fits their understanding of human nature. Counseling theory is a set of guidelines to explain how human beings learn, change, and develop. Counseling theory attempts to explain how to deal with issues and problems, a plan of action, or a model (Cullari, 2001).

# Theoretical Classification

There are several presentations available that classify theories according to different models. For the most part, they include differing amounts of cognition, affect, and behavior. Nugent (1994) classifies them as psychoanalytic-psychodynamic, humanistic, behavioral, cognitive-behavioral, and brief therapies. Peterson and Nisenholz (1995) catalog them into psychodynamic, humanistic-existential, behavioral-cognitive, and transpersonal theories (spiritual and holistic). Finally, Gladding (1996) divides his chapters and theories into psychoanalytic and Adlerian; person-centered, existential, and Gestalt; rational-emotive and transactional analysis; and behavioral, cognitive behavioral, and reality therapy. More and more, the research appears to reflect that when therapists report their theoretical identity increasing percentages indicate eclecticism on the increase. Nugent (1994) compiled a series of research surveys and noted that Garfield and Kurtz in 1975 reported that 64% of doctoral level students, and in 1985 APA found 41% of 415 clinical therapists, stated a preference orientation for eclecticism. Lazarus and Beutler (1993) report that as many as 60% to 70% of the professional counselors are eclectic in approach. The following description is provided only as a guide, as each will reflect a philosophical base, set of values and beliefs, theoretical model, and counseling practices.

## Models of therapy

1. Moral model:
    a. Reality therapy
    b. Rational-emotive therapy
    c. Existential therapy
    d. Person-Centered therapy
    e. Gestalt therapy
2. Compensatory model:
    a. Adlerian therapy
    b. Behavior therapy
    c. Transactional analysis
3. Transpersonal model:
    a. Spiritual
    b. Wholistic
4. Medical model:
    a. Psychoanalytic therapy
5. Constructivist therapies:
    a. Solution-focused
    b. Narrative therapy
6. Integrative and eclectic therapies:

    a. Technical and theoretical integration
    b. Psychodynamic behavior
    c. Multimodal therapy
7. Enlightenment model:
    a. Alcoholics
    b. Daytop Village
    c. Overeaters Anonymous
    d. Weight Watchers

## Responsibility

The major responsibility for the therapy has often been viewed as mostly the work of the therapist or client. Below is an estimation of the responsibility outcome in therapy.

1. Therapist:
    a. Behavioral
    b. Rational-emotive
    c. Psychoanalytical
2. Client:
    a. Client-centered
    b. Experiential
    c. Psychosocial

Theoretical orientation varies in counselor application. Research reflects that counselor choice of orientation is eclectic in style.

## Components of a Theory

Brown and Srebalus (2003) outline eight components of a theory that are to help the trainee and therapist in understanding human behavior.

These components are:

1. preconditions for therapy—motivation, minimal age, etc.
2. counselor characteristics—attitudes and behavior of counselor
3. relationship between counselor and client—considered by many to be the main element
4. diagnosis of client problem—tied to theory
5. counseling goals—objectives which are terminal and process
6. techniques—methods to explore, define, and treat objectives

7. process—may be stages or conditions preceding each movement
8. evaluate outcome—progress or lack of it

# The Counseling Process

The process of counseling can be as different as the theories of counseling. The process itself is a continuous, ongoing series of dynamics that describe how the counselor-client relationship contributes to the change process. Gladding (1988, 1996, 2002) and Peterson and Nisenholz (1995) describe the counseling process as developing in definable stages, beginning with the relationship-building stage where structure is established and motivation to change is harnessed (initial). Factors that influence the counseling process include the physical setting, the qualities and characteristics of the client and counselor, the skill of the counselor, and the quality of the therapeutic relationship (Gladding, 1988). Prochaska (1979) states that the counseling process actually begins when a decision to change is made. According to Corey (1986), counseling is a process of discovery. The counselor helps the client discover his/her strengths and understand the factors that are preventing him/her from using those strengths. Prochaska (1979) refers to this process as raising consciousness or increasing awareness. It involves increasing the information available to the client (through feedback, education, focusing, catharsis, etc.) so that she/he can make the most effective responses. Through increased awareness, the client becomes freer to choose how to respond. Increased awareness means becoming aware of more alternatives for action. It then is a matter of taking responsibility for choices.

Kottler and Brown (2000) view process as a series of steps and comment upon common variables in the research and counseling process. They identify nine steps as follows:

1. awareness of problem and need for solution
2. systematic study of the context and background of the problem
3. summary of what is known about the problem and what has been tried before to solve it
4. functional definition of the problem so that it may be solved
5. generalization from the study of the particular instances to a similar class of events
6. predicting the outcome and selection of actions based on their probability of success
7. testing of the hypotheses in a plan of action (treatment plan)
8. evaluation of results (formative or summative)
9. inferences drawn and generalizations made to other situations (p. 40)

## Stages of the Counseling Process

THE BEGINNING PHASE: Relationship-building through involvement and exploration.

The goals of the first stage of counseling are to build trust, develop a contract, establish limits, and learn about the therapeutic process (Moursund, 1985; Moursund & Kenny, 2002). Trust is built through establishing rapport with the client. Through acceptance, patient listening, positive regard, respect,

genuineness, empathy, support, encouragement, and caring, the counselor establishes an atmosphere where the client is comfortable enough to begin to self-disclose (Gladding, 1988; Nugent, 1994). The counselor responds to client self-disclosure in ways that reinforce and encourage further exploration.

The counselor also teaches the client how to use the counseling process. Through modeling, selective attention, and reinforcement, the counselor teaches the client how to focus and talk about concerns. The counselor also teaches new skills, such as self-monitoring, effective communication, and how to differentiate between thinking, feeling, and acting (Moursund, 1985; Moursund & Kenny, 2002).

The initial stage is a time to make the tentative diagnosis of a problem. The particular counseling orientation will determine the type of diagnosis performed by the counselor. Some theories, such as person-centered, do not make a diagnosis, while others do. This part of the process uses tests or inventories to assist in the diagnosis or in setting counseling goals. It is also a time in which counselors utilize different types of interviewing strategies such as structured, unstructured, and value-laden interviews.

The first stage of counseling involves contracting for change. Contracts establish mutually agreed upon goals that are specific, relevant to the concern, realistic, observable, and quantifiable (Gladding, 1988, 1996; Moursund & Kenny, 2002). Commitment to a contract provides direction to the working stage of counseling and establishes a means of knowing when the termination stage of counseling is appropriate.

According to social influence theory, Strong (1968) maintains the therapist's social power determines the extent to which therapy is successful. The variables that have been studied the most are expertness, trustworthiness, and attractiveness (Corrigan, Del, Lewis, & Schmidt, 1980). The most significant aspect of the therapeutic relationship is the working alliance, also called the helping alliance or the therapeutic alliance. Greenson (1967) proposed that counseling relationships consist of three interrelated components: the working alliance, the transference relationship, and the real relationship. Bordin (1979) defined the working alliance as consisting of three parts: an emotional bond between the client and therapist, an agreement on the goals of counseling, and an agreement about the tasks of the work. In summary, Gelso and Carter (1985) conceptualized the working alliance as "an emotional alignment that is both fostered and fed by the emotional bond, agreement on goals, and agreement on tasks" (p. 163). Kokotovic and Tracey (1990) noted that most clinicians agree that the "quality of the working alliance is especially important in the early phase of counseling. If the working alliance is not sound in the early phase, poor outcome is assumed to occur" (p. 17).

Poor outcome in therapy can be due to premature termination.

Premature termination is one of the most disturbing and persistent problems that trouble outpatient clinics and psychotherapists. Baekeland and Lundwall (1975) reported that 20% to 57% of clients fail to return after the first visit to an outpatient clinic, Pekarik (cited in Mennicke, Lent, & Burgoyne, 1988) estimated that 30% to 60% of all outpatient therapy clients drop out of treatment prematurely, and Epperson, Bushway, and Warman (1983) reported that 19% and 25% prematurely drop out of counseling in college counseling centers. Kokotovic and Tracey (1987) defined premature terminators as clients who failed to return for scheduled appointments after intake. McNeill, May, and Lee (1987)

defined premature termination as dropping out at any time during therapy without the therapist's agreement. Although definitions and dropout rates of premature termination differ the reasons for dropping out appear to center on the therapist (expertness, trustworthiness, attractiveness), relationship, low expectations of client improvement, high levels of ethnocentricity, dislike or disinterest in clients, and inexperience (Baekeland & Lundwall, 1975; McNeil, et al., 1987).

THE MIDDLE STAGE: Working through understanding and action.

In the middle stage, the focus shifts from external problem-solving to internal growing, changing, and deeper exploration. A shift in emphasis may see the presenting problem change in character or the client reach a solution. Counseling shifts from cognitive to emotional issues. Often the therapeutic relationship itself becomes the focus of the sessions (Moursund, 1985). As this shift occurs, the client begins to take more risks in looking at himself or herself, and reduces defenses and dependency on others (Nugent, 1994). Nugent (1994) and Gladding (1988, 1996) point out that transference and countertransference issues often arise during this phase of counseling. Working through transference issues with the client involves emotionally re-experiencing past patterns and practicing new responses in the therapeutic relationship (Moursund, 1985, 1990).

Countertransference issues, on the other hand, should be dealt with in supervision or consultation (Gladding, 1988, 1996).

Therapeutic impasse is a common occurrence during middle-stage work. The feelings of being stuck may, in fact, signal the entering of this stage. Resistance in the form of an impasse indicates that the client is dealing with very intense, often painful issues and is understandably seeking to protect himself or herself (Moursund, 1985).

Gladding (1996) describes the skills counselors tend to employ during the working phase. They include reframing, leading, interpretation, multifocused responding, accurate empathy, self-disclosure, immediacy, confrontation, and rehearsal. The type of skill is dependent upon the theoretical orientation of the counselor.

Most importantly, states Moursund (1985), the counselor should be sure to follow the client and avoid getting in the way of the client's work. This means not forcing, but rather respecting the ebb and flow of therapy and trusting the client to do the work he/she needs to do.

THE FINAL PHASE: Termination

Gladding (1996) describes certain client behaviors that often signify the approach of the termination phase of counseling. These include a decrease in work intensity, more humor and intellectualizing, and/or less denial, withdrawal, anger, mourning, or dependence. Termination is appropriate when the stated goals have been achieved or when it is clear that no more progress can be achieved at the present time (Moursund, 1985, 1990). Counselors should be careful not to delay terminating; neither should they prematurely terminate a client. Both situations indicate that the counselor is letting his/her needs interfere with the counseling. When it has been determined that termination is appropriate, three to four sessions should be used to address termination issues (assuming the counseling relationship has lasted three months or more). Some clients may want to terminate for financial

reasons, pressures from others, flight into health, sensing they are not making progress, therapy is reaching a painful point and they want to stop (resistance). Sometimes the counselor wants out. When counselors contract for sessions it is suggested that termination should be introduced at the beginning of the last one-sixth of the sessions.

Termination often becomes a microcosm of the entire counseling experience (Moursund, 1985). The stress of termination may reactivate old patterns. Often, major themes, conflicts, and fantasies are reworked in the context of ending the counseling relationship. It is also a time of evaluating and saying good-bye. Terminating provides an opportunity to work through the client's whole approach to dealing with losses.

Gladding (1988, 1996) lists several tasks that are appropriate for the termination phase. For instance, the counselor should be aware of the client's needs and wants as well as his/her own needs and wants. Also, the client should be invited to share his/her feelings about termination. The counselor should self-disclose his/her feelings appropriately. It is also good to review major events of the counseling experience and supportively acknowledge the changes the client has made. Finally, arrange for some type of follow-up and end on a positive note.

In conclusion, termination is a vital phase of counseling that can be determined by the success of all previous phases. The client must, therefore, be approached with knowledge and skill (Gladding, 1996). Thus, the ultimate goal of the counseling process is for the client to internalize the change process. When this is achieved, he/she is ready to autonomously pursue his/her goals and the counseling relationship is terminated.

**Question 5-21:**
The therapist expects which one of the following to take place in the initial phase of counseling?

a. development of the working alliance
b. working through transference
c. flight into health
d. working through of the problem

Answer: a. development of the working alliance. Working alliance of trust, expertness, and bonding.

## The Six Stages of the Counseling Process

The counselor should be aware that the interview is the foundation for completing an assessment and diagnosis. The elements of the six stages of the counseling process: assessment, symptom identification, diagnosis, referral, treatment planning, and follow-up (Hohenshil, 1996, p. 66):

1. Assessment is the gathering of pertinent information via interviews, psychological testing, structured interview instruments, problem checklists, mental status examinations, medical evaluations, and observations, from which an interpretation or diagnosis is obtained.

2. The purpose of treatment is to bring about symptom modification or change over a period of time necessary to accomplish this purpose. During the initial interview signs and symptoms are to be gathered.
3. Diagnosis is the process of comparing the client's symptoms with the criteria in the DSM-5™.
4. Referral to a qualified professional may be necessary to obtain additional specialized diagnostic or treatment services.
5. Treatment planning includes a determination of the short- and long-term objectives, the most effective treatment(s), and the client's motivation for therapy.
6. Follow-up is necessary to ensure the client's continued well-being. If there is a relapse, the counselor can recommend one or more counseling sessions or additional treatment, if necessary.

## The Counseling Process: Theory

If the vital role of communication is assumed, the counseling process can be viewed as an orderly progression of events. Each theoretical orientation highlights a progression that illustrates movement.

Examples are:

1. Adlerian-Individual Psychology
    a. Establishing the relationship
    b. Psychological investigation
    c. Disclosure
    d. Reorientation
2. Rational-Emotive Therapy (ABC)—Albert Ellis (Ellis, 1999)
    a. Bringing illogical thinking to consciousness
    b. Showing client how illogical thinking causes and maintains client’s disturbances and unhappiness
    c. Demonstrating exactly what the illogical links in client’s internalized sentences are and how they must be changed for there to be behavioral change in actual practice
    d. Teaching client how to re-think and re-verbalize these sentences in a more logical, self-helping way
3. Person-centered—Carl Rogers
    a. Positive regard of patient for the therapist and vice-versa
    b. Understanding and empathy by therapist for patient
    c. Perception by patient of empathic understanding
    d. Therapist provides more correct information regarding realities of patient’s environment

e. Emotional catharsis
f. Task assignments between therapy sessions
g. Gradual independence of patient

4. Interpersonal—Harry Stack Sullivan
    a. Informal inception (quiet observation)
    b. Reconnaissance (intensive interrogation)
    c. Detailed inquiry (hypothesis testing and client-counselor interchange)
    d. Termination

# OBJECTIVE 5D: Counseling Theories

## Psychoanalytic Theory

Psychoanalysis was founded by Sigmund Freud (1856-1939). He studied under Jean-Martin Charcot and Josef Breuer (originator of the "talking cure" cathartic method).

### Basic Assumptions

Deterministic Viewpoint

1. The key to understanding human behavior is understanding the unconscious. People are driven by instincts.
2. This is based on a psychology of conflict (Seligman, 2001). (Id Psychology)
3. Deterministic view of human nature is based on biological (instinctual), libidinal, or psychosexual drives. Individual behavior is determined by both interpersonal and intrapsychic factors (Psychic Determinism).

### Process of Psychoanalysis

The goal is to restructure the personality through the process of strengthening the ego and checking the id. The major cause of neurotic behavior is inhibited sexual development.

### Structure of Personality

ID: Stimulates the organism's basic needs and drives to discharge energy produced. Tensions released. Source of fixed reservoir of sexual energy. Two most basic human instincts: sex and aggression. Present at birth and is amoral, impulsive, and irrational. Operates by drives, instincts, and images (dreaming, hallucinating, and fantasizing). Id contains eros and thanatos (life/death instincts) (Kottler & Brown, 2000).

Function: To maintain the organism in a comfortable or low-tension state

Governed by: Pleasure Principle

EGO: Executive of personality. Strikes a balance between needs of ID and SUPEREGO. Not present at birth, second to develop. Kottler and Brown (2000) liken the ego to an integrator, pacifier, negotiator, and compromiser to socially meet the needs of the person.

Function: to develop muscular and sensory body and to sort out and understand the world.

Governed by: Reality Principle

SUPEREGO: Adopts parental values as well as the customs, values, and traditions of society and represents the conscience (model standard) and ego ideal.

## Role of Anxiety

Anxiety develops as a result of conflict between id, ego, and superego. When the ego cannot control anxiety by rational and direct methods, it relies on ego defense mechanisms to help it cope (Corey, 1986). Ego defense mechanisms are unconscious means of reducing anxiety by denying or distorting reality. They are adaptive if not used to extreme.

Development of Personality: (Psychosexual Stages)

1. Oral Stage (1st year):Oral erotic and oral sadistic. Sucking reflex. Adjustment to weaning. Gratification- feeding.
2. Anal Stage (1-3):Anal expulsive and anal retentive.
3. Phallic Stage (3-6):Self-manipulation of genitals a pleasure source. Oedipal and Electra complex.
4. Latency Stage (7-13):Sexual motivations recede (dormant) and emphasis is on socialization, skill development, activities.
5. Genital Stage (12+):Heterosexual relations are source of pleasure.

Techniques: Catharsis, Free Association, Interpretation of Dreams, Parapraxia (Freudian slips), Analysis of Transference, Analysis of Resistance

**Question 5-22:**
In psychoanalysis, Freud utilized which technique to explore the unconscious minds of his patients?

a. free association
b. interpretation
c. catharsis
d. Freudian slips

Answer: a. free association

## A Typical List of Ego-Defense Mechanisms

Freud was of the impression that the ego was in need of different defense mechanisms to assist in keeping the id and super ego happy. The need for defense mechanisms is a reaction to anxiety and stress. A defense mechanism is an unconscious response to a conscious stressor or anxiety. Defense mechanisms are tools to help the ego defend itself against threats. The ego senses a conflict between the id and superego and will employ one of the defense mechanisms to attempt to satisfy the need. Vaillant (1977) developed four levels of 18 defense mechanisms. The four levels are arranged to emphasize the primitive unhealthy defense mechanisms to healthy ones.

Level I: denial, distortion, delusional projection

Level II: fantasy, projection

Level III: intellectual (isolation, undoing, rationalization) repression, reaction formation, dissociation

Level IV: sublimation, altruism, humor

Whereas Freud mentioned only four defense mechanisms as many as forty-four have been identified. According to Coleman (1959), Vaillant (1977) and Kottler and Brown (2000) some defense mechanisms (sometimes called coping strategies) are defined as:

Denial (arguing against): A preconscious protecting of self from an unpleasant reality by refusal to perceive it.

Fantasy (daydreams-escape, anticipation of the future): Gratifying frustrated desires in imaginary achievements.

Compensation (overemphasize one behavior for another such as poor ballplayer but excellent pianist): Covering up weaknesses by emphasizing desirable trait or making up for frustration in one area by overgratification in another.

Identification (allying with someone else and become like them): Increasing feelings (exaggerated) of worth (attitudes, values, standards, characteristics) by identifying with person or institution of illustrious standing. Usually exercised with others of power and status.

Introjection (outside identification): Incorporating external values and other standards to avoid anxiety and conflict; the adoption of other people's attitudes or behaviors as if they were one's own (Novie, 2003).

Projection (placing unacceptable impulses): Projection is a denial that some aspect of behavior is a part of oneself. Finding a reasonable explanation for an unreasonable one or unacceptable behavior in order to make it sound appropriate. An individual will project this toward another person.

Rationalization (supplying logical or a rational reason as opposed to real): Attempting to prove that one's behavior is "rational" and justifiable and thus worthy of self and social approval. This is an

attempt to provide reasonable explanations for questionable behaviors to appear logical, rational, or valid. Often used when there are conflicting messages. Frequently used to react to guilt.

Repression (pulling into the unconscious): Preventing painful or dangerous thoughts from entering consciousness. Feelings, thoughts, and memories are pushed down and stored in the unconscious as recall may be painful (Novice, 2003). Affective repressed, a censorship.

Reaction formation (taking opposite belief): Reaction formation is often referred to as overcompensation. Reaction formation is the preventing of dangerous desires from being expressed (repress them) by exaggerating (express openly) opposed attitudes and types of behavior and using them as "barriers" (anxiety and guilt). There may even be a substitution or going in the opposite extreme, a replacement for the threat.

Displacement (taking out or redirecting impulses on a lesser or safer person): Discharging or transferring pent-up feelings, usually of hostility, on objects less dangerous (safe place) than those that initially aroused the emotions. This is a moving away from one object and toward another that is less threatening.

Emotional Insulation: Withdrawing into passivity to protect self from hurt.

Isolation (can be a form of intellectualization): Isolation is hiding one's emotional response. Cutting off affective charge, a detachment, from hurtful situations or separating incompatible attitudes by incompatible attitudes by logic-tight compartments. Information retained.

Regression (returning to previous stage): Retreating to an earlier developmental level (stage of development) involving less mature responses and usually a lower-level aspiration.

Sublimation (acting out unacceptable impulses in a socially acceptable way): Gratifying frustrated sexual (example) desires in substitute non-sexual activities and socially acceptable or creative activities. Kottler and Brown (2002) suggest that an athlete may unconsciously choose his/her profession to release anger. This is a positive form of displacement.

Undoing (a behavior that negates a previous one): Undoing is atoning for and thus counteracting immoral desires and acts. A person may say something negative about another individual and then proceed to do something good for the person. This is an attempt to undo what harm they may have caused the person (a job, girlfriend, etc.)

Suppression (intentional exclusion): Suppression is an intentional exclusion of the threat from consciousness. A person preparing to take the NCE the weekend following spring break does not want to think of the examination over spring break.

## Ego Defense Mechanism - Matching Exercise

This is a matching exercise to practice acquired knowledge of the defense mechanisms. Match the defense mechanisms with the correct definition. Answers are to be found immediately after the exercise.

a. Unconsciously exhibiting overly nice behavior to conceal hostile feelings
b. Pushing unacceptable reality or painful material into unconscious
c. Reverting to a less-mature state
d. Attributing to others qualities or traits that are unacceptable to his/her own ego
e. Deal with anxiety by closing his/her eyes
f. Directing energy toward another
g. Manufacturing "good" reasons to explain a bruised ego
h. Assuming abusing parents' way of handling
i. Masking perceived weakness or developing positive traits to make up for limitations
j. Redirecting sexual energy into creative behaviors

**Question 5-23:** Displacement Letter: _____

**Question 5-24:** Sublimation Letter: _____

**Question 5-25:** Introjection Letter: _____

**Question 5-26:** Reaction Formation Letter: _____

**Question 5-27:** Projection Letter: _____

**Question 5-28:** Repression Letter: _____

**Question 5-29:** Compensation Letter: _____

**Question 5-30:** Denial Letter: _____

**Question 5-31:** Regression Letter: _____

**Question 5-32:** Rationalization Letter: _____

Answers:
**5-23. f.** Displacement-taking out impulses on a less threatening target.
**5-24. j.** Acting out unacceptable impulses in a socially acceptable way such as a career. Sublimating aggressive impulses.
**5-25. h.** Introjection is to absorb the super ego from the parents. The child incorporates the attitudes of the parent(s) and assumes those are his/her own. Introjection is to incorporate external values and standards into the ego. The person will assume responsibility for events outside of their control and blame oneself such as a failed marriage or loss of a ballgame. The person fails to understand their thoughts and behaviors are coming from the outside as it is coming from the inside. It is the opposite of projection.
**5-26. a.** Reaction formation is taking the opposite belief because the true belief causes anxiety.
**5-27. d.** Projection is placing unacceptable behavior in oneself onto another.
**5-28. b.** Repression is to pull the threat into the unconscious such as to forget something traumatic

which took place in childhood.
**5-29. i.** Compensation or substitution to attempt to make up for some feeling of inadequacy by excelling.
**5-30. e.** Denial is to argue against the anxiety by denying that the anxiety exists.
**5-31. c.** Regression is returning to a previous stage of development.
**5-32. g.** Rationalization is to give excuses for a shortcoming and to avoid a disappointment or criticism.

## Summary

## Psychoanalytical Basic Assumptions

1. Medical model (biological bases)
2. Deterministic view of human nature
3. Personality is determined by
    a. unconscious motivation
    b. irrational forces
    c. sexual and aggressive impulses
    d. early childhood experiences
4. Treatment is a lengthy process of analyzing inner conflicts that are rooted in the past.
5. Therapy is the process of the therapist's direction in restructuring the personality.
6. Development of ego and differentiation and individuation of the self.

## Goals

1. Make unconscious conscious.
2. Assist client to relive earlier experiences and work through repressed conflicts.
3. End goal of restructuring personality.
4. Analysis of resistance and transference.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Successful resolution of both psychosocial and psychosexual issues at appropriate developmental stages.

Negative: Failure to meet critical developmental task or a fixation at some early level of development.

## Object Relations Theory: A Psychodynamic Theory

Key Figures: Margaret Mahler, Otto Kernberg, Heinz Kohut

Object relations, a theory of psychoanalytic thinking, focuses on very early developmental stages of the self in relationship to others (objects). The quality of experience with objects (others) during the early years determines the ability of the individual to love and identify with others (Prochaska, 1979). In this theory, the child internalizes aspects of the loved-hated parents in order to control the objects in the child's inner world. These internalized objects have both good and bad characteristics and become psychological representations of external objects. These internalized objects undergo splits and become part of the individual's personality structure. Poor object relations in infancy can result in severe pathology (i.e., narcissistic character disorder, borderline personality disorder, psychoses, etc.). Object refers to people. Kohut believes an object can be a person or thing (Prochaska, 1979). The individual fails to form a satisfying connection with his/her family of origin.

Philosophy: This theory suggests that early psychosocial relationships influence the development of the child. Children who do not form this connection develop splits with the family. Some family therapists, such as Framo, use this theory in treating families. The child tends to introject what he/she sees as good in others and will reject and project what is bad.

### Mahler's Developmental Stages (St. Clair, 1986)

Normal Autism: Infant perceives parts, not unified self or object. (3-4 weeks)

Normal Symbiosis: Pronounced dependency. (3-8 months)

Separation-Individuation: Child disengages from psychological fusion with mother and gains a sense of being autonomous. Ego emerges.

Four subphases

1. Differentiation and Body Image. (4-5 months)
2. Practicing begins when infant starts walking. (10- 18 months)
3. Rapprochement. (18 months-2 years)
4. Emotional Object Constancy and Individuality. (2- 3 years)

## Ego Psychology

Key figures: Erikson (see Chap. 7 for his stage theory), Fromm, Horney, Rapoport

Ego psychology is an extension of psychoanalytic thought, however the primary emphasis is on ego function or ego strength. Intrapsychic conflicts are not denied, but the striving of the ego throughout the life span for mastery and competence is emphasized. Ego theory went beyond Freudian psychology by incorporating cultural and social influences.

In Ego Psychology, the ego is not viewed as dependent on Id impulses. The ego has its own source of energy and its own processes (Prochaska, 1979). Besides defense mechanisms, ego processes include memory, perception, and motor coordination, all of which are inborn. The ego's striving for mastery provides the primary source of motivation as the personality develops (Prochaska, 1979).

Psychopathology can result from inadequately developed ego processes such as judgment and moral reasoning, not just from inadequate resolution of early sexual and aggressive conflicts. Therefore, later stages of development are seen as just as critical to development as early stages. Abnormal behavior results from a breakdown in ego functions that result in an inability to cope.

Ego theory does not attempt to resolve defense mechanisms, but rather it concerns itself with maladaptive energies.

### Techniques:

Control of process: maintain focus on tasks

Control of ambiguity: maintain highly ambiguous state

Transference: not as emphasized as psychoanalytic

Diagnosis and interpretation

Building new ego functions

## Adlerian (Individual Psychology)

Key figures: Alfred Adler, a colleague of Freud's, who broke away from psychoanalytic theory and established Individual Psychology in the early 1900s.

Rudolf Dreikurs was responsible for developing the theory and applying it to education, group work, and child guidance in the United States. Dreikurs established the five basic norms of Adlerian theory. These norms are socially embedded, self-determined and creative, goal directed, subjective, and holistic (Dreikurs, 1950).

Don Dinkmeyer, Sr., another well-known Adlerian.

Adlerian counseling emphasizes the social context for human behavior, the interpersonal nature of the client problem, the cognitive organization of a client's style of thinking, and the importance of choice and responsibility in making decisions (Kottler & Brown, 2000; Milliren, Evans, & Newbauer, 2003).

## Basic Assumptions

Social forces have a greater impact on human behavior than biological forces. Individuals actively create their own unique lifestyle, rather than being passively shaped by the environment. It is an interactive process.

Consciousness is the center of the personality and social interests.

A basic feeling of inferiority is the ultimate driving force in humans and the source of anxiety. Inferiority feelings are not feelings but a belief system or reasoning about how one should be. It motivates people to strive for mastery, superiority, and perfection. People strive to become successful; a striving for perfection. In summary, the basic assumptions are (Corsini & Wedding, 2005):

1. all behavior occurs in social context
2. rejects reductionism in favor of holism
3. is interpersonal psychology
4. consciousness and unconsciousness are used to further goals
5. cognitive reorganization and life style is important to understand the individual
6. change occurs in the context of immediate change and long range goals
7. people are not pushed by causes rather by hereditary and genetics
8. striving is for perfection, completion, superiority, competence, and mastery
9. individual is confronted with alternatives
10. the freedom to choose involves value and meaning
11. life has no intrinsic meaning

## Human Nature

Positive view of human nature. Growth model. Grounded in principles of social psychology. People can only be understood in their social context.

All people develop some sense of inferiority. Body or organ defects, older and more powerful siblings, or parental neglect or rejection exaggerate this sense of inferiority. The individual copes with inferiority by compensating (inferiority complex, superiority complex). The life tasks of the individual are 1) social, 2) occupational, and 3) sexual. Dreikurs and Mosak added a fourth and fifth, spiritual and relationship to self. Conflict is the struggle between our wishes and dreams for superiority, our attempts to achieve it, and the social realities that make us feel inferior. Psychopathology results from discouragement.

## Central Constructs

Life style is an individual's subjective convictions, world view, and self-view (Seligman, 2001). Life style is an individual's unique way of thinking, feeling, and acting that remains relatively constant and contains belief, perceptions, and methods for dealing with life's tasks. A person develops a lifestyle in the first five years of life.

Basic mistakes are misperceptions, faulty values, and false goals that are part of the lifestyle and must be challenged in therapy for growth to occur. Five basic mistakes are (Mosak, 1989, p. 87):

1. overgeneralization
2. false or impossible goals of security
3. misperceptions of life and life's demands
4. minimization or denial of one's worth
5. faulty values

Family constellation is the social and psychological structure of the family system that includes the birth order, sibling characteristics, perception of self, and parental relationships (Dreikurs, 1967).

1. First-born are conformers, achievers, pleasers; they follow orders (behave), take responsibility in the absence of parents, experience loss when second is born and tend to be the pioneer.
2. Middle-born are negotiators, choose areas where they can be successful, do not develop close personal relationships, and learn about the politics of living. They frequently try harder (Milliren, et al., 2003).
3. Youngest-born are attention-receivers, charmers, and tend to have role models.
4. An only-born is a child five to seven or more years separated from a second sibling (Milliren, et al., 2003). He/she is a charmer, on the throne, matures early, a high achiever, and has a good or strong imagination.

Masculine protest is a striving for power.

Early recollections: These are memories the individual holds of early experiences. The therapist is interested in the client's perception of the event. These early memories are considered lessons of life the client clings to as a guide or influence for their current functioning (Milliren, et al., 2003).

## Theory of Personality

1. Holistic—the individual is approached as an integrated unified personality.
2. Teleological—behavior is purposive, goal-directed. Fictional finalism is the imagined central goal that guides the person's behavior.
3. Self-determining—individual is responsible for own feelings, thoughts, and actions.

## Four Phases of Therapy

1. Establish a therapeutic relationship through attending, empathy, goal-setting, etc.
2. Analysis and assessment of lifestyle, family constellation, early recollections, dreams, goals.
3. Interpretation that leads to insight and self- understanding.
4. Achieving reorientation, or translating understanding into action.

Intervention Strategies: the life style analysis (goals and motivation of the client), apperception (experiencing things mediated by attribution of meaning), family constellation, family atmosphere, family values, gender guiding lines, family role played by each child, early developmental experiences, and encouragement.

## Goals

Dreikurs (1968) believed that children who are discouraged attempt to achieve social interests by one of four goal-directed behaviors:

1. prove their power
2. get attention
3. display deficiencies
4. get revenge

### Goals for therapy are to:

1. establish a positive sense of self-esteem and overcome feelings of inferiority.
2. challenge faulty assumptions (basic mistakes) and reeducate, restructure, and to develop a healthy lifestyle.
3. foster and cultivate social interest.
4. encourage and motivate toward accomplishing socially useful goals. Causes of behavior are not the issue.

## Techniques

| | |
|---|---|
| Interpret family constellation | Early recollection |
| Contract | Homework assignments |
| Encouragement | Paradoxical intention |
| Confrontation | Empathy, intuitive guess |
| Asking the question | Task-setting |
| Spitting in the client's soup | Acting "as if" |
| Catching oneself | Push button |

## Summary

## Adlerian Basic Assumptions

1. People are social beings, shaped and motivated by social forces.
2. Human nature is creative, active, and decisional.
3. People are pushed by a need to overcome inherent feelings of inferiority and pulled by striving for superiority.
4. We develop a style of life aimed at compensating for inferiority feelings and becoming the master of our fate.
5. Lifestyle consists of views about ourselves and the world, and the behaviors we adopt in pursuit of our life goals.
6. Clients are discouraged and need encouragement to correct mistaken beliefs.
7. Counseling is a collaborative effort, working on mutually agreed-upon goals.

## Goals

1. Help client develop social interest.
2. Provide encouragement.
3. Facilitate insight into mistaken beliefs

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Growth principle of client lifestyle. A positive connection between past, present, and future.

Negative: Disunity in personality, mistaken notions, and faulty assumptions. Too much inferiority, overcompensation, and/or discouragement. Too little social interest.

# Person-Centered Therapy

Key figure: Carl Rogers founded nondirective therapy in the 1940s in reaction to psychoanalysis. Person-centered therapy was the first truly American system of psychotherapy. Person-centered is a unique approach based on a warm and responsive therapeutic relationship. This theory is phenomenological in perspective.

## Human Nature

Human beings are innately motivated to strive to reach their potentials (growth-oriented). That is, each person has a self-actualizing tendency that seeks growth and full functioning. Pathology is when this tendency had been impeded through frustration of basic impulses or needs of love and

belonging, a concept closely related to Maslow's need hierarchy. Humans are capable of resolving their conflicts but are limited by their lack of self-knowledge. Conflicts are defined as a discrepancy between basic needs and the need to gain approval from others. Counseling is a process of learning about the self. The perception of people is based upon four beliefs: (1) people are trustworthy, (2) people innately move toward self-actualization, (3) people have the inner resources to move themselves in positive directions, and (4) people respond to their uniquely perceived world (Hazler, 2003).

## Therapeutic Relationship

The counselor-client relationship is central to achieving change. The therapist participates fully as a person. Rogers believed that there must be present necessary and sufficient conditions for change to take place. These conditions are trust, openness, acceptance, permissiveness, and warmth (Kottler & Brown, 2000). The therapist's attitudes (core conditions) are necessary and sufficient for change to occur (Seligman, 2001). The counselor is nondirective and focuses on the core conditions. The client moves toward autonomy.

## Core Conditions

1. Respect: Communicating unconditional positive regard. Accepting the client and trusting his or her ability to manage himself/herself.
2. Genuineness: Being fully and freely himself/herself. Matching one's inner experiencing with external expressions.
3. Empathy: Being able to get into the internal frame reference of the other person and communicate understanding of his or her subjective experience.
4. Concreteness: The specificity with which we treat the client's experience.
5. Immediacy: Ability of the counselor to get the client to focus on the here and now. Talking about the counselor/client relationship.
6. Self-disclosure: Making the self known by revealing personal information.
7. Confrontation: A skill in which the counselor invites a client to examine his/her behavior and the consequences. The counselor can point out discrepancies.

## Goals

There are no predetermined goals.

1. increased self-awareness and trust in one's own actualizing processes (Seligman, 2001).
2. empower client through relationship of trust and safety.
3. actualize potential for growth, wholeness, spontaneity, and inner-directedness.
4. an encounter with self.

## Techniques

Techniques are considered secondary to counselor's attitudes (Corey, 1986). Therapy is relationship-centered, not technique-centered. Counselors use active listening, reflection of content/feeling, clarification, summarization, confrontation, direct or open-ended questions. Diagnoses or interpretations are considered detrimental to the process. Counselors refrain from giving advice or solutions, moralizing, or making judgments.

## Criticism of Weaknesses

Considered ineffective with nonverbal clients such as young children or disadvantaged people. Peterson and Nisenholz (1995) point out that the theory does not include spiritual or environmental domains and lacks in problem-solving approaches.

## Summary

## Person-Centered Basic Assumptions

1. We have the capacity to understand our problems and we have the resources within us to resolve them.
2. Emphasis is on the basic trustworthiness of human beings.
3. Therapist gives little structure or direction.
4. Clients need understanding, acceptance, support, and positive regard from the therapist.

## Goals

1. Provide climate of understanding and acceptance.
2. Enable clients to move toward greater openness, increased self-trust, and increased spontaneity.

## Basic Health (Well-Being): Positive and Negative Conditions

Person-centered

Positive: Actualize potential for growth, wholeness, spontaneity, and inner directedness.

Negative: Divergence of real self and ideal self.

# Transactional Analysis

Key figures: Eric Berne (1910-1970); Mary and Robert Goulding (prominent during the 1970s)

## Basic Assumptions

1. Humans are free to choose and shape their own destiny (life script) through awareness (antideterministic view of human nature).
2. Personality is composed of three ego states: Parent, Adult, and Child. "An ego state is a consistent pattern of feeling and experience related to a corresponding consistent pattern of behavior" (Berne, 1964, p. 364).
3. Children grow up with parental injunctions ("don'ts") that result in early decisions aimed at survival, recognition, attention (strokes), etc. Games are created to support these early decisions.

## Key Concepts

1. Games: a series of stereotyped and predictable patterns of behavior that end with surprise and bad feelings for at least one player (Corey, 1986). Serve to prevent intimacy.
2. Rackets: habitual feeling (depression, guilt, anger) that is clung to after a game (Corey, 1986).
3. Life Scripts: personal life plan created by early decision regarding self, others, and world.
4. Parental injunctions: verbal and nonverbal messages telling the child what he or she must do and be to get recognition (Corey, 1986). These are usually negative messages.
5. Stroking: a form of recognition. Can be positive or negative, conditional or unconditional.

## Counseling Process

The process is contractual. The client decides what to change based on awareness of the following steps:

STEP 1 in the process is structural analysis, the analysis of the person's ego states.

1. Structural Analysis (Personality): The client examines the content and functioning of the following ego states:
2. Parent Ego State: Instructions, attitudes, and behavior handed down mostly by parents and authority figures.
3. Nurturing Parent State-supportive, caring, encourager
4. Critical Parent State-harsh, fault finding (do and don'ts)

Adult Ego State: Objective side of our personality is logical and nonemotional. This is the thinking part of our personality, the computer part of our personality that provides objective information using reality testing. Assimilator and evaluator of information focused on facts, not feelings. They keep the Parent and Child ego states in balance.

## Child Ego State: Three components

Adapted child: controlled, product of demands, whines, cries, rebels

Natural child: spontaneous, impulsive, untrained, self-loving, pleasure-seeking, expressive

Little Professor: intuitive wisdom

Contaminations and exclusions are important interactions between and among the ego states such as:

Contamination: when one ego state is affected by data from another ego state

Exclusions: rigid or too flexible boundaries that prevent energy from flowing to different ego states

STEP 2 in the process is transactional analysis, understanding the transactions in which the person engages.

Transactional Analysis: Study of transaction. Three types:

1. complementary: a specific ego state sent, a specific ego state responds. (example: child/child transaction)
2. crossed: unexpected response to a message. (example: child/adult transaction)
3. ulterior: overt message is different from covert message.

STEP 3 is a game analysis. The counselor and client attempt to understand the interpersonal communication of the games and the bad feelings that ensue.

1. Game Analysis: Ulterior transactions. Games often result in a bad feeling that serves as "pay off." (Example: Karpman Drama Triangle: Persecutor, Victim, Rescuer).

STEP 4 is script analysis, a review of his/her plan in an effort to gain control, develop congruency, and revise his/her life scripts (Peterson & Nisenholz, 1995).

1. Script Analysis: The script dictates where a person is going with his or her life and what paths are taken. The life pattern is identified through a specific checklist. The components of a life script include life position, rackets, and games.

Psychological (life) positions: a stance that the client assumes in early childhood regarding his or her intrinsic worth and that of others:

1. I'm okay, you're okay: optimal position (evolutionary)
2. I'm okay, you're not okay: paranoid (revolutionary)
3. I'm not okay, you're okay: depressive (devolutionary)
4. I'm not okay, you're not okay: helpless (obvolutionary)

**Question 5-33:**
The following communication takes place between a 14-year-old female and her mother. The 14-year-old indicates she would like to join a volunteer organization such as Habitat. The mother replies that the daughter does not do enough work around the home and doesn't know how to work. This is an example of:

a. an injunction.
b. an egogram.
c. a victim.
d. a stroke.

Answer: a. an injunction. An injunction is a negative message.

## Goals

1. Teach clients to recognize which ego state they are operating out of so that they can learn to choose a given ego state (Corey, 1986).
2. Teach clients how to be autonomous (i.e., script-free and game-free) through increasing awareness.
3. Teach clients to "write their own script" through understanding early decisions and then making new decisions (redecisions).
4. Teach clients to understand the nature of transactions so that interpersonal relationships can be free of game-playing and characterized by directness, wholeness, and intimacy.

## Techniques

These are didactic in nature. Examples include:

1. contract
2. script checklist
3. script analysis
4. structural analysis
5. analysis of games and rackets

## Therapeutic Relationship

Client and therapist are equal partners. Joint responsibility is part of the contract. Client finds his or her own power to change (i.e., make decisions). Therapist serves as teacher, trainer, and resource person.

## Summary

## Transactional Analysis Basic Assumptions

1. We are influenced by the expectations and demands (injunctions) of significant others.
2. Certain early decisions we made may be nonfunctional, so that we must make new decisions that are more appropriate.
3. Therapists play an active, directive role, and therapy is a collaborative effort.
4. Clients carry out contracts to change and make new decisions.

## Goals

1. Help client become more autonomous through increased awareness and insight.
2. Help client make new decisions based on awareness.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: "Writing one's own script" and living autonomously.

Negative: Enslavement to early decisions, games, and scripts.

# Gestalt Therapy

Key figures: Fritz Perls (1893-1970), Erving and Miriam Polster, and James Simkin. An experiential therapy is focused on awareness and integration of fragmented parts of the personality in the "here and now" (Corey, 1986). Gestalt, meaning whole figure, is rooted in existential philosophy and phenomenology, process-oriented rather than content-oriented (Seligman, 2001). Finally, Gestalt therapy is focused on what and how and unfinished business (Kottler & Brown, 2000).

Terms: Unfinished business, stuck, polarization, here and now, hot seat, double chairing, and owning the projection.

## Basic Assumptions

1. Growth comes through personal relationship with therapist, not through techniques, interpretations, etc.
2. Clients are autonomous and responsible beings with the capacity to do their own work (experiencing).
3. The most important area of concern is the immediate, present awareness of one's experience (Seligman, 2001).
4. Every element of the person is connected to the whole (holism).

5. Contact is necessary for growth. Good contact means interaction with the environment without losing one's sense of individuality (Corey, 1986).
6. Frustration is essential for growth. Without it people have no reason to employ their own resources and take responsibility for their own growth rather than trying to manipulate others into doing it for them (Corey, 1986).
7. Troubled individuals rely too much on an overdependence on intellectual experiences, that is, they reduce the importance of the emotions and senses.

## Human Nature

The individual is born with an innate ability to function well and live successfully. Significant others have taught the person to devalue and distrust him or herself. These attitudes have been introjected and result in reduced awareness (Seligman, 2001). The person is capable, however, of becoming a self-regulating being who can achieve a sense of unity and integration in his/her life. Mental health is the ability to maintain awareness without being distracted by the various environmental stimuli that constantly vie for attention.

Difficulties can be experienced by:

1. losing contact with the environment and the resources.
2. over-involvement with the environment and becoming out of touch.
3. failure to put aside unfinished business.
4. experiencing a conflict between top dog and the underdog.
5. not handling dichotomies in life.

## Theory of Personality

Blocked energy is a form of resistance. Often it shows up in nonverbal and verbal behavior. (examples: body tensions, postures, restricted voice, verbal expressions, etc.).

Five layers of neuroses (similar to onion layers). Keep energy up in the service of pretenses (Corey, 1986):

1. Phony layer: Stereotypical, inauthentic, roles, games.
2. Phobic layer: Avoid emotional pain associated with denied aspects of ourselves. Resistances to self-acceptance. Fear of rejection if we are who we really are.
3. Impasse layer: Sense of deadness, feeling stuck, and lack of trust of inner resources.
4. Implosive layer: Fully experience deadness, expose defenses, and begin to make contact with the genuine self.
5. Explosive layer: Let go of phony roles and pretenses. Unused energy is found that was previously tied up with maintaining phony existence.

Five major channels of resistance: Ego defense mechanisms that prevent authentic experiencing:

1. Introjection: Uncritical acceptance of others' beliefs and standards.
2. Projection: Disowning parts of the self by ascribing them to others (the environment).
3. Retroflection: Turning back onto ourselves something we would like to do (or have done) to someone else.
4. Confluence: A disturbance in which the sense of boundary between self and environment is lost.
5. Deflection: A way of avoiding contact and awareness by being vague and indirect.

## Goals

1. Major goal: To help client live a fuller life.
2. Deepen awareness, experience the "here and now" more fully. (Awareness is seen as curative in itself).
3. Bring unfinished business and other forms of resistance and blocked energy into present awareness.
4. Move from environmental support to self-support. Teach client to take responsibility for thoughts, feelings, and actions.
5. Reintegration of previously disowned aspects of the self (polarities, dichotomies).

## Techniques

Experiments are designed to promote client awareness, intensify direct experiencing, and integrate conflicting feelings. They grow out of interaction between client and therapist and should not be applied mechanically.

1. Bring into awareness bodily signs of resistance
2. Empty chair technique (externalize introjects such as top dog/bottom dog)
3. Making the rounds (group technique)
4. "I take responsibility for…"
5. The exaggeration experiment
6. Staying with the feeling
7. Dream work

## Summary

## Gestalt Basic Assumptions

1. People must find their own way in life and accept personal responsibility if they are to hope to achieve maturity.
2. Therapists should provide a climate in which the clients can experience their "here and now" awareness.
3. Clients do experiments aimed at change and at finding their own meanings.
4. They expand their own level of awareness and integrate the fragmented and unknown aspects of themselves.

## Goals

1. Increased awareness in the "here and now."
2. Reintegration of all aspects of the self.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Creative adjustment. Capacity to feel, sense, perceive, and interpret in the present meaning.

Negative: Denial of parts of the self. Lack of awareness. Manipulation of others, rather than taking responsibility for the self

# Existential Therapy

Based on existential philosophy (Kierkegaard, Nietzsche, Heidegger, Jean-Paul Sartre, Martin Buber, Sidney Jourard, Abraham Maslow, and Irvin Yalom).

Key figures: Victor Frankl, Rollo May, and Irvin Yalom

## Basic Assumptions

1. Central concerns are loneliness, isolation, alienation, and meaninglessness.
2. Emphasis is on anxiety, values, choices, freedom, responsibility, and self-determination.
3. Growth and health is the focus, finding meaning in life not pathology.
4. Frankl (1962) wrote "one could find the meaning in life by doing a deed, experiencing a value, and by suffering" (p. 113).

5. Psychopathology is the failure to make meaningful choices and to maximize one's potential. Frankl viewed maladjustment as a conflict between different moral or spiritual values. There is disagreement among the existentialists as to maladjustment.

## Human Nature

Humans are self-determining and capable of self-awareness. They are free and responsible. Anxiety is a part of humanness. Death and awareness of death are part of humanity and can be used as a catalyst for creating meaning. Being human means being "in the process."

## Terms

Peak experiences are when a person feels truly integrated and connected to the universe in an emotional way. An existential vacuum is when a person feels normlessness and valuelessness.

## Goals

1. Increase self-awareness by exploring.
2. Help the client recognize freedom to make choices and create meaning.
3. Help the client realize the importance of responsibility, freedom, awareness, and potential.
4. Help the client learn to live authentically.

## Techniques

There are no well-defined procedures. Techniques can be drawn from any theoretical orientation (Corey, 1986). Confrontation is one technique used by many existential counselors. Paradoxical intention is a technique in which clients exaggerate fears and anxieties rather than deny them. Focusing, a technique emphasized by Gendlin (1984), is to become aware of one's body as a vehicle for deriving meaning.

## Summary

## Existential-Basic Assumptions

1. We define our lives by our choices and are authors of our lives.
2. Clients lead a "restricted existence" using limited ways of dealing with life situations.
3. Therapists must help clients become aware of their restricted life and their part in creating it.

## Goals

1. Increased self-awareness and more authentic existence.
2. Acceptance of responsibility for making choices.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: To accept aloneness and create meaning in life.

Negative: Not living with authenticity; avoiding responsibility.

# Rational-Emotive Behavior Therapy (REBT)

Characterized by brevity; active, highly directive and didactic (cognitive). Rational emotive therapy stresses the role of action in combating irrational beliefs. Rational emotive therapy derives concepts from cognitive, behavioral, and emotional behaviors.

Key Figure: Albert Ellis formulated this theory in the 1950s.

## Basic Assumptions

1. Therapy is a process of re-education. Thoughts and beliefs are the roots of emotional disturbances.
2. Perception, thought, emotion, and behavior tend to happen simultaneously (Corsini, 1979).
3. Emotional disturbance happens because the individual keeps actively reinforcing magical beliefs and re-indoctrinating himself or herself. The individual is responsible for the continuation of irrational thinking (Seligman, 2001).

## Human Nature

Individuals have the potential to be rational as well as irrational. They have an innate self-defeating tendency to insist that life be perfect. They "catastrophize" and "musterbate." On the other hand, they also have an innate ability to self-actualize, but they often sabotage themselves (Seligman, 2001). What disturbs people are not events, but interpretations of those events.

Theory of Personality: ABCDE theory of personality change.

1. Activating event
2. Beliefs (thoughts or perceptions about that event which can be rational or irrational)
3. Consequences (feelings that result from beliefs)
4. Disputation that is directed at an irrational belief
5. Effect of the disputation (rational conclusion, positive emotion)

People are primarily responsible for their feelings about themselves, others, and the environment. People are prone to create emotional consequences, but the culture, society, and family exacerbate the tendency through social conditioning (Seligman, 2001). Anxiety is not "irrational" but is an appropriate feeling stemming from an irrational belief.

REBT discourages the use of absolutes, such as "must", "should", and "ought." "Awfulizing" is also discouraged. These are forms of irrational thinking.

People can understand, think about their feelings, and employ self-discipline to change or eliminate self-sabotaging beliefs (Seligman, 2001).

## Goals

1. Increase happiness and decrease pain by eliminating self-defeating outlook. Changing client's thinking will result in changes in feelings and behavior (Corey, 1986).
2. Directly dispute and teach client to dispute irrational beliefs. Help client internalize the rules of logic and the scientific method so that he or she can think rationally (Seligman, 2001). Undermine irrational beliefs. Show how irrational beliefs cause dysfunctional consequences.
3. Cognitive restructuring through a basic change in values.

## Therapeutic Relationship

The therapist is a teacher: highly didactic, directive, active, and confrontative. A warm relationship is neither necessary nor sufficient for change. The therapist fully accepts the client but avoids fostering dependence in the client. The therapist functions as a scientist who discovers and annihilates unrealistic, illogical thinking (Seligman, 2001).

## Techniques

A variety of cognitive, emotive, and behavioral techniques are employed. The two main techniques are teaching and disputing. The function of teaching is to learn about emotions and how they are linked with behavior, and is the result of thoughts, not events. Furthermore, self-talk influences behavior (Gladding, 1996). According to Walen, DiGuiuseppe, and Wessler (1980), there are three forms to disputing thoughts. They are cognitive (syllogisms), imaginal, and behavioral disputations.

## Cognitive Techniques

1. recognize and give up "shoulds," "oughts," and "musts"
2. Socratic dialogue
3. reasoning, logic, and persuasion are used to dispute irrational thoughts and beliefs
4. syllogisms (two premises and a conclusion)

## Imaginal (emotional-evocative) Techniques

1. role-playing
2. modeling
3. humor
4. unconditional acceptance
5. imagery
6. shame attacking exercises

## Behavioral Techniques

1. homework assignments
2. assertion training
3. operant conditioning
4. desensitization
5. relaxation

## Summary

## Rational-Emotive Behavior Therapy Basic Assumptions

1. Our problems are caused by our thoughts and perceptions of life situations, not by the situations themselves, nor by others, and not by past events.
2. It is our responsibility to change distorted thinking that leads to emotional and behavioral disorders.
3. Therapists use active, directional procedures to help clients change their faulty thinking.
4. The goal of therapy is to substitute a rational belief system for an irrational one.
5. Cognitive restructuring occurs through the use of homework, suggestions, and teaching.

## Goals

1. Change irrational beliefs into rational beliefs that lead to more effective functioning.
2. Teach client how to use scientific method to solve his or her problems.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Rational thinking.
Negative: Inaccurate and dysfunctional thinking. The uncritical acceptance of irrational beliefs.

## Reality Therapy (Control theory to Choice to theory)

Reality therapy was designed for working with youthful offenders in detention facilities. It is a short-term approach that is positive, action-oriented, and focused on present behavior. In 1981, Glasser extended his theory to include control theory (Glasser, 1998). The focal points of control theory is that all behavior is generated from within the person. The main tenets consisted of reality, responsibility, and right and wrong and that all people have two basic human needs to love and be loved (Seligman & Reichenberg, 2010). Thus, the human brain functions influence inner perceptions. The client works toward a "success identity" and away from a "failure identity." The major emphases are problem-solving, personal responsibility, natural consequences, and the need to cope (Kottler & Brown, 2000). Reality theory is cognitive and behavioral and the focus is present-oriented. Glasser's original theory evolved into a theme of control in which people were driven by an inner control that guided their behaviors and emotions. The control system promoted the idea that awareness and assessment were central to changing or modifying the control system. Later Glasser dropped control and incorporated elements of choice theory to enhance the quality of life. Thoughts, feelings, and actions were the means to determine between what we want and what we have.

Key figure: William Glasser, developed reality theory in the 1950s and 1960s and added components of control theory in the 1980s (Glasser, 1969). This is also known as cybernetics. Cybernetics understanding for human functioning involves understanding self-regulating systems. The regulation takes place when we have a discrepancy between some desired state and a present state (Day, 2004).

### Basic Assumptions

1. Human behavior is purposeful and originates from within the individual (Corey, 1986). The human's purpose is to get what it wants.
2. Glasser believed that all behavior is aimed at fulfilling five basic psychological needs. These needs are belonging, power, enjoyment, freedom, and the physical need for survival. Successfully meeting these needs is a result of control.
3. Behavior change results from identity change.
4. Glasser defined identify failure incorporates features of receiving inadequate love and consequentially feels worthless.

### Human Nature

Individuals are self-determining and responsible for their own lives. They are goal-oriented. Behavior is aimed at fulfilling basic needs for survival, belonging, power, freedom, and fun. Consciousness is the driving force in humans. Like client-centered therapy, reality therapy believes there is a life force within everyone that propels him/her to grow. This life force is physical and psychological.

## Theory of Personality

Identity is the basic requirement of all people. An individual forms a success identity, a perception that he or she is worthwhile and loved, or a failure identity, characterized by loneliness, delinquency, withdrawal, and mental illness. Identity forms as a result of interaction between the self, others, and the environment. There are two critical times in children's lives. The first is between the ages of two and five, when socialization skills are learned. This is a time of frustration and disappointments. What are needed are love, acceptance, guidance, and support from parents. A failure identity can form around five or six years of age, at about the time a person enters school. The second time is between five and ten years of age, when individuals can develop a failure identity because of socialization or learning problems (Glasser, 1998).

Reality therapy rejects the medical model of psychopathology.

Mental health is conceptualized in terms of a success identity as opposed to a failure identity. Individuals have a mental image of what their needs are and behave in accordance.

Reality therapy ignores the unconscious and rejects using unconscious motivations as excuses to avoid taking responsibility.

## Counseling Process

The process works through a WDEP which is a cluster of interventions. Glaser believed that we have a universal set of needs: survival, power or achievement, freedom or independence, and fun. As such, the interventions are wants (W), Direction and Doing (D), Evaluation (E), and Planning (P). The therapist needs to be able to instill hope and to reframe the problem or issue. The use of Choice Theory was Glasser's way to convey self-regulatory behavior for clients. The process focuses on behavior, not feelings.

Transference is discouraged. The therapist actively attempts to decrease distortions (Seligman, 2001). Therapy is a teaching process, not a healing process and is aimed at teaching clients how to solve problems.

The counseling process is composed of (1) an environment conducive to counseling (motivation and involvement) and (2) procedures leading to change. The eight steps of the counseling process follow:

1. Build a good relationship. Demonstrate involvement and concern throughout the whole process.
2. Examine present behavior (thoughts, feelings, actions) in a nonpunitive and noncritical way.
3. Client evaluates and makes value judgments about his or her behavior, and answers the question, "Is your present behavior getting you what you want now and will it take you in the direction you want to go?"
4. Look at possible alternatives (i.e., changing behavior, changing direction, etc.).
5. Select alternatives and make a commitment to an action plan.

6. Use logical consequences.
7. Follow through with commitment. No excuses are accepted.
8. The therapist avoids getting discouraged with counseling failures and does not give up on the client.

The control system is composed of the perceptual, comparing, and behavioral systems.

## Goals

Goal attainment is to help clients become psychologically strong and rational (autonomous and responsible) and to clarify what they want in life.

1. Teach the client to find better ways of meeting needs for belonging, power, freedom, and fun that do not hurt others in the process (Corey, 1986).
2. Teach the client to accept responsibility for his or her life, live more effectively, and thereby achieve a success identity.
3. Formulate a realistic plan to achieve personal needs and wishes.
4. Develop a relationship with the client.
5. Focus on behavior and the present.
6. Eliminate punishment and excuses from the client's life (Gladding, 1996).

Choice theory states that all behavior is chosen and driven by our genes to satisfy five basic needs (survival, belonging, power, freedom, and fun). Love and belonging is a prerequisite for satisfying all needs. Choice theory promotes the idea that disconnectedness is the source of all human problems. Ten axioms of choice theory support the seven caring habits of support, encourage, listen, accept, trust, respect, and negotiate differences. The ten axioms are:

1. The only behavior we can control is our own.
2. Information is all we can give others.
3. Relational problems are the source of psychological problems.
4. Problem relationship is always a part of the present life.
5. The past has everything to do with what we are today.
6. We can only satisfy our needs by satisfying the pictures in our quality world.
7. Behave is all we do.
8. All behavior is total behavior made up of acting, thinking, feeling, and physiology.
9. Total behavior is chosen and direct control is only over acting and thinking. Feelings and physiology are indirectly controlled through our actions and thinking.
10. Total behavior is designated by verbs and named by the part that is most noticeable.

## Summary

## Reality Therapy Basic Assumptions

1. Identity forms by age five or six through interaction between environment, self, and others.
2. Humans have a growth potential (an anti-deterministic and positive view of human nature).
3. Behavior is goal-oriented toward achieving basic needs for self-worth, love, belonging, etc.
4. People are responsible for their behavior, thoughts, and feelings.

## Goals

1. Teach client to take responsibility for his or her life and for getting his or her needs met.
2. Help client develop a success identity through responsible behavior, which leads to feelings of self-worth and love

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Acceptance of responsibility for one's own behavior and one's own life. A success identity.

Negative: Refusing to face reality. Behaving irresponsibly by blaming the past, others, environment, etc. A failure identity.

# Behavioral Therapies

Spiegler and Goevremont suggest that most behavior therapies have in common a number of factors. Five of these factors are an emphasis on the present, changing specific dysfunctions, relying on research for interventions, meaningful treatment outcomes, and matching specific treatments to specific problems (as cited in Kottler & Brown, 2000).

## Key Figures

B. F. Skinner (radical behaviorism)

Joseph Wolpe (classical conditioning)

Arnold Lazarus (multimodal therapy)

Albert Bandura (social learning theory)

## Major Procedures for Counseling

Classical Conditioning: Ivan Pavlov, Joseph Wolpe, and John Watson were early pioneers in behavior technology. Classical conditioning is also known as respondent conditioning or associative learning. It

is based on a mechanistic, deterministic view of behavior. The organism is considered to be passive. A conditioned stimulus is paired with an unconditioned stimulus to produce an unconditioned response.

## Techniques

1. systematic desensitization
2. internal inhibition (flooding)
3. counterconditioning
4. aversive conditioning (noxious stimulus)
5. implosive therapy (Stampfl)
6. relaxation training

Operant Conditioning: B. F. Skinner. Operant conditioning is also known as instrumental conditioning or behavior modification. The organism is active. The premise is that learning cannot take place in the absence of reinforcement (positive or negative). Behavior can be increased or decreased depending upon the type and timing of stimuli (Kottler & Brown, 2000). Reading, writing, driving a car, etc., are all operant behaviors.

## Techniques

1. shaping
2. contingency contracting
3. self-management
4. biofeedback
5. token economies
6. time out
7. over correction
8. response cost
9. negative reinforcement
10. positive reinforcement

Cognitive-Behavioral: Aaron Beck, Donald Meichenbaum, Michael Mahoney, Arnold Lazarus, Albert Bandura.

Cognitive approaches focus on changing thoughts and thought processes (Peterson & Nisenholz, 1995). Behavioral counseling is a modification of behavior. Counselors work at changing faulty perceptions and beliefs that underlie the client's thinking and behaving.

## Techniques

1. modeling
2. cognitive restructuring
3. assertion training (uses feedback, modeling, social reinforcement, behavioral rehearsal)
4. self-management
5. multimodal (uses classical, operant, and cognitive techniques)

Imitative learning: Imitative learning is the acquisition of new responses through models demonstrating the desired behavior

Emotional learning: Emotional learning is the substitution of acceptable emotional responses for those undesirable emotions (Krumboltz, 1966, 1979)

## Summary

## Behavioral Therapies Basic Assumptions

1. Behavior results from learning.
2. Disorders are best understood from an experimental perspective (Corey, 1986).
3. Techniques should be based on the results of rigorous research and evaluation, commitment to the scientific method, and experimental approach.
4. Humans affect and are affected by their environment.
5. Current behavior is the focus of therapy.
6. Therapy is action-oriented.

## Goals

1. Establish a collaborative relationship between client and therapist.
2. Establish an agreed-upon contract detailing mutually agreed-upon goals, treatment procedures, methods of evaluation, etc.
3. Use action-oriented techniques to eliminate maladaptive behaviors and to learn more adaptive behaviors.
4. People are shaped by learning and social or cultural conditioning, interaction between person and environment.
5. Client has ability to eliminate maladaptive behavior and acquire constructive behavior.
6. Comprehensive assessment, then setting of specific goals.
7. Therapist teaches client how to recognize and alter maladaptive behavioral patterns.
8. Client must practice new behaviors in real-life situations.

9. Eliminate maladaptive behavior.
10. Learn adaptive behavior.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Using adaptive behaviors for problem solving.

Negative: Faulty learning and unadaptive behavior

# Cognitive Therapy

Cognitive therapy is a set of treatment techniques designed to relieve symptoms of psychological distress through direct modification of the dysfunctional ideation that accompanies them.

Key figures: Aaron Beck (Cognitive Therapy); Donald Meichenbaum (Cognitive-Behavioral Modification, Self-Instructional Training, Stress Inoculation Training); Arnold Lazarus (Multimodal); Michael Mahoney (Cognitive-Developmental Theory).

## Comparison to other therapies

1. Cognitive compared to psychoanalysis:
    a. Cognitive doesn't demand early developmental history.
    b. Cognitive focuses more on conscious, not unconscious.
    c. Cognitive treatment is seen as a collaborative effort.
2. Cognitive compared to behavioral:
    a. Both are highly structured and active.
    b. Both are focused on the here and now.
    c. Both focus on specific symptoms and behavior problems, but cognitive also concentrates on ideation associated with symptoms.
    d. Cognitive seeks not only symptom reduction, but also modification of attitudes, beliefs, and expectations.
3. Cognitive compared to REBT:
    a. REBT assumes problems stem from universal irrational ideas, but cognitive seeks to elicit and modify the client's thinking.
    b. Specific cognitive distortions.
    c. Cognitive initiates change through experiential learning. REBT initiates change through authoritative "disputing" by the therapist.
    d. Cognitive places greater emphasis on experiments and real-life learning.
    e. Cognitive is more "behavioristic" than REBT.

### Beck's Cognitive Therapy

Human Nature: People live by rules (premises) that influence distorted thinking. These can cause emotional problems if they are unrealistic or applied excessively or rigidly (Corey, 1986). Beck believes that people live by rules.

## Goals

1. Recognize and discard self-defeating cognitions (cognitive distortions).
2. Discover relationship between thoughts and emotions.

## Theory of Personality

Cognitions are made up of schemas, processes, and events. These cognitions lead to emotional and behavioral responses.

## Cognitive Distortions

1. Selective abstraction: Focusing on a detail out of context.
2. Arbitrary inference: Conclusions made on the basis of inadequate or improper information.
3. Overgeneralization: Blanket judgments or predictions based on a single incident.
4. Personalization: Overestimating extent to which particular events are related to the person.
5. Polarized thinking: Sorting information into dichotomies.
6. Magnification and exaggeration: Overemphasis on most unpleasant, negative consequences that can arise.
7. Assuming excessive responsibility: Attribute negative events to supposed personal deficiencies.
8. Incorrect assessments regarding danger vs. safety: Phobias or underestimating dangers.
9. Dysfunctional attitudes about pleasure vs. pain: Setting up unrealistic goals that lead to depression and hopelessness.
10. Tyranny of the "shoulds" (automatic self-injunctions): Setting unrealistically high standards for conduct.

## Techniques

Beck teaches the client to make self-observations whereby he/she can observe his/her thought pattern distortions, faulty inferences, misperceptions, and exaggerations. The next step is to teach coping skills.

Socratic dialogue

1. behavioral technique
2. self-monitoring
3. humor
4. problem-solving
5. homework

### Meichenbaum's Cognitive-Behavioral Modification

Like the other cognitive-behavioral counselors, Meichenbaum believes distorted thinking is the basis of stress and emotional problems.

## Techniques

Cognitive restructuring and stress inoculation therapy are two management skills he teaches to clients.

### Lazarus's Multimodal Therapy

Arnold Lazarus tailored his therapy to use techniques from different theories, the cognitive-behavioral, psychoanalytic, psychodynamic, and humanistic. Multimodal therapy is mainly theoretically based in social learning. Maladjustment is a result of a deficiency or dysfunctioning in faulty social learning. He uses the BASIC ID therapy in which:

1. B is behavior observed
2. A is the affective (emotion)
3. S is sensation (feeling)
4. I is images
5. C is cognitions (thoughts)
6. I is interpersonal relations
7. D is drugs (biological)

Lazarus introduced the terms of bridging and tracking, which are used in other therapies. Bridging is when the therapist tunes into the client's preferred modality before branching off into other dimensions. Tracking is an examination of the firing order of the different modalities. An example is a SCI order, that is, sensory, cognitive, and image. Other clients create negative emotions with a different firing order such as the CISB (cognitive-image,-sensory-behavior).

## Summary

## Cognitive Therapies Basic Assumptions

1. Primary motive for humans is search for patterns (Mahoney).
2. There are two types of meaning: tacit and explicit.
3. Emotions are very powerful, knowing processes.
4. Behavior is neither good nor bad.
5. Problems are defective learning patterns.
6. Maladaptive thoughts and beliefs are unconscious, automatic, and individual.

## Goals

1. Separate rational from irrational thoughts.
2. Demonstrate self-maintaining pathology.
3. Cognitive restructuring.

## Basic Health (Well-Being): Positive and Negative Conditions

Positive: Distorted thinking.

Negative: Irrational thinking. Blaming self and others.

## Existential (Alvin Mahler)

As cited in Corsini and Wedding (2005), Mahler's existential therapy is a model of usefulness rather than a theory of truth.

1. Personality offers the potential for experiencing a relationship with another.
2. The client constructs his/her own personal world.
3. The origins of the infant lie within the parents.
4. Personality development offers a deeper potential for re-experiencing a relationship with another.
5. Pain, unhappiness, and suffering are rooted in hateful, negative, antagonistic, and disintegrative relationships.
6. Change comes about through a major qualitative change in personality. It can be from negative to positive, from hateful to loving, and from disintegrative to integrative.

## Dialectic Behavior Therapy (Marsha Linehan)

Linehan's research and theory construction was based on her work with women. The therapy uses the term dialectic to mean a form of argument in which opposing positions are taken to the one employed by the client. The therapy's effort is to synthesis a solution between the two extremes (Linehan, 1993).

Dialectic Behavior Therapy (DBT) is a biosocial theory of borderline personality disorder. Linehan's hypothesis is that an individual grows up in an 'invalidating' environment. The premise behind her view of environment is that the child's personal communication is not accepted as accurate therefore the child's feelings are not true feelings. This type of environment requires self-control and self-reliance. A child exposed to this type of environment often fails to understand and control emotions.

The two parts for treatment are individual (self-injurious and suicidal are first priority) followed by interfering behaviors of therapy, and finally life issues. Skill development is an outcome of the individual therapy. The second component is group. The client uses skills that are broken down into 4 modules (mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance skills).

Mindfulness derives skills from Zen. Interpersonal effectiveness is similar to assertiveness training and problem solving. Distress tolerance is defined as the naturalness of the mindfulness skills that are aimed at tolerating and surviving crises and accepting life as it is. Emotion regulation skills include a number of identification of emotions and taking opposite actions.

Linehan's theory uses 'dialectic dilemmas'. The client swings between two opposites, as both ends are stressful. The client continues in crisis one following another and referred to as 'unrelenting crisis'. The client copes with the intense and painful feelings through self-mutilation and suicidal attempts.

## Eye Movement Desensitization and Reprocessing (EMDR)

Another cognitive behavioral treatment paradigm is Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995). EMDR, an information processing model, was specifically utilized for individuals who experienced trauma and diagnosed with Posttraumatic Stress Disorder (PTSD). EMDR is a combination of systematic desensitization and substitution of positive thought patterns for negative ones. (This method employs re-experiencing a disturbing event and guided by a therapist using an exercise of rapid, rhythmic back-and-forth eye movements. It is suggested that this back and forth eye movement unblocks the distressing event from a neurologically tapped state and releases them.

EMDR is a therapy of unfolding stages with a baseline of dysfunction. Selected are one or more disturbing memories for the treatment. The client is trained in self-soothing and relaxation techniques. The client will re-experience one of the identified memories coinciding with a traumatic scene. The client is encouraged to involve or immerse oneself while watching the therapist's hand movement back and forth a number of times (15-30). After a restful period the client reports on feelings, images, thoughts, and distress level. This is repeated with another series of eye movements and the same event or another one. Cognitive interweave is the term for encouraging new perspectives taking.

# OBJECTIVE 5E: Family Systems Perspective

Systems theory is utilized by many family therapists in working with families. A system's approach operationalizes the family members influencing one another. The family is in constant change and as a result any change with one member influences change with other members and the family as a whole. Based on the concept of a healthy family that is open and self-regulating it is able to reconstitute itself using negative and positive feedback loops to balance. It is important to recognize the characteristics of a healthy family because it makes it easier to assess when a family is dysfunctional. According to Krysan, Moore, and Zill (1990) characteristics of a healthy family include; a) commitment to the family and its individuals, b) appreciation for each other, c) willingness and desire to spend time together, d) effective communication patterns, e) high degree of religious/spiritual orientation, f) ability to deal with crisis in a positive manner, g) encouragement of individuals, and h) clear roles.

This overview of family counseling summarizes some important developments, influences, and contributors in the field of family therapy. Historically, family counseling has several notable figures and contributions. Such contributors include: Sigmund Freud in his writings and subsequent consultation with the father of Little Hans, Moren's group work in psychodrama, exhaustive research in roles in families with schizophrenic members, and general systems theory first developed by Ludwig von Bertalanffy (Bertalanffy, 1968; Goldenberg & Goldenberg, 1991). The family as a social system derived from marriage counseling, psychiatry, and research on schizophrenia (Brown & Christensen, 1999).

An accepted definition for family is difficult to achieve, because some writers prefer a broad definition to include unmarried cohabiting, couples, gay couples, childless blended families, and single parents. An early and yet a standard definition of family offered by Murdock (1965) is: "The family is a social group characterized by a common residence, economic cooperation, and reproduction. It includes adults of both sexes, at least two of whom maintain a socially approved sexual relationship, and one or more children, own or adopted, of the sexually cohabitant adults" (p. 1). According to Murdock and this definition the family has four functions:

1. sexual regulation
2. economic cooperation
3. reproduction
4. education

A second definition by Schulz (1976) pictures a family as "a social institution that has the primary personal function of providing nurturance and support for its members and the primary social function of the reproduction and replacement of members" (p. 23).

Goldenberg and Goldenberg (1991) describe a family as "a natural social system, with properties all its own, one that has evolved a set of rules, is replete with assigned and ascribed roles for its members, has an organized power structure, has developed intricate overt and covert forms of communication, and has elaborated ways of negotiating and problem-solving that permit tasks to be performed effectively" (p. 3).

More generally speaking, a family is a social unit in which members see themselves as a family, are recognized by others as an acceptable form of a family, meet each other's intimacy needs as well as other functions society recognizes as pertinent to a family, and where the members recognize and accept a life-long relationship. Gladding (1996) states "functional families follow rules and are flexible in meeting the demands placed upon them by family members and outside agencies" (p. 399). Family systems counselors stress how change in one member's functioning affects all other family members as well as the family as a whole (Gladding, 2000).

Peterson and Nisenholz (1995) view family counseling as a unit or a type of group counseling. Working with families allows individual therapists to work with an individual, a relationship within the family, the entire family (system), extended families, generations of family members, sandwich generations, and many other compositions of related members. Specifically, the issues a family brings to therapy may range from interracial marriage conflict to financial planning. A family is a system that is a series of interconnected and interdependent parts, which are linked to each other through mutual causation. Any change in one part will have an effect on the rest of the members. Every family confronts stress and the health of the family is dependent upon the health of the individual members. As a result, family issues surface. Counselors find themselves confronting a multitude of problem statements which raise additional questions such as assessment, referral, counseling one or two of the members, counseling the entire family, counsel some and refer the remaining members, and whether or not a gender-specific counselor is the better choice. Some issues which often surface, each with their own cobweb of component parts, are: divorce, post-divorce, divorce and children, remarriage, two families become one, child custody, death of a member, finances, religious differences, communication, discipline, learning dysfunctions, child-rearing practices, dependent relationships, physical and psychological abuse, substance abuse, dating, sexual adjustment, personality differences, conflict resolution, friends, equalitarian roles, leisure, and work (Brown & Christensen, 1999; Srebalus & Brown, 2001). Any one of these can be phrased into a question for this examination.

More recently feminist theory advocates that sexism and structured inequalities are not corrected through improving relationships among family members. Rather the goal is to strengthen the growth of a strong and competent woman in control of the resources and to work toward change (Libow, Raskin & Caust, 1982). A common view is that sexism limits the psychological well-being of women and men (Enns, 1992).

Becvar and Becvar (1988) and Srebalus and Brown (2001) stress that an understanding of developmental stages of a family is needed for successful counseling. Counselors working with families would do well to understand social class structure and behaviors, ethnic family life style and values, family structure, family strengths, societal influences on family, and the family life cycle. One family life cycle example is that of Becvar and Becvar (1988). This model includes emotional issues and critical tasks for each stage. These stages are:

1. unattached adult
2. newly married
3. childbearing

4. preschool-age child
5. school-age child
6. teenage child
7. launching center
8. middle-age adult
9. retirement

At each of these stages, one or all of the family members are confronted with critical tasks and associated emotions. Assuming the family and individual members are functional they will meet these tasks successfully and continue on to the next stage. If individuals, two or more members, or the entire family unit becomes stressed beyond their coping mechanisms, they become likely candidates for counseling. Members in a family who are healthy often have viable role models, take appropriate responsibility for family processes, have adequate resources to solve problems, have adequate inter- and intra-personal skills, have adequate judgment skills, and have systemic skills (respond to limits, that is; they are responsible, adaptable, and flexible).

**Question 5-34:**
In planning a treatment program for a family, a systems oriented counselor would use an intervention that focuses on:

a. linear causality
b. circular causality
c. hexagonal causality
d. member causality

Answer: b. circular causality. All members influence each other in the family.

# OBJECTIVE 5E: Theoretical Perspectives in Family Counseling

Theory: According to Gladding (2000), the profession of marriage and family counseling has grown rapidly since the 1940s. In working as either a marriage or a family counselor, the helping professional must be aware of the theoretical basis of the approach being employed in the counseling process.

Psychodynamic: Nathan Ackerman is the current theorist representing psychodynamic family therapy. Psychoanalytic theory suggests that the inner lives and conflicts of family members interlock and bind together, thus creating disturbances for family members. It is believed that troubled marriages or families suffer from or are contaminated by the pathogenic introjects from past relationships which reside within the person. Psychodynamic family therapists believe "insight leads to understanding, conflict reduction, and ultimately intrapsychic and interpersonal change" (Goldenberg & Goldenberg, 1991, p. 91). The role of the therapist is to make interpretations of individual and/or family behavior patterns. Goals of therapy may include:

1. insight
2. psychosexual maturity
3. strengthening of ego
4. functioning more satisfying object relations

Interlocking pathology, a term used by Ackerman, is a term to describe how an unconscious process takes place with family members that keeps them together. An inadequate separation from the mother will lead to returns to the mother-figure. Major family theorists and practitioners who work from the psychodynamic perspective are: Ackerman, Framo, and Boszormenyi-Nagy. In Kernberg's object relations theory the term splitting has been used by psychodynamic therapists to explain choices that couples make and family interaction patterns. Key terms to describe the family were family identities, social roles, and role relationships (Wagner, 2008). Treatment techniques are similar to individual therapy, transference, dream analysis, confrontation, focusing on strengths, life history, and complementarity. The therapist may not have all family members present but the counselor would attempt to get them to engage in transference and to ventilate feelings (catharsis), examine cultural and family patterns, explore unconscious, and to utilize family strengths.

## Experiential Theory

The familiar family therapist is Carl Whitaker. It was his idea that each patient in therapy is both patient and therapist. Families are changed as a result of their experiences. Experiences are outside our awareness (unaware of their emotions and suppress them) and gaining access is through nonverbal or symbolical means. The focus of therapy is process and what occurs during the family session. A basic strategy is to build on the absurd (half truthfulness), and therapy occurs in stages. His therapy is often referred to as the Leaning Tower of Pisa because it is unconventional and later labeled symbolic-experiential.

To the experiential family therapist, free choice and conscious self-determination are more important than conscious motivation. "Self-awareness of one's immediate existence leads to choice, responsibility, and change" (Goldenberg & Goldenberg, 1991, p. 91). The experiential family therapist is an active facilitator for growth and provides the family with new experiences. Goals of treatment include:

1. growth
2. deeper fulfillment
3. more effective communication
4. increased awareness
5. increased authenticity

Skills used to treat families are spontaneity, creativity, and the therapist's personality. Whitaker was not technique oriented rather process oriented. His process included redefining symptoms, model fantasy alternatives to real life, separate interpersonal and intrapersonal stress, interventions, augment despair

of a family member, promote affective confrontation, and treat children like children and not like peers (Keith & Whitaker, 1982).

## Systemic Therapies

Systemic is the study of biological processes leading to increasing complexity of organization (whole). Cybernetics often is associated closely with systemic as an outgrowth and is the study of methods of communication and control that are common to living organisms. Systemic therapy is the study of the relationship of the pieces or parts of a system. Terms common to systemic therapies are boundaries, hierarchic, homeostasis, servomechanisms, feedback loops, double bind communication and identified patient.

## Communications: Humanistic

Virginia Satir, an experiential family therapist, has a combination of systemic theory, ego psychology, and Gestalt. Virginia Satir, a recognized family communication expert, in her communications theory, suggests that family disturbances have a root cause: faulty communication. It is her belief that four problem areas constituted most of the family difficulties. The trouble areas are self-worth or self-esteem, communication patterns, rules, and contact with society (Satir, 1972). These humanistic theorists believe that interaction among members is essential to understanding dynamics and the psychological processes of any person. The therapist will concentrate on how members send messages, what they perceive other members' communications to be, and what processes of feedback and behavioral response affect the transmission and processing of messages. Virginia Satir in Conjoint Therapy suggests that whatever people were doing represented the best that they were aware of and could do at that time. The largest deficit was the extent of our knowledge. Families get better by freeing themselves from the past. Self-esteem is the basic human drive and is related to one's participation in the family. Behavior is directly related to one's family position and view of that position. Children in the family represent the third angle of a triangle but do not form a triangular relationship. Her belief is that two persons shift with the third. Satir postulates that the body communicates where a person is at the time. She uses five (5) body postures: placater, blamer, computer, distracter, and leveler. Conjoint therapy focuses on feelings. The blamer omits feelings, placater omits feelings about themselves, super-reasonable omit feelings about the subject being discussed, and irrelevant omit everything. The method is both physical and emotional. The family is led in role-playing a situation with actions and reactions interpreted. She will use different props to illustrate where members are in relation to each other. Satir developed a technique called sculpting. Sculpting is when family members will assume certain of these positions that reflect how they communicate with one another. She was adept at having clients exaggerate a posture to realize a communication. The therapist is active and directive in consciousness rising. In summary, her theory has four components. These components are: family member feelings of self worth, communication abilities of the family, a system focused, and rules of the family. Satir's theory is in three stages. The first is to make contact with each family member and create trust. The second stage is chaos, a time when

the family members move through their comfort zone and are challenged to open up and reveal. The third and final stage is integration, a time of closure unveiled during the chaos stage (Reiter, 2014).

## Strategic Family Therapy

Strategic family therapy is a method-oriented theory for problem solving. Strategic systems therapists generally pay little attention to past history. The attention is toward the changes as the family develops. Jay Haley, who was influenced by Gregory Bateson (double bind theory) and Milton Erickson, believed relationships were defined by communications and power struggles. Haley believed that behind every communication is the command for interpersonal power. Power persons determine what is going to happen. The therapist develops a strategy for solving the client's presenting problem. During a conflict one will eventually use "surrender tactics." Haley attempts to intervene by shifting the family organization so that the presenting problem no longer serves a purpose or function. Change is through the therapist providing structure and direction rather than insight and understanding. Haley contends that control of the relationship is at the center of all interpersonal interaction. If one individual can control the definition of the relationship he/she will continue to manage the difficulties. Another technique used is contingency management where the therapist recommends an ordeal. The ordeal recommended is more severe than the problem. The cure is worse than the illness. Haley's main terms are family hierarchy, coalitions, and paradoxical directives (as cited in Goldenberg & Goldenberg, 1991). Important aspects are:

1. focus on power and control struggles
2. here and now communication (present)
3. communication defines nature of relationship
4. develop strategy for each presenting problem
5. therapist is in control, directive, manipulative
6. relabeling dysfunctional behavior
7. stages are: social—observes family interaction, problem—information gathering, interaction —family discusses problems, and goal setting—precise problem and contract.

Haley considered paradoxical work to be one of the most powerful in his treatment. It is giving permission to the family or family members to do something. The forms of paradox are restraining, prescribing, and redefining. Restraining is to tell the family they are incapable of doing something. Prescribing is to instruct to enact a troublesome behavior in front of the therapist. Redefining is to attribute positive meaning to the symptomatic symptoms (Haley, 1976).

Family Systems Theory states that family systems can be studied from structural, functional, and developmental perspectives.

Murray Bowen's theory refers to an emotional system composed of communication and need fulfillment request. It is a theory suggesting that difficulties are passed down and repeated in families if not rectified. Repeating behavior is more likely when family members are fused and emotionally cut

off. Prochaska and Norcross (1999) interpret Bowen's differentiation of the self as having " the ability to be emotionally controlled while retaining the emotional intensity of one's family" (p. 380). Fusion is what interferes with this ability to differentiate. This undifferentiated process creates ego mass, which is interpreted as "stuckness." Bowen employed eight concepts that are interrelated and connected logically. These concepts are; 1) differentiation, 2) emotional system, 3) multigenerational transmission process, 4) nuclear family emotional system, 5) family projection process, 6) triangles, 7) sibling position, and 8) social regression. A differentiated self is the most widely known concept in his theory. In order to have a solid sense of self Bowen believed that the individual desires to have individual expression and fulfillment and at the same time wanting to be a part of a stable relationship. A useful concept in his family system is triangulation, which is the source of tension and conflict. The therapy focuses upon emotional units through understanding mother-child symbiosis, eight interlocking concepts, and the genogram. Bowen saw himself as a coach rather than a therapist.

Denial and isolation are two forms of emotional cutoffs some use to cope with their unresolved attachments to parents.

## Structural Family Theory

Salvador Minuchin defines family as a differentiated social system that develops identifiable transactional patterns for how, when, and to whom each member relates. This therapist is concerned with what maintains the psychopathology rather than the causes. Causes for these family issues are history and what can be changed are the contemporary factors not history. A family system will carry out its task through subsystems. That is, each person participates in a number of subsystems. Troubled families have rigid boundaries (enmeshed) or diffused boundaries (disengaged) and are clear, diffused, or rigid. This therapy focuses on the process of feedback between circumstances and the person involved. Coalition is an alliance between specific members of a family and a third member. Subsystems are an important aspect of Minuchin's theory which are smaller units in the system. Some examples are sibling subsystem, parental, and cross-generational. Boundaries and permeability are focal points in the therapy. These boundaries or lack of cause emotional cut offs, lack of clarity in identity, and triangulating. The therapist joins the family with the idea of changing the family organization so that family members experience change, are aware of alignments, triangulation, parentified child, power, and rules of a family.

Component parts are:

1. family's hierarchical organization (wholeness) and independent functioning of subsystems
2. complementarity of functions
3. boundary permeability—too accessible or not at all (enmeshed, disengaged, clear)
4. disengagement
5. alignment, power, coalition
6. triangulation
7. family mapping

8. family pathology as a result of dysfunctional sets

Techniques used by this therapist tend to be: consciousness raising, joining, reframing, social isolation, and joining the family (accommodation, mimesis, confirmation, tracking), marking boundaries, and blocking. Tracking is to follow the content of the family. Mimesis happens when the therapist joins in some way with the family, becomes like them, not necessarily in entirety but in specific ways such as humor or in conversation. Confirmation is to use a feeling word that expresses how a family member may be feeling. Accommodation is the final way the therapist joins the family by making a personal adjustment to achieve alliance (Gladding, 2007).

**Question 5-35:**
Minuchin, a structural family therapist, sees as the therapist's task to join the family. He indicated there are four ways to join the family. In addition to tracking, accommodating, and mimesis what method is missing?

a. alignment
b. confirmation
c. coalition
d. complementarity

Answer: b. confirmation

## Key Terms in Family Counseling

To prepare for the NCE, it may be helpful to study key terms related to family theory and practice. Oftentimes, family counseling terminology will be imbedded in questions throughout the exam.

Alignments:
Clusters of alliances between family members within the overall family group. Affiliations and splits from one another, temporary or permanent, occur in pursuit of homeostasis.

Boundary:
An abstract delineation between parts of a system or between systems, typically defined by implicit or explicit rules regarding who may participate and in what manner.

Brief family therapy:
Short-term treatment that focuses on resolving the presenting problem rather than viewing that problem as a symptom.

Circular causality:
This type of dynamic occurs when one person does have an effect on all other members. This is process-oriented, in that dynamics are interwoven and difficult to unravel.

Closed system:
A self-contained system with impermeable boundaries, operating without interactions outside the system, resistant to change and thus prone to increasing disorder.

Coalitions:
Covert alliances or affiliations, temporary or long-term, between certain family members against others in the family.

Complementary:
A type of dyadic transaction or communication pattern in which inequality and the maximization of differences exist (for example, dominant/submissive) and in which each participant's response provokes or enhances a counter response in the other in a continuing loop. Haley describes complementary relationships when two people engage in two different types of behavior that fit together (Reiter, 2014). The example Reiter offered was when one person was in a superior position and the other in a secondary and one offered criticism and the other accepted and one offers advice and other accepts it (p. 130).

Conjoint:
Involving two or more family members seen together in a therapy session.

Conjugal family:
Husband, wife, and children born into wedlock. "They bond together by legal bonds, economic, religious, and other rights, often a network of sexual rights and prohibitions and varying feelings of love, affection, respect, and awe" (Levi-Strauss, 1966, p. 266).

Cotherapy:
The simultaneous involvement of two therapists, often for training purposes, in working with an individual, couple, or family.

Cybernetics:
The study of methods of feedback control within a system, especially the flow of information through feedback loops.

Detriangulate:
The process of withdrawing from a family role of buffer or go-between with one's parents, so as to not be drawn into alliances with one against another.

Differentiation of self:
The separation of one's intellectual and emotional functioning; the greater the distinction, the better one is able to resist being overwhelmed by the emotional reactivity of his or her family, and is thus less prone to dysfunction.

Disengagement:
A family organization with rigid boundaries, in which members are isolated and feel unconnected to each other, each functioning separately and autonomously and without involvement in the day-to-day transactions within the family.

Double-bind concept:
The view that an individual who receives an important contradictory message about which he or she is unable to comment, is in an impossible situation; if this message is repeated over time, the individual may respond in kind and/or show signs of schizophrenia.

Dysfunctional:
Abnormal or impaired in the ability to accommodate to or cope with stress.

Dysfunctional family:
A family unit where members are not able to meet their own or member needs.

Enmeshment:
A family organization in which boundaries between members are blurred and members are over-concerned and over-involved in each other's lives, making autonomy impossible.

Extended family:
Two or more nuclear families formed by adding the families of married children.

Family of origin:
The family of birth or at least raised from infancy and where one acquired his or her initial value system and rules for conduct.

Family sculpting:
A physical arrangement of the members of a family in space, with the placement of each person determined by an individual family member acting as "director." The resulting tableau represents that person's symbolic view of family relationships.

First-order changes:
Changes within a system that do not alter the basic organization of the system itself. These changes are solution attempts that are within the existing rule structure of the family (Reiter, 2014).

Flawed relationship:
Each individual is viewed as a representative of the family system. Relationships are flawed between members or dyads within a family. Treatment efforts by therapists are to alter the transactional patterns, which have become flawed.

Genogram:
A schematic diagram of a family's relationship system, in the form of a genetic tree, usually including at least three generations, used in particular by Bowen and his followers to trace recurring behavior patterns within the family.

Homeostasis:
A dynamic state of balance or equilibrium in a system, or a tendency toward achieving and maintaining such a state in an effort to ensure a stable environment. A state that is always threatened by external and internal stresses.

Identified patient:
The family member with the presenting symptom; thus, the person who initially seeks treatment or for whom treatment is sought.

Joining:
Engaging the family in a respectful manner by demonstrating respect and understanding (Srebalus & Brown, 2001).

Linear causality:
Linear causality addresses problems described as one event causing the next. An example: When Mark joined the high-school football team Dad seemed to think I should take over Mark's responsibilities. Thus, Mark caused the problem by joining the football team.

Marriage:
Two subsystems, each of which bring a set of rules, expectations, and ways of living to a commitment (union) and become reconciled to order the couple's life together.

Nuclear family:
A family composed of a husband, wife, and their offspring, living together as a family unit.

Redundancy principle:
This is the notion that a behavioral pattern repeats itself in each marriage. That is, one begins to act and behave as his or her parents did in their relationships. These patterns can be with divorce, severe punishment, inability to sustain relationships, and even withdrawal (conflict).

Scapegoat:
A family member, likely to be the identified patient, cast in the role that exposes him or her to criticism, blame, punishment, or scorn.

Second-order-changes:
Fundamental changes in a system's organization and function. Second-order changes are with rules in the system (Reiter, 2014).

Skewed marriage:
A weak partner allows the stronger partner to dominate. A schism exists.

Stepfamily:
A linked family system created by the marriage of two persons, one or both of whom has been previously married, in which one or more children from the earlier marriage(s) live with the remarried couple.

Symbiosis:
An intense attachment between two or more individuals, such as a mother and child, to the extent that the boundary between them becomes blurred, and they respond as one.

Triad:
A three-person relationship.

Triangulation:
A process in which each parent demands that a child ally with him or her against the other parent during parental conflict.

## Couples Counseling

Counselors frequently encounter couples in therapy. They may be a high-school couple who found it difficult to share their selves with others, one or both are overly possessive of the other (controlling), jealous, experiencing non-acceptance by the other's parents. Other issues may be interracial dating/marriage, religious differences, sexual inadequacies/promiscuity, risky sexual behavior (for example unprotected sex), experimentation, or a myriad of concerns. These same concerns are relevant with married couples, those contemplating a second relationship, or for couples who have been married for many years. If there are grown children and they have departed the home, the couple may be experiencing readjustment concerns from communication, to being overly needy, loss of purpose, or other dynamics not previously experienced. Aging couples continue to experience loss of friends, mobility limitations, decreasing body functioning, communication breakdown, medication, depression, loss of memory, and a lack of patience, to name a few. Needless to say, some form of mediation, consultation, and/or counseling is being requested. Once again, the counselor has a decision based upon the problem assessment as to competence. Does the counselor counsel the couple, one of them, counsel with both of them but separately, refer one spouse yet periodically conduct a joint session, or even suggest group counseling for the couple? Landis and Landis (1948) suggest that there are six key areas of marital adjustment.

They are:

1. sexual relationships
2. spending family income
3. social activities
4. in-law relationships
5. religious activities
6. mutual friends

Even though Landis and Landis (1948) is an old source, these key areas remain common concerns shared in therapy by couples today. Other issues, which often surface, have to do with pride, conflicting cultural definitions (class differences, culture change, and culture conflict), and social roles. Social roles include: wife and mother, companion, partner, worker, and so forth. Landis and Landis found sexual relationships to require the most time for adjustment in a married relationship.

During the intake process, a thorough assessment should take place to discern sexual problem areas for the couple entering counseling (Gurman & Kriskern, 1991). Sexual dysfunction in a relationship can be seen as a symptom of a troubled relationship or as a problem itself requiring medical as well as psychological intervention. As a counselor working with couples who come to therapy experiencing problems related to sexual functioning, it is important for the counselor(s) to rule out medical

problems. A referral to a medical physician may be necessary or at least beneficial. Furthermore, it is important to rule out physiological causes if sexual problems exist in a relationship. Masters and Johnson, pioneers in the area of sex therapy, made tremendous advances in the treatment of sexual problems and couples therapy. The Masters and Johnson Institute in St. Louis offers treatment to couples experiencing sexual problems. This treatment program relies heavily on behavioral techniques (Goldenberg & Goldenberg, 1991). According to Masters and Johnson, a primary reason for sexual dysfunction is that the participant is critically watching (this is referred to as "spectatoring") his or her own sexual performance instead of abandoning himself or herself to the giving and receiving of erotic pleasure with a partner. Masters and Johnson point out that in order "to enjoy fully what is occurring, partners must suspend all such distracting thoughts or anxieties about being evaluated (or evaluating oneself) for sexual performance" (as cited in Goldenberg & Goldenberg, 1991, p. 236).

In conclusion, family and couples counseling is often the context for sex therapy: When counseling couples in this area, it is crucial that counselor(s) make a thorough assessment of all presenting concerns and that any medical problems be ruled out as causal factors. Furthermore, a referral may be a necessary step in assessing a couple's difficulties in the area of sexual relations.

**Question 5-36:**

A family of four has been referred to a counseling agency. The parents' presenting concern is the well-being of their adolescent daughter who is failing in school. The family composition is a father, stepmother, nine-year-old daughter, and 16-year-old daughter. First, one of the co-therapists completes a genogram. During this process it becomes evident that there are no clear boundaries between family members and that the father allies with his daughter whenever there is conflict with his wife. In this stepfamily, who is most likely the scapegoat?

a. father
b. stepmother
c. children
d. none of the above

Answer: d. none of the above. A scapegoat is a family member who is subjected to the role of criticism, blame, or scorn. In the family described above, it is the adolescent daughter's trouble in school that has brought the family to counseling. Therefore, it is only the 16-year-old daughter who may be considered the scapegoat.

**Question 5-37:**

A male senior-high-school student was referred to the community counseling center for counseling. The counselor indicated to the counseling center upon referral that two different classroom instructors reported that this student appeared to be panic-stricken when speaking in class. Although the student was rarely called upon he would raise his hand to speak and then begin to swallow, finding it difficult to speak. One day it became so unbearable he broke down and cried during one of these episodes. The parents, when contacted by the school and counseling center, signed a release-of-information form and were provided the client-rights form. This form indicated that the center might find it necessary at times to give personality tests. In this case, the counselor decided to administer a

personality test often administered to determine if a referral would be necessary or if a personality disorder might exist. When this became known, the parents immediately called the counseling center demanding to see the test results. The appropriate action by the center or counselor is to:

a. provide the results as requested.
b. inform the parents the counselor is not able to release the test results because in doing so would violate the rights of the youth.
c. inform the parents the counselor will do so only after he/she has notified the client (student) that his parents desire the results.
d. immediately destroy the results, as test results are only good at the time they were administered.

Answer: From the available options, c. is the best choice.

The Buckley Amendment provides for the right of parents to review the records. Informing the client conveys respect and allows the counselor to prepare the client for any concerns he might express. Hopefully, this would have been taken care of at the time the discussion was held with the student and parents. Be sure you are aware of the agency policies regarding testing and release of information.

**Question 5-38:**
A family of four self-referred because the parents felt that they may have caused some type of harm to their five-year-old boy who has been striking matches, hurting the family pets, and often is found awakening the newborn baby. He is doing this with sharp objects and pinching, causing the baby pain and crying. The counselor might consider which of the following to address the stated concern:

a. counsel the entire family
b. counsel and observe the five-year-old, even though the counselor is not especially trained in very young children
c. refer the family to a family group therapy
d. refer the boy for assessment and play therapy

Answer: d. refer the boy for assessment and play therapy

The immediate concern is to discern the seriousness of the problem. If harmful acts have indeed been committed, referral for assessment is warranted. If the assessment warrants sibling rivalry, play therapy might be the choice. In either case, continued therapy with the parents to provide reassurance, parenting skills, developmental counseling, and adjustment is suggested.

**Question 5-39:**
A couple was referred by their clergy for marital counseling. The stated concern quickly expanded beyond a lack of patience for each other to spending little time together and examples of blaming (selfish behaviors). The female began to state that they feel put out by the demands being placed upon them by the husband's siblings. It seems that the husband will not stand up to his brothers and demand that they take equal responsibility in caring for their parents. The parents call the husband

frequently because he will drop whatever he is doing and respond to their call. Although this is greatly appreciated by all except his wife, it has caused friction and a lack of intimacy to the point they have neglected to respond to each other with hugs, holding hands, and kisses. The counselor's best course of action would be to:

a. counsel this couple in intimacy issues and refer them for intergenerational issues.
b. request the parents for counseling with this couple.
c. counsel the parents for independent living.
d. request the brothers and spouses meet with this couple for communication issues and clarification of direction.

Answer: d. request the brothers and spouses meet with the couple for communication issues and clarification of direction. After a session or two, when it is determined this is the central issue, bringing all parties together will determine if the parents are in need and if shared help is required. The mediation will serve to put all the issues on the surface and facilitate problem-solving.

# OBJECTIVE 5F: Consultation

Consultation in the ACA Code of Ethics (2014) is covered in Section D.2.: competency (D.2.a.) and consent (D.2.b.).

## History of Consultation

The history of consultation is rather thin, dating back to clinical consultation by physicians. Brown, Pryzwansky, and Schulte (1991) describe the history emanating from two sources. The first was a concern for making mental health services effective and efficient. The second concern was to enhance the functioning of organizations. Caplan was one of the early pioneers in the movement and recognized the need for consultation. He advocated the need for interpersonal skills to achieve effectiveness.

During the 1950s Kurt Lewin's field theory made a significant impact on the recognition of the need for such a service. It stimulated the human relations aspect of consultation. There is some criticism toward a lack of theory for consultation. However, Gallessich (as cited in Brown, et al., 1991) points out that clinical models grew out of medical practice, while mental-health, behavioral, and organizational models are also lacking in theory. She does indicate that some models are based upon individual psychology, operant learning, and social learning theory. All models are aimed at some sort of intervention. According to an intervention model by Morrill, Oetting, and Hurst (as cited in Brown, et al.,1991) the basic aim is to identify a target, the purpose of an intervention, and a method of intervention.

## Definition of Consultation

Dustin and Ehly (1984) define consultation occurring when a professional helper (consultant) works with a second party (consultee), to help the consultee solve a problem that concerns a third party (client). It is triadic in nature because it provides indirect help to a third party. The relationship between the consultant and the consultee is egalitarian and can be characterized by "openness, warmth, genuineness, and empathy since authentic communication is essential to the success of the enterprise" (Brown, et al., 1991, p. 6).

Collaboration is a term closely linked with consultation. Brown, et al. (1991) defines collaboration as a shared role between the consultant and consultee in objective development, defining the problem, intervention planning, implementation, and evaluation.

Dustin and Ehly's (1984) model of consultation is a stage model composed of the following stages:

1. Phasing in: relationship building reentry, listening, self-disclosure, empathy
2. Problem identification: focusing skills, setting goals, commitment
3. Implementation: feedback, resistance dealing
4. Evaluation: risk-taking, persistence
5. Termination: feedback

## Consultation versus Counseling

The natures of counseling and consultation are different. Counseling is a "direct relationship in which the aim is to alter the behavior of the person/client receiving the service" (Brown, et al., 1993, p. 7). Consultation is an indirect service; the consultant indirectly assists the client through the consultee. Consultation is triadic; often the client not physically present, while counseling is direct with the client. Frequently, consultation is directed at the hidden client while counseling is directed at the client. The consultant may not have direct contact with the client while a counselor does (Newman, 1993).

## Ethical Issues in Consultation

Newman (1993) outlines four aspects of consultation which are potentials for ethical decision-making. These four are relationship issues, values in consultation, competence, and intervention.

## Target Populations

1. individuals
2. groups
3. organizations
4. communities

## Purposes of Consultant Intervention

Primary: This type of intervention is proactive. The aim is to enhance the mental health of some group, which is assumed to have positive mental health.

Secondary: This type of intervention is designed to identify and treat the condition before it becomes serious. Early identification is a common goal of secondary intervention.

Tertiary: This type of intervention is concerned about reducing the debilitating mental-health problems

### Methods of Consultation

1. Direct: Face-to-face such as teaching, supervision, counseling
2. Consultation: Includes a variety of approaches
3. Informational: Media, TV, radio, books, etc.

## Locus of Consultant

# Internal Consultant vs. External Consultant

It is believed that the internal consultant often has less status, is restricted to his/her role definitions, and finds it difficult to be objective. There are also some advantages such as familiarity, knowledge of power structure, and resources not available to an external consultant.

## Types of Consultants

1. Client-centered: Focus is on consultee's management of a particular client; prescriptive.
2. Program-centered: Focus is to serve as an expert in mental health administration and provides recommendations.
3. Consultee-centered : Focus is on program development and administrative administration with focus on increasing consultee effectiveness.

## Types of Consultation

1. Mental-health Consultation: Gerald Caplan has developed the most influential model of consultation, often referred to as mental-health consultation. Caplan defines consultation as a "voluntary, nonhierarchical relationship between two professionals who are often of two different occupational groups" (Brown, et al., 1995, p. 6).

Caplan (as cited in Brown et al., 1995) suggests that the consultant and consultee are experts in a nonhierarchical relationship. He describes his consultants as those who attempt to help the consultees do what they already know.

Theme interference is one aspect of Caplan's model that is unique to him. It is a view held by the consultee that the situation is hopeless. He makes several false starts and confirms his view.

Caplan identifies two goals for intervention: first, improve the functioning of the consultee, and second, develop skills of the consultee for present and future use.

2. Behavioral Consultation: Bergin (as cited in Brown, et al., 1995)) defines behavioral consultation as a problem-solving endeavor that occurs within a behavioral framework. It is based upon behavioral change and scientific methods. The premise is that all behavior is learned. The consultation and intervention are through a relationship and behavioral orientation services are provided to a client through the mediation of important others in that client's environment.

   For the most part, this is an indirect service. The client is the focus so that the client is able to use indirect services and rely on behavioral principles to design, implement, and assess the consultative interventions. The major learning principle is operant and it is a rigidly theory-bound model of consultation: indirect problem solving where the consultant acquires and communicates psychological data. Verbal structuring is a primary technique. The major role is to provide psychological information and principles to the consultee.

3. School Consultation: School consultation is defined by Dettmer, Thurston, and Dyck (1993) as "an activity in which professional educators and parents collaborate within the school context by communicating, cooperating, and coordinating their efforts as a team to serve the learning and behavioral needs of students" (p. 14).

   School consultation is beneficial in many ways. It helps the classroom teacher effectively and efficiently handle the variety of student needs. Miller and Sabatino (as cited in Dettmer, et al., 1993) state that students whose teachers are consultees benefit academically.

**Question 5-40:**
An intervention is being considered for a particular company, which is experiencing many workers complaining of being stressed out. The workers have had an unusual number of sick days, requests for vacations, health problems such as high blood pressure, and conflicts with other employees. The manager is considering bringing in a consultant and should consider which type of intervention?

a. primary
b. secondary
c. tertiary
d. entry

Answer: c. tertiary. The focus is on those already disabled.

## Volunteer Agencies for Crises Response

The Federal Emergency Management Agency (FEMA) was developed when several agencies came together to form the National Volunteer Organization Active in Disaster (NVOAD). NOVAD is made up of the American Red Cross, The National Organization of Victims Assistance, (NOVA) among others. Several national disasters have taken place recently, such as tornadoes, floods, tsunami, earthquakes, bombings, and other catastrophic incidents where many individuals are involved in a trauma.

# OBJECTIVE 5G: Crisis and Trauma Intervention

In recent years there have been a number of crises with a sufficient magnitude of trauma and death such as 9-11, Hurricanes Katrina and Sandy, bombings and a number of sweeping tornadoes causing deaths and financial trauma to many. Countless numbers of tragedies stemming from fire, water, wind, and earthquakes have called for major responses from the federal and state governments and local safety personnel. In addition, first responders and debriefing counselors have been deployed to sites in which major disasters have taken place. Responses to victims of these disasters first gained attention with the Coconut Grove fire. The Coconut Grove fire is the critical point at which Dr. Lindeman made the observation that many of the victims of the fire had common emotional responses and needs (Lindeman, 1944). Gerald Caplan was involved with the survivors and is credited with shaping crisis theory today. He described a crisis as when a person experiences an event that is greater than the customary problem solving methods. He proposed that there was a time of disorganization where several attempts are made to solve or respond to the situation. Parad and Caplan (1960) identified five elements of a crisis for a family. These five are:

1. A problem is encountered in which the solution is considered insolvable.
2. The problem over-taxes the psychological resources.
3. The problem or situation is viewed as a threat or danger to life goals.
4. The crisis mounts to a peak and then falls.
5. Crisis awakens past and present unresolved key problems.

A crisis is the interpretation that a person makes of an event or situation that he or she judges as being insurmountable and beyond the scope of his or her resources and coping mechanisms (Gilliland & James, 1988). James and Gilliland (2001) describe six different authors' definitions of crisis. A summary of those definitions describes a crisis as "a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3). A crisis is the interaction of the stressful event and the personal resources of the client that determines his or her reaction to the crisis and if unresolved will likely affect affective, behavioral, and cognitive functioning. Gladding (2001) defines crisis counseling as "a special type of counseling that is often directive in nature and that focuses on helping a client find ways to respond productively and constructively in the midst of a chaotically urgent or acute emotionally disturbing situation" (p. 33). The goal of crisis counseling is to help the person in crisis find new ways to cope, relate, or solve problems (Moursund, 1985). Resources in the person's own social and work environment should be

mobilized so that the client can continue coping on his or her own, apart from the therapist (Moursund, 1985). An acute crisis is considered to last no more than six to eight weeks (Janosik, 1984). A final crisis definition by Cavaiola and Colford (2006) is a "predictable or unpredictable life event that an individual perceives stressful to the extent that normal coping mechanisms are insufficient" (p. 3).

Lindemann (1956) was one of the first researchers to study grief and bereavement. The Coconut Grove Nightclub fire was his major study in which he researched the bereavement reaction of the survivors. His work focused on a normal grief reaction and was later applied to crisis theory. These stages of grief were: preoccupation with the loss, identification with the lost one, expressions of guilt and hostility, some disorganization in daily routine, and some evidence of somatic complaints (Janosik, 1984). Lindemann approached the resolution of grief through equilibrium and disequilibrium. From his work has evolved crisis-intervention techniques.

## Three Levels of Crisis

Situational: A sudden change in the environment; loss of a loved one, loss of finances, job, home, etc.

Intrapsychic: A conflict between the ego and superego; a crisis that challenges the deepest values, etc.

Disintegration of the ego: Psychosis, ego-fragmenting drug crisis induced by a hallucinogenic drug, etc.

Two-Levels of Crisis: Collins and Collins (2005) suggest two levels of crisis, that of situational and developmental.

Situational: When there is a clear external precipitating event. There is a sudden onset, and an unexpectedness calling for an emergency.

"A developmental crisis is when a person is overwhelmed, unable to cope, and/or unable to function adaptively in response to expected stressors and potential conflicts" (Collins & Collins, 2005, p. 7).

Aguilera and Messick (1982) view a crisis as a time of danger and opportunity. Individuals tend to react in one of three ways. Depending upon his/her coping skills he or she can cope with the crisis and move forward. A second reaction is to survive the crisis but to close off awareness of the hurtful effect and revisit elements of the crisis at different times of his or her life. A third group of individuals psychologically are at the mercy of the crisis and appear incapable of moving forward without assistance (James & Gilliland, 2001).

## Crisis Theory

It is important for counselors to understand crisis theory, so that they don't get taken in by the overwhelming confusion and disorganization that clients are experiencing. The key, according to Moursund and Kenny (2002) and Moursund (1985), is to move quickly and decisively during the acute phase of crisis. The counselor should respond to the client within the first 24 hours of the crisis. Treatment should be relatively direct and short (three to six sessions) with emphasis on direct

problem-solving skills (Moursund, 1985). The goal is to help the client regain his/her previous level of functioning. According to Brammer (1985) crisis theory has three components: normal development crises, situational crises, and existential crises. James and Gilliland (2001) added a fourth: environmental crises.

A normal developmental crisis occurs in the normal developmental aspects of human growth and development. Examples given by James and Gilliland might be a birth, graduation, and retirement. Situational crises are typically unforeseen events such as an assault, illness, breaking and entering of one's domicile, and being fired. Existential crises can be identity confusion during the adolescent years and at other times a loss of meaning in life. Environmental crises are natural or human-caused, which affects all members of a community or nation. These can be disasters or fears of an impending disaster, such as another Washington sniper, 9/11, and another outbreak of anthrax mailings.

Gilliland and James (2001) provide an outline of steps in working with a client in crisis. This outline is to:

1. define the problem
2. ensure client safety
3. provide support
4. examine alternatives
5. make plans
6. obtain a commitment from the client

## Crisis Theory Models

There are a number of crisis theories such as psychoanalytic, systems, adaptation, interpersonal, chaos, and, most recently, another by James and Gilliland (2001), the ecosystem theory.

For purposes of this review and preparation crisis theory will be approached indirectly by studying how the person experiences the crisis.

Equilibrium: A person experiencing a crisis is in a state of disequilibrium in which his/her usual problem-solving skills and coping skills are failing to work. This model appears to be most appropriate for early intervention. The goal of crisis counseling is to restore the pre-crisis equilibrium (Gilliland & James, 1988; James & Gilliland, 2001).

Cognitive Crises: Cognitive crises are based on faulty thinking and cognitive distortions concerning the events or the situations involved. The goal is to help the client become aware of these distortions and adopt more adaptive ways of thinking and acting (Gilliland & James, 1988; James & Gilliland, 2001). This model is most appropriate for the time after the crisis.

Psychosocial Transition: The client is a product of his or her heredity and environment (genes-learning). The goal of counseling is to assess both internal and external difficulties contributing to the crisis, determine workable alternatives to current behaviors, and utilize environmental resources

(Gilliland & James, 1988; James & Gilliland, 2001). This model is most appropriate for the time after the crisis.

## Six Steps in Crisis Intervention

The first three steps are listening activities and the last three are action activities (Gilliland & James, 1988; James & Gilliland, 2001).

1. Define the Problem: The client tells his or her story. The counselor must learn what has happened, who was involved, what is the greatest pressure at the moment, and what solution is expected. The counselor begins to build a relationship and models coping skills as the problem is sorted through and broken down into manageable segments (Moursund, 1985). It is also important to assess the client's resources during this phase. This includes situational support (i.e., significant people, work, activities, and finances) as well as personal coping skills (i.e., positive and constructive thinking patterns, verbal skills, psychological health, etc.).
2. Ensure Safety: Minimize the physical, emotional, and psychological danger to the self and others. Be clear with the client about the limits of confidentiality. The counselor may need to take steps to ensure the safety of the client or others by talking to people in the client's support system (Moursund, 1985).
3. Provide Support: Acknowledge and validate emotional responses to the crisis. Guilt, confusion, loss, longing, and anxiety are very common emotions that are experienced. Counselors should communicate caring and empathy.
4. Examine Alternatives: Problem-solving skills are utilized to help the client see that many alternatives are available. The counselor interrupts destructive thinking and focuses on what can be achieved. It is also important to assess what the client has already tried to do to remedy the situation. This will help the counselor determine the client's problem-solving skills (Moursund, 1985).
5. Make Plans: Giving advice may be appropriate as the client formulates a plan of action. The central goal in planning, however, is to give control and autonomy back to the client.
6. Make a Commitment: A contract provides the client with a sense of direction and a sense of hope that he or she can take positive action to deal with a crisis. A contract spells out the client's responsibility and helps him or her resume control over his or her life. With a contract, the client leaves the counseling session knowing what to do next (Moursund, 1985; Moursund & Kenny, 2002). This contract should emphasize what the client can do and is referred to as response-ability.

## Types of Crises

There are many types of crises or traumas. The intensity and destruction of crises will vary from war, hurricane, floods, fires, to an individual teenager's thoughts of being pregnant, suicide ideation and attempt, to an adult who because of an impending divorce feels can no longer respond to the

situation or continue with life. Shallcross (2013) pointed out the need for first responders to receive resiliency training, learn how people experience stress and to work with an experienced crisis team. It is also important to realize that first responders can also experience the trauma as a part of working in the disaster environment.

The crisis in context theory composed of microsystem, mesosystem, exosystem, macrosystem and chronosystem and is a basic foundation of the work of Bronfenbrenner's (1994, 1995). Crises concept is explained by three principles: individual, system, and community and in layers (Myers & Moore, 2006). The layers are considered as they are in proximity to one another. The three premises are layers of a crisis, reciprocal effect, and time factors.

1. Individuals and systems experience the impact of crises in layers. The layers are dependent on two elements: (a) physical proximity to the disaster with respect to physical distance and (b) reactions that are moderated by the perceptions and meanings attributed to the crisis event (p. 141).
2. An understanding of the impact of crises takes into account that a reciprocal effect occurs among individuals and systems affected by the event. Understanding the reciprocal effect involves recognition of two elements: (a) the interactions among the primary and secondary relationships and (b) the degree of change triggered by an event.
3. Time directly influences the impact of crises. Two elements of time are (a) the amount of time that has passed since the event and (b) special occasions such as anniversary dates and holidays following the event (pp. 141-143).

The resulting meaning of the three premises is to recognize that the level of crises, reciprocal effect, and time factor provide the impact of a crisis. The result is not to predict the severity rather to isolate the factors for response.

## Suicidal Client

Suicide theory may best be understood by studying four theoretical models (Laux, 2002). These models are:

1. Overlap Model (Blumenthal & Kufer, 1986)-greater the overlap in domains the greater the risk of suicide
2. Three-element Model (Jacobs, Brewer, & Klein-Benham, 1999)-predisposing factors, family history, social environment, personality, life situation and availability of means.
3. Suicide Trajectory Model (Stillion, McDowell, & May, 1989)-interactive influences of risk factors
4. Cubic Model (Shneidman, 1987)-that people have reached a point of hopelessness and suicide is the only exit.

Each of these models identifies risk factors, predisposing factors, family history, social environment, personality, life situations, suicide methods, and response by a professional.

The dynamics of suicide are explained both from a psychodynamic and sociological approach. The psychodynamic approach is to view suicide as triggered by an intrapsychic conflict when under psychological stress. Durkheim explains the sociological approach to suicide as a reaction to societal pressures and influences (as cited in Gilliland & James, 1993). Durkheim identifies three types of suicide: egoistic, anomic, and altruistic.

Suicide attempts or successful acts may be the most numerous crises. Counselors should know the myths of suicide. Collins and Collins (2005) list a few of those myths considered to be false:

1. Those who talk of suicide are not going to commit suicide and desire attention.
2. Impulsive acts of suicide are rare.
3. If a person survives suicide, the person will not make a second attempt.
4. Attempting suicide is genetic.
5. A person is mentally ill if attempting suicide.
6. Talking about suicide gives the person the idea.

## Risk Factors

Some types of risk factors associated with suicide:

1. past history of gestures or previous attempts
2. family history of suicide
3. involved drug or alcohol use
4. history of psychiatric disorder
5. history of severe trauma
6. isolation from others
7. radical shifts in behavior or mood
8. expression of hopelessness or helplessness
9. chronic medical illness
10. suicidal ideation or a plan and means
11. living alone or divorced
12. relationship instability
13. poor support system
14. childhood trauma
15. physical illness
16. financial stress

In summary, warning signs include changes in behavior and personality, recent family changes, recent loss or loses, suicide statements or acts, difficulty concentrating, preoccupation with death, withdrawing behaviors with silence.

## Therapist Tasks

Dacey and Travers (1994) recognize the warning signs of potential suicide to be:

1. a withdrawal or moodiness
2. accident proneness
3. change in eating or sleeping habits
4. other significant changes in usual behavior
5. talking about killing oneself
6. talking about "not being" or having any future
7. giving away prized possessions

Blumenthal and Kupfer (1986) indicate that risk signs are:

1. history of previous attempt
2. family history of suicidal behavior and/or affective disorders associated with substance abuse
3. associated with conduct disorders (impulsive disorders)
4. associated with affective disorders
5. precipitating humiliating events

Moursund (1985) recommends the following guidelines for counseling with the suicidal client:

1. take threats and attempts seriously
2. recognize ambivalence about living and ally with the healthier part that wants to live
3. some are depressed, but not all; may appear agitated, anxious, psychotic, organically impaired
4. most suicides involve another significant person in the client's life
5. ask directly about suicidal intent; this may minimize anxiety and act as a deterrent

Assess danger:

1. has a method been chosen?
2. is the method available?
3. how specific is the plan?
4. how lethal is the method?
5. a previous attempt is the best indicator of future attempts; the first three days after an unsuccessful attempt are the riskiest

Take action:

1. hospitalization is called for if in clear danger

2. psychiatric evaluation for medication and consultation
3. enlist help of the client's support network; know all potential community resources
4. discuss suicide and death and all of the ramifications with the client
5. make a "no suicide" contract with the client
6. utilize consultation and supervision when working with a client

In summary, Gutheil and Applebaum (2000) suggest that while conducting an interview the counselor should determine the following:

1. presence of severe depression or the lifting of a depression
2. presence of a psychosis (with hallucinations to commit suicide)
3. history of substance abuse and poor impulse control
4. loss of a loved one, job, residence, or academic or social standing
5. history of marginal adaptations and few accomplishments or recognition
6. lack or presence of social support and living in a hostile environment
7. thoughts and fantasies with destructive content (revenge and "resting in peace")

All of these conditions should be elements of the interview in addition to determining suicide intent, specific plan, means to commit the suicide, and previous attempts.

Blumenthal and Kupfer (1986) suggest five components to be a part of a treatment strategy. The five components are: psychiatric diagnosis; personality factors; psychosocial factors, life events and chronic medical illnesses; family history/genetics; and biological factors.

## Rape and Sexual Assaults

The literature suggests that rape and sexual assault are used interchangeably (Collins & Collins, 2005). Rape may be date rape and marital rape. Groth, Burgess, and Holmstrom (1977) identified rape as power rape, anger rape, and sadistic rape. The motives of the perpetrator in meeting psychopathological desires are often the means to identify one of the three. Scully and Moralla (1985) list a number of other types of rape and respective definitions.

1. A rape victim is not like other victims, but a person who has suffered a unique trauma.
2. Post-counseling is divided into three time periods: hours after, weeks after, and long-range.
3. Provide the assaulted victim with objective information of what to expect from police, examination, and family.

## Psychological First Aid During and Post-Disaster

Responses may be different if the responder is present or immediately after the disaster or the first aid is post disaster. The 2000 Disaster Mental Health Handbook has a detailed set of offering and

guidelines that includes types of disasters, normal reactive processes, stressors, risk factors, mental health outcomes (acute stress disorder, PTSD, depression, bereavement, health outcomes, and natural versus human-made responses) and special populations (NSW Health, 2000). The psychological responder is to be conscious of safety needs and is capable of reassuring responses, counseling for assessment, and aware of mental health complication such as those issues associated with loss such as acute stress reaction and PTSD. The manual suggests techniques that have been helpful for different mental health conditions.

Singh and Raphael (1981) suggested that practical help may be seen as more helpful than psychological care. Although the role of first responders is to assist in establishing safety, food and water, and accommodations, psychological first aid is very important. Psychological care or first aid is the social provision of physical care dealing with the fear and loss of family members, belongings, sense of stability, and the future.

Immediate responses to a disaster include psychological first aid, provision of information, triage, debriefing, supportive counseling, and convergence.

Psychological first aid is to offer support, reassurance, comforting and calm communication and a physical presence. The emotional well-being through psychological first aid includes basic human responses of comforting and consoling. Raphael (1993) likens these tasks as conveying compassion and recognition for what the victims have gone through and presently experiencing. The Disaster Mental Health Handbook includes the following psychological first aid recommendations:

1. Protecting the person from further threat or distress as is possible
2. Furnishing immediate care for physical necessities, including shelter
3. Providing goal orientation and support for specific reality-based tasks
4. Facilitating reunion with loved ones from whom the individual has been separated
5. Sharing the experience
6. Linking the person to systems of support and sources of help that will be ongoing
7. Facilitating the beginning of some sense of mastery.
8. Identifying needs for further counseling or intervention

# Unit 5 - Terms

ABREACTION:
Abreaction is an expression of pent-up feelings. An abreaction usually occurs after recalling a painful experience (trauma) that has been repressed. This term is sometimes referred to as catharsis.

BASIC ID:
Conceptual framework of multimodal therapy (Arnold Lazarus) that assesses the individual's functioning in seven major areas: behavior (B), affective response (A), sensations (S), images (I),

cognitions (C), interpersonal relationships (I), and drugs/ biological functions (D). A cognitive-behavioral theory.

BIBLIOTHERAPY:
A form of therapy where the client is instructed to read material relevant to his/her talk therapy. Bibliotherapy is a supplement to therapy and is intended to engender hope, a form to identify and to help provide meaning in the client's life (Peterson & Nisenholz, 1995).

BRIEF THERAPY:
Brief therapy is sometimes referred to as time-limited therapy. A limited number of goals and sessions are set. The aim of therapy is to help the client develop coping skills so he/she will be capable of anticipating and managing any future encounters or problems. History is given very little attention and time is spent on present circumstances, teaching skills, and reinforcing practicing new behavior.

CATHARSIS:
Recalling and reliving of earlier painful experiences. A cathartic experience is a ventilation of feelings. It can be helpful or harmful, depending on the functionality of the therapist and the coping skills of the client.

COGNITIVE RESTRUCTURING:
"A process of actively changing maladaptive thoughts into constructive thoughts. The client is taught to identify, evaluate, and change self-defeating or irrational thoughts which negatively influence his/her behavior" (Gladding, 1996, p. 274). Used in cognitive and cognitive-behavioral therapies.

COMPENSATION:
A process of overcoming feelings of inferiority. Compensation is a defense mechanism in which one tries to cover up a deficiency. To compensate is to make up for this inferiority through a fanciful one. The individual strives to excel to make up for the deficiency. Alfred Adler used the term "over-compensation" to describe how a person attempts to deal with a failure identity.

CONSTRUCTIVISM:
Constructivists believe that an individual cannot know or attain under any circumstances reality knowledge that is objective or independent of the knower (Held, 1995). Reality is developed or constructed inside the person and based upon the culture, language, or theory applied to a particular phenomenon (Prochaska & Norcross, 1999). Empiricism is an opposing thought that is reality and can be discovered if correct scientific methods are utilized.

CONTROL THEORY:
Control theory states that behavior is internally motivated toward controlling the environment so as to achieve some purpose or fulfill some psychological need, such as belonging, power, freedom, and fun. Glasser added control theory to Reality Therapy in the 1980s (Corey, 1986).

COUNTER-TRANSFERENCE:
Counter-transference is a feeling the therapist has toward the client that may interfere with objectivity. These feelings may result from the therapist's unresolved conflicts.

ECLECTICISM:
A theoretical orientation that involves choosing the particular psychological principles that are best suited to a particular problem and/or a particular client. The majority of therapists consider themselves to be eclectic. McBride and Martin (1990) developed a hierarchy of eclecticism levels. These are: syncretism (unsystematically connecting unrelated concepts); traditional (orderly combination from a variety of theories to form some degree of integration); theoretical integrationism (mastery of two theories before developing nay combinations); and technical eclecticism (procedures from different systems are selected and used in treatment).

EMPOWERMENT:
Wellins, Byham, and Wilson (1991) define empowerment as passing along authority and responsibility. To empower is to put onto another authority, control, and dominion. According to Johnson (1997) there are two ways to empower a person. Empowering is being open to negotiations and being flexible in the alternatives you like best. Empowering through choice reflects your willingness to consider that there are better ways to do things.

EVIDENCED BASED OUTCOME THERAPIES:
Sharf (2008) summarizes treatments or theories that have published data to support that client outcome have been positive and works for certain disorders. Examples are: Behavior therapy (depression, obsessive compulsive disorder, general anxiety disorder, phobic disorder, and posttraumatic stress disorder), Cognitive therapy (depression, anxiety, substance abuse) and interpersonal therapy (depression).

FEMINIST THERAPY:
Brown's (1994) definition for feminist therapy or philosophy is based on a collection of philosophies as a transformation of patriarchical and inequalities through radical social change. Androgyny was an early formation of feminist therapies. Liberal feminism became an off shoot of or evolutional change in radical feminism. According to this theory men and women are socialized differently. Major principles include the personal is political, commitment to social change, egalitarian relationships, honor women's experiences, recognize all types of oppression, and reformulated understandings of psychological distress (Capuzzi & Gross, 2003).

FIGURE/GROUND:
In Gestalt psychology, perception involves seeing an object (figure) against a field (background). The individual is focused on one-awareness (figure) at the time, and everything else becomes the ground. Often referred to as the front and back of awareness.

HAKOMI BODY-CENTERED THERAPY:
A therapy focusing on innate wholeness and interconnectedness (self-healing). Principles are more important than techniques. The principles are: unity, organicity, mindfulness, mind-body holism, truth, and mutability.

IATROGENESIS:
A condition that is created, aggravated, or induced by the therapist's attitude, examination, treatment, and/or comments (Edgerton & Campbell, 1994). The therapist prescribes risks or fails to inform clients

that they may be exposed to a part of themselves that may be dangerous or make them feel more relaxed.

IMPASSE:
Sense of being "stuck," experiencing threatening feelings, imagining something terrible will happen. In Gestalt therapy the layer of impasse is one in which the client is wondering how he or she is going to make it to the environment. What is lacking is a sense of direction, possible indecision, and a desire to flee.

INTEGRATIVE THERAPY:
Transtheoretical approach by Prochaska and Norcross is based on client readiness to change, type of problem needing change, and processes for techniques. The process focused on the five stages of change (precontemplative, contemplative, preparation, action, and maintenance), five levels of psychological problems (symptoms, maladaptive thoughts, interpersonal, family, and intrapersonal), and 10 processes of change (Sharf, 2008).

LIBIDO:
In psychoanalysis, the libido is the instinctual drive of the id that provides psychic energy.

LOGOTHERAPY:
Victor Frankl developed Logotherapy. It literally means, "healing through reason" and is an existential approach to therapy. The therapy focuses on the search for meaning.

MASCULINE PROTEST:
In Adlerian theory, masculine protest is a striving for power.

MORITA THERAPY:
Japan (Shoma Morita) developed a change theory initially for anxiety and obsession disorder. This theory was earlier referred to as experiential, natural, and awakening therapy (Kitanishi & Mori, 1995). This therapy does not concern itself with the past or reasons for the concern rather the focus is with the present. There was an emphasis on bed rest (in-home), family, and on (social obligation to family and society). The family (inner circle) is central to the work of the client and counselor. Amae is defined as love provided not sought. Three major constructs for this therapy are naturalism, collectivism, and family and Amae (Capuzzi & Gross, 2003).

NARCISSISM:
Narcissism is an extreme self-love; a grandiose and exaggerated sense of importance which conceals a poor self-concept.

NARRATIVE THERAPY:
Narrative therapy is a social constructivist approach emphasizing the belief that there is no objective social reality. Interaction with others is central to the change philosophy. Life is a series of stories and thinness and thickness refers to the qualities of those stories. Thicker and thicker is derived from telling the stories again and again. The process is listening to the story of the problem followed by alternatives to the problem with an alternate story created through focusing on unique outcomes. The client is asked if the alternate story is preferred. The final step in the process is to build a support group

for the new story. Beels (2001) identifies a critical term for narrative therapy to be externalizing (outside of the client).

NEGATIVE REINFORCEMENT:
Withdrawing an unpleasant stimulus when a desired behavior is performed. Result is increase in desired behavior.

PARAPROFESSIONAL:
A human service worker with some formal training in human relations skills, but he/she works as part of a team such as mental health technicians, child care workers, probation personnel, or youth counselors (Gladding, 1996).

PHENOMENOLOGY:
Reality is what the client sees as reality. The person's view of self, the self-concept is a major construct of this type of theory. Phenomenology is a method of exploration that focuses on the subjective world of the client. Adlerian, Person-centered, Cognitive, Gestalt, Existential, and Reality therapies are all phenomenological.

POSITIVE REINFORCEMENT:
Adding a positive consequence or reward when a desired behavior is performed. This act results in an increase in the behavior.

PUNISHMENT:
Punishment is an aversive consequence that follows an undesired behavior and serves to repress that behavior (examples: time out, response cost, restitution).

SECONDARY REINFORCERS:
Money, praise, love, blame, etc. Objects, events, or needs that have reinforcement value because of their association with primary reinforcers.

SELF-MONITORING:
Process of observing specific factors regarding oneself and how one interacts in the environment.

SOCIAL LEARNING THEORY:
Social Learning Theory states that behavior must be understood by considering the social context that impacts learning. Learning is acquired through observation and imitation. Albert Bandura is the key figure.

SOLUTION-FOCUSED THERAPY:
The counseling emphasis is on the strengths of the clients rather than on their weaknesses in order to resolve a problem. Change is looked upon with optimism and hope. Frequently solution-focused therapy does not promote analyzing the problem or investigating the presenting concern. The focus is on exceptions to the client problem behavior and the goal is for small changes. Solution-focused therapy is better adapted to those clients who cooperate and have the ability to solve their problems. People have the ability to construct solutions.

TRANSFERENCE:
According to Brammer and Shostrom (1977) a definition of transference is the projection of past or present feelings, attitudes, or desires by a client on the counselor. The term transference is not restricted to psychoanalysis and can be applied for several patterns expressed directly or indirectly.

UNFINISHED BUSINESS:
Unexpressed feelings from the past that interfere with effective psychological functioning in the present. The term is utilized in Gestalt therapy.

# Unit 5 - References


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# UNIT 6 - Group Work

## Introduction

The content of Unit Six focuses on the dynamics and process of group work. The latter part of this unit outlines several major group theorists and their respective theory of group work. For study, it is important to be able to differentiate among the theories and to understand the role of the leader and participants, various techniques and stages, and how group work is accomplished.

The majority of examination questions about groups have not been to question group theory. These theories appear to be so similar to individual counseling theories that those questions are found within the counseling theory section. The majority of group content material is directed at the specific dynamics and processes of group work, such as self-disclosure, cohesiveness, communication, interpersonal interactions, member roles, norms, stages, and leadership.

Those who have limited academic preparation in group work should acquaint themselves with ethical resources in applied group practice (ACA and ASGW Ethical codes and the standards for Training Leaders), the process of forming a group, group stages, leadership, and the appropriate action to be taken by a leader if certain member behaviors occur during a group. A good starting point is a clear definition of group, group guidance, group counseling, and group psychotherapy. There are approximately 20 group questions, of which 15 count toward your total score.

# CACREP Objectives

CACREP 2009 objectives for group counseling are not presented in full. Therefore, those preparing for the NCE may want to download from the CACREP website the full standard objectives.

These objectives are briefly outlined for the CACREP 2009 standards

A. principles of group dynamics-process, stage theories, group member roles, therapeutic factors
B. group leadership styles, characteristics
C. theories of group counseling, research and literature
D. group counseling methods, selection criteria and evaluate effectiveness
E. small group experience as participant for 10 hours

**Question 6-1: (Objective A.)**
When a group progresses from the initial stage to the transitional stage, which of the following is observed?

a. anxiety, defensiveness, resistance, and control struggles
b. cohesiveness
c. self-disclosure
d. control-taking

Answer: a. anxiety, defensiveness, resistance, and control struggles

**Question 6-2: (Objective A.)**
Self-disclosure is more frequent at which stage of group development?

a. initiating
b. transition
c. working
d. termination

Answer: c. working

**Question 6-3: (Objective A.)**
A member who is terminating from an ongoing or open group should do which of the following?

a. deal with his or her separation issues
b. close off the unfinished business because of lack of time
c. give feedback to the other members
d. announce ahead of time (sessions) of departure

Answer: d. announce ahead of time (sessions) of departure

**Question 6-4: (Objective A.)**
"Here and Now" reflective loop aims to achieve which goal?

a. to bring misunderstood communication back to the group for reinterpretation
b. to process through the phases or stages of group maturity and recycle the life of the group
c. to help the group members process their development and feedback
d. to enable responsible self-disclosure and feedback

Answer: d. to enable responsible self-disclosure and feedback

**Question 6-5: (Objective B.)**
Research in group work suggests that leaders who utilize structured exercises can expect which outcome?

a. a significant increase in depth of process involvement compared to non-structured leader groups
b. long-term outcome will be less effective than non-structured leader groups
c. the process outcomes will be most positive
d. the members will provide less feedback than those from non-structured groups

Answer: b. long-term outcome will be less effective than non-structured leader groups

**Question 6-6: (Objective B.)**
One type of group that can exceed 20 members and still function as a group is:

a. task.
b. encounter.
c. growth.
d. Balint

Answer: a. task

**Question 6-7: (Objective C.)**
The group theory that encourages spontaneity, creativity, present, encounter, and 'tele" is:

a. Person-centered.
b. Psychodrama.
c. Adlerian.
d. Psychoanalytic.

Answer: b. Psychodrama.

**Question 6-8: (Objective D.)**
The ethical code for growth group formation recommends a pre-interview. One reason for this ethical recommendation is to:

a. organize a group.

b. ensure all members know before group who the leader is and to reduce the power differential.

c. reduce any pre-group anxiety.

d. eliminate applicants who might possibly exhibit anti-group efforts.

Answer: d. eliminate applicants who might possibly exhibit anti-group efforts.

**Question 6-9: (Objective D.)**

The code of ethics for group counselors indicates that a group leader or members of a group are to respect the rights of each member of a group. Should a member elect not to talk, the members and leaders may be confused as to an appropriate action. Counselors are trained to involve members and also respect members. Leaders should be careful to avoid the use of:

a. techniques to bring the member out.

b. coercion to bring the member out.

c. a wait and see attitude.

d. non-verbal communication to bring the member out.

Answer: b. coercion to bring the member out.

**Question 10: (Objective D.)**

Which of the following is a primary consideration in developing a growth group?

a. interviewing all group members before the first session to explain goals of the group

b. keeping the group from becoming too large

c. ensuring that a trained, capable leader will be present

d. ensuring that each member feels accepted

Answer: a. interviewing all group members before the first session to explain goals of the group

**Question 6-11: (Objective E.)**

In 1992, the Association for Specialist in Group Work (ASGW) published the standards for group leaders. Two levels of training are required at the master level programming. The first level is a cognitive requirement of knowledge and skill acquisition. The second level for trainees is to specialize in one of four group work specializations. Which group specialization would emphasize interpersonal and interactive feedback, and support methods in the present?

a. facilitative

b. psychoeducation

c. counseling

d. psychotherapy

Answer: c. counseling (Conye & Wilson, 1998)

# Terms

Definitions for the following terms can be found at the end of this chapter.

Autocratic Leadership
Balint
Blocking
Boston Model
Capping
Charismatic Leader
Co-leadership
Conformity
Contagion
Critical Incidents
Dynamics
Emergent Norm Theory
Empowerment
Encounter
Entitativity (group
Farewell Party Syndrome
FIRO
Fishbowl
Group Mind
Group
Here and Now
Icebreaker
Leveling
Lewin, Kurt
Mandate Phenomenon
Mindlessness
Norms
Power
Premature Termination
Primary Group
Reingelmann Effect
Self-help group
Sociometry
T-group
Task group
University

# Group Work

ACA Code of Ethics regarding group work includes an emphasis for screening (A.9.a.), protecting clients (A.9.b.), and group work (B.4.a). The ASGW ethical code has coverage across the domain of group work practice and training.

The origin of group work has been attributed to a number of individuals. Early group work spearheaded by F. H. Allport centered on the study of competition and thought processes to determine whether performance is better alone or in groups. Organized group work after 1900 (although the leaders were not necessarily trained in the dynamics and process of effective groups) first appeared in schools. Jesse Davis and Charles Jacobs were credited with utilizing groups for curriculum requirements in the 1930s. Capuzzi and Gross (1992) credit Joseph Pratt as being the first to instigate psychotherapy groups in hospital settings. Pratt recognized the importance of the therapeutic value of groups with his tuberculosis patients as they became more interested in the other group members (patients). The small-group phenomenon originated with the work of Charles Cooley,

Gustave LeBon, and George Mead as they defined an intimacy that developed in a small group of individuals (Posthuma, 1996). Cooley believed that social process and social control were always found in face-to-face encounters. He called these types of groups primary groups. The psychological structure of the group was most important in understanding individuals. He believed that individuals were responsive to each other's feelings, actions, and opinions (Bonner, 1959). Cooley went on to write about group influence, group cohesion, and decision-making. Kurt Lewin in the late 1920s and early 1930s was influential in developing group dynamics (Lewin, 1944). Lewin and associates began to promote the use of groups as agents of change, a concept from which the present-day T-groups, encounter, and sensitivity groups evolved. According to Gazda (1989), Dr. Richard Allen in the 1930s coined the terms "group counseling" and "case conference."

## Brief History

For a brief history of group development and individual contributors, review Gladding (1995) and the section on history and models. Many names are omitted in this review; however, key individuals will be identified.

J. L. Moreno in 1936 coined the term "group psychotherapy." He is the founder of psychodrama and organized the first society for group therapists.

F. Parsons and J. Davis started group guidance. Jesse Davis, an English teacher, devoted one class per week to vocational and moral guidance to develop life skills and values.

Dr. R. Allen in 1931 utilized group counseling with senior-high-school students.

J. L. Moreno and K. Lewin identified group dynamics, a concept Hubert Bonner developed in the late 1800s. Between 1935 and 1939, Newcomb formalized the study of sociometrics. This term refers to the attitudes of individuals that are strongly rooted in the groups in which people belong and the relationships they share with one another. He went on to point out that group members will evaluate one another based upon their conformity to group norms (Cartwright & Zander, 1968).

W. Whyte introduced "higher order," a term similar to social structure, which includes cohesion, leadership, and status. He studied social clubs and political groups and learned about the social functioning by joining these groups. Two such groups were the Norton Street gang and the Italian Community Club. His work pointed out the importance of group properties and processes in group interaction.

A leadership study was conducted at the Iowa Child Welfare Research organization by Lewin, Lippitt, and White in 1939. This classic study with 10-and 11-year-old boys who met regularly examined leadership styles exhibited by adults who played roles of democratic, autocratic, and laissez-faire (Cartwright & Zander, 1968).

M. Sherif (1936) conducted a classic study on the autokinetic effect. Individual responses were adjusted to meet group standards. Social norms are formed when the individual range of judgments

converges to a group range that is particular to the group. Then the person will use the group range and norm rather than his/her own judgment (Sherif, 1936).

S. Asch (1952) conducted a study on individual independence from group forces. He found that groups encourage conformity and discourage nonconformity.

R. Bales studied small-group problem-solving (leader task) and developed it to study group interaction. From this study he found 12 categories of behaviors, ranging from positive to negative reactions. The behaviors that eventually emerged from this work by others were a list of different types of problems encountered in a clinical group setting.

Wilfred Bion (1948) focused on group cohesiveness and group dynamics that promoted the progression of a group while at Tavistock Institute of Human Relations-Great Britain.

J. Gibbs and W. Shutz (1973) promoted human growth groups at the same time Irv Yalom promoted a "Here and Now" approach.

Solution-focused groups are gaining in popularity because they are compatible with managed-care companies. Group work is considered to be brief, all concerns are similar, participants are goal-oriented, and the focus is on counseling and therapy for solutions (Gladding, 2003).

# OBJECTIVE 6A: Dynamics-Process (Dynamics and Process)

Forsyth (1990) indicates that there are important distinguishing characteristics of most groups. Some characteristics are interaction, structure, size, goals, norms, cohesiveness, and the concept of change. Cartwright and Zander (1968) elaborated on the definition of group dynamics, a term associated with Kurt Lewin. Their definition is as follows: "a field of inquiry dedicated to advancing knowledge about the nature of groups, the laws of their development, and their interrelations with individuals, other groups, and larger institutions" (p. 7). Group dynamics and group process are two terms frequently used interchangeably throughout the literature.

Group dynamics are the forces operating in a group, such as what is expected (norms), feelings (nonverbal), belonging (cohesion), and being safe (Bonner, 1959). Brown's definition (as cited in Posthuma, 1996) of forces in a group includes "nonverbal behaviors, communication patterns, levels of participation, expression of feelings, and resistances and avoidances" (p.7). Bion (1985) referred to three group dynamics: dependency, fight-flight, and pairing.

Group process may be thought of as the interplay of the group forces (dynamics) that make up or lead to the development of the group. Fuhriman and Burlingame (1990) identified process variables as catharsis, reality testing, identification, and systemic (circular) in nature. Process goals are designed to teach group members the appropriate methods of sharing and providing feedback to others. Carroll and Wiggins (1990) list a few process goals as helping members stay in the here and now, how to confront others with care and respect, to give non-evaluative feedback, and speaking from the first person. It is easy to review definitions for group dynamics and group process and note how they tend to blend with one another.

## Group Dynamics

Earlier in this chapter it was pointed out that some lack of clarity might exist as to the difference between group dynamics and group process. Even though the stages-phases of a group might be considered a dynamic, when they are connected into a whole, the stages reflect a group process. Dynamics might be those component parts or terms that are necessary for a group process to take place. Group dynamics are forces within a group that lead to group process (i.e., interaction of group members). Several important dynamics will be highlighted for study.

## Cohesion

Cohesiveness, according to Lewin, has two distinct parts or levels. The first component is the individual level where members hold an attraction for each other based on trust, respect, and mutual liking. The second component is the group level where the members sense a feeling of togetherness, as a separate but complete unit. This is sometimes referred to as a "we" feeling.

## Definition of Cohesiveness:

1. The degree to which members of the group desire to remain in the group (Cartwright, 1968, p. 91).
2. "The total field of forces acting on members to remain in the group" (Festinger, Schachter, & Bach, 1950, p. 164).
3. "Quality of a group, individual pride, commitment, meaning, as well as group stick togetherness, ability to weather crises, ability to maintain itself over time" (Shepherd, 1964, p. 88). Subtract all of the forces pointing away from group from those forces pointing toward group membership, and the result is cohesiveness.
4. "The collective expression of personal belonging leading to greater tolerance, deeper association, and concern for one's co-members. It is composed of emotional bonding, stabilizing effect during conflict, and the establishment of a frame of reference whereby diverse opinions are tolerated" (Lakin, 1972, p. 42).
5. "Involves group's attractiveness to the participants and a sense of belonging, inclusion, and solidarity" (Corey, 1990, p. 116). It is an ongoing process in which members earn solidarity and safety through risks with one another whereby members respect this vulnerability, thus a safe place (Schneider, Corey & Corey, 1997).

In summary, cohesion is a give-and-take generating a sense of connectedness (Moursund & Kenny, 2002). According to Golembiewski (1962), cohesion has three meanings: (a) attraction of a group for its members; (b) the coordination of the efforts of group members; and (c) the level of motivation of group members to do a task with zeal and efficiency.

Cohesiveness is the establishment of common bonds and sentiments of the members and is most often the strongest in the third stage. Tuckman's norming stage and Corey's working stage both center

on cohesion and move the group through conflict entanglements to the establishment of feelings of unity. Lakin (1972) and Yalom (1985) agree that cohesion binds members emotionally to the task, as well as to the individual members. Variables of cohesion which are suggested by Lakin and Yalom are:

Cohesion Variables (Lakin):

1. Group size
2. Physical proximity of members
3. Boundary permeability
4. Role differentiation
5. Role compartmentalization
6. Information flow

Cohesion Factors (Yalom)

1. Interpersonal
2. Group size
3. Group environment

Yalom further divides the three factors into specific parts: interpersonal, factors, and environment. The vital interpersonal factors are attractiveness of members, homogeneity of members, interdependence, and atmosphere. Important group factors are size, goals, activity, history, and leadership. Factors for the group environment are intergroup conflict and group status.

How cohesiveness unifies a group:

1. assists group maintenance
2. increases group influence over the members
3. increases group productivity
4. increases group identification
5. has desirable effects on members
6. "fosters action-oriented behaviors such as self-disclosure, immediacy, mutuality, confrontation, risk-taking, and insight" (Corey, 1990, p. 117).

This development and bonding, according to Braaten (1991), comes about and is explained through five paired variables. These paired variables are: attraction and bonding; support and caring; listening and empathy; self-disclosure and feedback; and process performance and goal attainment. Slavin (1993) suggests that cohesion is more likely to take place in the present orientations, rather than in theories focusing on the future or past.

## Self-Disclosure

Self-disclosure is a complex social act that is framed in the context of the group experience. Corey (1990) refers to two levels of self-disclosure. The first involves sharing reactions to what is happening in the group. The second is revealing relevant and unresolved personal issues, goals, aspirations, fears, strengths, and weaknesses, all of which are matched with the purpose of the group. Self-disclosure is best conducted at the pace of the member and progresses as the group matures. It is a subjective act and usually highly personal. Some individuals reveal secrets never shared with others. Yalom (1985) suggests that caution should be exercised by members and leaders when personal sharing occurs. According to Yalom, sharing takes on two dimensions: vertical self-disclosure and horizontal self-disclosure. Vertical self-disclosure is a more in-depth sharing of the where, when, why, and how of the disclosure. Horizontal self-disclosure has to do with the interactional aspect of the disclosure. That is, the here and now of why the member chose to share at this moment and how he/she feels having shared, and whether he/she has future concerns for having shared. Yalom suggests that leaders and members may need to shift from vertical to horizontal responding when a disclosure takes place.

Corey (1990) points out that self-disclosure is at the heart of most American group theories. It is also a concept not necessarily valued by different minority groups. Thus, the reinforcement of this sharing of the self and other exposures creates conflict and tension for some members. Self-disclosure is shared in the context of the relationship with others in the group. When it occurs, a deeper, richer, and more intimate relationship frequently develops. Every self-disclosure involves some risk. The amount of risk is dependent upon how personal the material is, the degree of emotional investment made, and with whom the sharing takes place. A person who self-discloses has a moment of vulnerability and during this time requires support from the membership. Appropriate self-disclosure in any situation is the norm. This takes place as the group undergoes cohesion. Some members may exercise maladaptive self-disclosure. Some examples are as follows:

1. Too little: Some group members offer too little self-disclosure and thus do not receive feedback. They may fear the loss of control. It is at this time they feel they would be vulnerable to the control of others.
2. Nondisclosers: These members may fear being alone and vulnerable.
3. Too much: These members may fail to discriminate between intimate friends and distant acquaintances.

Pierce and Baldwin (1990) developed a scale from one to ten to help leaders guide self-disclosure. The scale ranges from defensiveness, withholding, inadequate risk, and inadequate skill to lack of restraint, provocation, domination, questionable judgment, and questionable skill. The middle of the scale represents appropriate self-disclosure.

One technique that reflects how communication of self-disclosure can flow in a group is the Johari Window technique, developed by Joe Luft and Harry Ingram (Luft, 1969). The concept of self-disclosure was developed by Sidney Jourard.

## Here and Now

Yalom (1985) is best known for his interactional experience of the "Here and Now." The "Here and Now" has two components. The first is member awareness to his/her feelings and responses to other members in the group. The second is the "illumination process." This process occurs when the group is able to reflect upon itself and understand its own process. Yalom calls this the self-reflective loop. This occurs through the usage of self-disclosure, catharsis, and feedback. Sklare, Keener, and Mas (1990) point out that "you" language, questioning, speaking in third person, rescuing, analyzing, resistance, and "we" language inhibit the Here and Now process. The leader is encouraged to think about how to bring what is being said into the present. Therapists pay particular attention to nonverbals (paralanguage, proxemics, kinesics, etc.), what is omitted, tensions, primary tasks and secondary gratifications, therapist's feelings, and meta communication. Some members resist the Here and Now because of socialization anxiety, social norms, fear of retaliation, and power maintenance.

## Group Conformity

Group members exert pressure in the form of influence upon one another. This influence can be either positive or negative. In addition, it can change opinions and decisions toward the majority. It has also been demonstrated by the majority to persuade a minority/deviant member to come into line and conform to the majority. Forsyth (1990) offers three reasons why conformity comes about in a group. These influences are normative, informational, and interpersonal.

1. Normative: Norms are pressures that bring about changes in our thinking, feeling, and acting (Forsyth, 1990). A few quick examples of these norms are bathrooms (that is for males and females), fast food and theater lines, parking lanes, etc. These spots, places, and actions are temporary but become norms. Sherif (1936) in his classic autokinetic effect study described the development of norms. The study indicated that when external surroundings lack a stable, orderly reference point, members are caught in an ensuing experience of uncertainty and mutually contribute to each other a mode of orderliness in order to establish their own orderly patterns.
2. Informational: Members join groups to gain information. In groups, they acquire information as to how others respond to events of interest to them. This is explained by the Social Comparison Theory (Festinger, 1954), which suggests that each person gains feedback as to the accuracy of his/her perceptions and beliefs.
3. Interpersonal: When an individual differs from the majority, the majority will attempt to influence this person. Schachter (1951) conducted a study regarding group cohesiveness, attraction, and opinion conformity. The results of the study confirmed the initial hypothesis in that the deviant would be rejected. In addition, the deviant was assigned lower-status positions in the group.

## Power

Social exchange theory advocates that power is based upon having control of valuable resources. Resources can be in the form of ability, material, means of punishment, position, identity, and information.

These examples are considered resources only if the other person desires them. Power and influence are two dynamics that come into play very early in any interaction. Hollander (1985) defines power as having two major themes, to exert and to defend. That is, one form of power attempts to control others and events, and the other protects against some power. One should keep in mind that power is the perception of the person regarding the resources, rather than the actual resources themselves.

French and Raven (1959, 1968) researched influence as a power in group interaction. They listed six sources of power or power bases. These are:

1. Reward Power: French and Raven (1968) describe reward power when "the member is able to distribute both positive and/or negative rewards. These rewards must be valued, available to the power holder, and promises must be viable" (p. 263). If the leader is the only one who can dispense the wanted type of reward, this further increases the reward power.
2. Coercive Power: Coercive power is "the ability to dispense punishment to those who do not comply with the group's norms and standards" (p. 263-264). In addition, the leader is capable of removing positive consequences. One positive attribute of the use of coercive power is when it is used to bring out into the open a conflict to be resolved.
3. Legitimate Power: Legitimate power "is a right given by some social sanctions (position) and entitles the person to require and demand compliance" (p. 265). Teachers, law enforcement officers, supervisors, are examples. Members generally believe it is their duty to follow these people. This type of power is generally used to arbitrate or mediate a conflict.
4. Referent Power: Referent power "is derived from the members who desire to be identified with this group. The attraction and respect for the power holder is a key element" (p. 266). The members of a group like, respect, and want to be like this leader.
5. Expert Power: Expert power is when "the member has superior skills and abilities which are important to the group membership" (p. 267). This superior skill is usually a special knowledge or skill, and this leader is looked upon as a very trustworthy person. Goldstein and Myers (1986) research revealed that people are more attracted to high-status people or those perceived to be experts.
6. Informational Power: This type of power is information, which is needed to accomplish a goal or task, and is not available elsewhere.

Each of these power bases has a subset of power tactics. The power tactics are the means by which the power holder is able to exercise and maintain control of the group. Some of these tactics are promise, reward, threat, request, punishment, discussion, instruction, persuasion, persistence, manipulation, evasion, and disengagement (Forsyth 1990). Falbo (1977) and Kipnis (1984) have categorized the

power tactics as falling into one or more of three methods of application. These methods are as follows:

1. Directness: Overt methods such as threats, demands, and indirect methods such as evasion
2. Rationality: Tactics which employ bargaining, reasoning and persuasion, while the nonrational ones utilize misinformation and emotional responses
3. Bilaterality: Tactics whereby both parties are involved in negotiation. Unilateral tactics are one way, such as demands or disengagement.

In summary, Schultz (1986) concluded that emerging leader attributes and behaviors demonstrated consisted of four characteristics; self-assuredness, formulated goals, gave directions, and provided summaries.

## Group Roles

The different positions a group member occupies during the process are known as group roles. A role is defined as "a set of expectations defining the appropriate behavior of an occupant of a position toward other related positions". (Johnson & Johnson, 1997, p. 20). As the group progresses through the process toward maturity or incompleteness, different member roles emerge. This is known as role differentiation. When the expectations of different obligations for roles conflict, a role conflict is noted.

There is a need for different roles at different stages. These positions will be met by different members. Benne and Sheats (1948) identified two sets of those roles: task and socioemotional. The task roles are those that focus on the performance of the group as it does its work. These task roles at times can be seen as sources of stress and tension in the group. Socioemotional roles are those that ease the strain and stress of the group interaction. Bales (1955) hypothesizes that very few group members can fulfill both roles at the same time. It is very difficult to order, direct, restrict, and reflect task production while attempting to reduce the interpersonal distress and discomfort of the members. Role conflict and role ambiguity are two stresses associated with emerging group needs. Role conflict is when a member is playing one or more roles that are at odds with each other. Role ambiguity is when the person is unsure of the behavioral requirements.

Lifton (1967) and Benne and Sheats (1948) provide a list of roles associated with the categories of task, growth, and antigroup. For a more detailed description of the functions, refer to pages 20-21 of Lifton (1967). Gladding (2003) referred to these categories as group building and maintenance (positive social-emotional roles), task roles, and individual roles (negative social-emotional roles). A brief presentation will illustrate three sets of roles commonly agreed upon as task, growth, and antigroup.

## Task Roles

1. Initiator contributor: suggests new ideas
2. Information seeker: requests factual data
3. Opinion seeker: clarifies value premises

4. Information giver: brings own experience
5. Opinion giver: expresses own beliefs, which might be relevant
6. Elaborator: gives examples/rationale
7. Orienter: summarizes, questions direction
8. Evaluator: compares standards to group activity
9. Energizer: stimulates group to activity
10. Recorder: keeps record of content/action

## Growth-Vitalizing Roles

1. Encourager: praises, agrees, accepts
2. Harmonizer: mediates and relieves tension
3. Compromiser: comes halfway, yields to move
4. Gatekeeper: facilitates participation
5. Standard setter: expresses standards for group
6. Observer: records group process
7. Follower: goes along

## Antigroup Roles

1. Aggressor: deflates status
2. Blocker: negativistic
3. Recognition seeker: calls attention to self
4. Self-confessor: expresses personal thoughts, feelings, actions
5. Playboy: lacks involvement
6. Dominator: asserts authority/ manipulates
7. Help seeker: gets sympathy

## Group Norms

Group norms are intended to integrate the actions of the group members. Norms are rules that are designed to govern the behavior of the members. Norms are to reflect the appropriate behavior, attitudes, and perceptions of the members (Johnson & Johnson, 1997). Conformity and compliance are two intended purposes of instituting norms in a group. Several definitions of norms are listed below:

1. structure individual's behavior and judgments in group settings (Forsyth, 1990)

2. social standards that describe what behaviors should and should not be performed in any social setting (Rossi & Berk, 1985)
3. what is expected and/or allowed in the group (Gazda, 1989)
4. a set of assumptions or expectations held by members of a group or organization concerning what is right or wrong, good or bad, appropriate or inappropriate, allowed or not allowed (Schein, 1981).

Sorrells and Kelley (1984) describe two types of norms: prescriptive and proscriptive. Prescriptive norms are those in which members treat each other politely and reflect desirable behaviors for the group members. Proscriptive norms identify negative behaviors and are to be avoided.

Gibbs (1981) describes three characteristics of norms. These are collective expectations, collective evaluations, and collective enforcement. Expectations are standards, which lay out behaviors to be performed and behaviors to be avoided. Evaluation is the process of judging whether or not the members meet the normative standards. Enforcement entails the punishment or reinforcement when norms are broken or adhered to in order that future members are aware of effects.

Schein (1981) also has two types of norms, pivotal and peripheral. With pivotal norms, members use reason and logic in treating other members politely. With peripheral norms, members are simply not rude to one another. These are desirable norms but not crucial to the functioning of the group.

Douglas (1991) describes norms as explicit and implicit. Explicit or formal norms are standards or guidelines that all members have an awareness. Implicit norms or informal evolve from prior standards and that the members endorse. This type of norm can cause intense pressure and stress in the group and can be negative or positive. Conformity may be a concern with informal norms.

**Question 6-12:**
It is through group _____ that members learn to regulate, evaluate, and coordinate their actions:

a. dynamics
b. norms
c. feedback
d. roles

Answer: b. norms

# 6A: Composition of Group Formation

## Composition

Yalom (1985) believes that seven to eight members is a good group size, but anywhere from five to ten members is acceptable. He says that three to four members to constitute a group is too small, because

a critical mass will not occur. His rule of thumb is that when disturbance is high and self-control is low, the group should be small in number. An appropriate number for a group is dependent upon the purpose, structure, and membership of a group. Four is the minimum number for a therapy group and eight is the maximum. Nugent (2003) is of the opinion that the number in a group is more a function of age. Berg, Landreth, and Fall (1998) recommend size be limited to nine to ten for adolescents and adults and five to six for children. If intimacy depth is not required, the number can surpass eight. Levine (1991) considers four couples the optimum number in conducting a group for couples. As such Corey (1995) recommends eight as an optimal size with college students or adults. Adolescent size groups can be in the range of six to eight and for elementary age students in the three-five range.

Gazda (1989), in presenting different theories of groups and specific populations, makes the following suggestions:

1. Elderly, six to eight;
2. Substance abusers, 12 to 20;
3. Alcohol abusers and adolescents, eight to 12;
4. Alcohol and adult inpatients, five to six; Psychotherapy theme, six to eight;
5. Psychoeducational theme, ten to 14;
6. Insight and personal change, eight to 12; Self-help, ten to 20;
7. Preschool, five or less;
8. Preadolescent, five to seven;
9. Adolescent, short duration five to seven, longer duration seven to ten;
10. Existential, problem solving eight to 12; Under medical care three to four;
11. Person-centered, eight to 12;
12. Adlerian, ten to 12;
13. Multimodal, four to 10;
14. Gestalt, eight;
15. Cognitive-behavioral, six to 12

The specific group sizes are not listed for purposes of memorization, but rather for awareness of the consistency of small numbers. Groups are affected by a number of variables, such as interaction, type of leadership, themes, settings, etc. Research suggests that as the size of the group increases, the group tends to become more leader-centered, and the members tend to provide information and suggestions. Thus, there is less of a tendency to ask for opinions and provide personal sharing. Typically, intensive group experiences that have groups larger than eight seem to subgroup and develop factions.

The critical question in group composition seems to be whether the group is homogeneous or heterogeneous. An example of a homogeneous group would be one composed of a special identity such as all teenage girls, all divorced males, or all addicted gamblers. A heterogeneous group would

have an accumulation of members of different genders, different relationship orientations, and/or different dysfunctions. The purpose of the group will sometimes divide the group into homogeneous or heterogeneous format. Each has its advantages and disadvantages. Furst (1963) developed a list of advantages and disadvantages for anxiety neurotics taking part in homogeneous and heterogeneous groups (p. 407-410).

Homogeneous:

1. more rapid, mutual identification
2. more rapid development of insight
3. shorter duration of psychotherapy
4. more regular attendance
5. decreased resistance and destructive behavior
6. less cliquing and subgrouping
7. more rapid symptom removal
8. more rapid group identification

Cohesiveness theories represent this type of grouping and promote the idea that members will develop cohesiveness, openness, and exploration of issues.

The heterogeneous type of group represents a typical microcosm of society, will focus on the present, conduct reality testing, and will produce anxiety which in effect creates change.

Heterogeneous: (in many ways opposite in development than the homogeneous)

1. therapy is deeper
2. reality testing is more thorough
3. intragroup transferences are more readily formed
4. groups are more easily put together
5. better for reorganization of character

Therefore, heterogeneity is better suited for conflict areas and coping, and homogeneity for ego strength, patient vulnerability, and capacity to tolerate anxiety.

In summary, identification groups (age, gender, issue) provide the group with a feeling of solidarity (Donohue, 1982). Homogeneous groups operate at a more superficial level and are less prone to making permanent change although tend to be more cohesive, have better attendance, fewer conflicts, and faster relief of symptoms (Hansen, Warner, & Smith, 1980).

**Question 6-13:**
Homogeneous as opposed to heterogeneous groups tend to reflect all of the following except:

a. greater success in changing permanent behaviors

b. are more cohesive

c. are better attended

d. have fewer conflicts

Answer: a. greater success in changing permanent behaviors. Rather, in homogeneity, members have a tendency to experience less success in changing permanent behaviors (Hansen, Warner, & Smith, 1980). Homogeneous groups tend to have faster relief of symptoms from mutual support.

**Question 6-14:**

Research tends to support that groups that are formed on the basis of age, gender, or issues tend to generate a group feeling of:

a. individualism

b. solidarity

c. immunity

d. confidentiality

Answer: b. solidarity - a feeling of relative comfort and security.

## Why people join groups

There are many reasons why people seek group experiences. Some individuals have been referred by therapists and friends. Earlier it was noted that five types of problems are typically brought to a group setting (Ohlsen, et al., 1988). Below is a list of reasons for joining a group keeping in mind the type of growth, task, support or event developed. The outcome of group formation often eliminates or adds different dynamics to the time spent in a group.

1. Motivation: Individuals have specific reasons, such as learning to meet others. Yalom believes that many join groups to re-experience an unsuccessful experience with their primary family. They learn to renegotiate and become successful.
2. Intellectualizing: A group is good for those who tend to intellectualize. Usually there are effective stimuli available to help them come out of their heads and into their hearts (feelings).
3. Other reasons typical of growth groups:
    a. a sense of something missing in life
    b. feelings of meaninglessness
    c. to diffuse anxiety
    d. anhedonia
    e. identity confusion
    f. mild depression
    g. self-derogation/self-destruction
    h. compulsive work aholism

i. fear of success

j. critical incidents

Forsyth (1990), in reviewing group research (objective 6c-research), draws from the work of Mackie, Goethals, and Moreland. From this research they isolated two major reasons groups form: a functional perspective and interpersonal attraction. The functional perspective looks at the support that groups offer their members, while the interpersonal attraction aspect states that groups form because people like one another and choose to be together. According to Forsyth (1990), groups meet the following functional needs:

1. Survival: feeding, defense, nurturing, reproduction
2. Psychological: affiliation, power, affection
3. Interpersonal: emotional and social support
4. Collective: come together to serve a special need

The interpersonal aspect of group formation is given special emphasis for this study. Forsyth (1990) has isolated several concepts to explain this function. The attraction members have for one another, if strong enough to form a group, is explained by several factors or hypotheses. Some of these are as follows (objective 6b):

1. Similarity/attraction effect. Newcomb (1961) said there are four forces acting to cause a similar attraction effect. The fact that people like others who are similar to them is reinforced by the values and attitudes in others that serve to reinforce that their perceptions and beliefs are accurate.
    a. interaction at a future time is more likely and will be free of conflict.
    f. people feel unity with those like them.
    g. to dislike someone similar is distressing.
    h. people like others who are similar to them
2. Complementarily-of-needs hypothesis. People are attracted to those who are dissimilar in that they fulfill or complement their needs.
3. Proximity/attraction effect. This closeness concept is one of "mere exposure" where people tend to like those that they are constantly exposed to or are near. People who are near and choose to be near tend to like or be attracted to one another.
4. Self-evaluation maintenance model. Tessar and Campbell (as cited in Forsyth, 1990) suggest that one joins a group whose members do not outperform that person in tasks in which he/she excels. However, group members should perform very well on tasks they do not consider very important.
5. Birging. Cialdini, Borden, Thorne, Freeman, and Sloane (as cited in Forsyth, 1990) coined this term to reflect how certain groups will increase people's self-worth. People join prestigious groups to increase their social identity. The self-evaluation maintenance model is utilized to explain how to interpret downward social comparisons.

6. Comparison Level (CL) and Comparison Level for Alternatives (Clalt). Thibault and Kelley (as cited in Forsyth, 1990) believe that people join groups according to CL, which is the standard used to judge the desirability of group members. The Clalt is a choice where the greatest reward/cost is evaluated. The individual will utilize a balance sheet when alternative groups are available.
7. Buffering hypothesis. Cohen and Willis (as cited in Forsyth, 1990) in researching stress, offer the hypothesis that people who belong to groups experience fewer psychological and physical problems than those who do not belong to groups.

## Reasons Members Drop Out of Groups

As with individual therapy, a member may drop out of the group for reasons unknown to the therapist. However, in groups there is usually a member aware of what caused the individual to drop out. Below are several common reasons for dropping out:

1. External Factors: These are factors outside of the group.
    a. physical, such as moving, scheduling, illness, etc.
    b. external stress, such as disruption of significant member of his/her life.
2. Group Deviancy: Member does not fit in and every group has the potential to have a member (youngest, unmarried, student, clown, hostile, etc.) who acts out. A deviant member by definition often:
    a. lacks psychological sophistication
    b. lacks interpersonal sensitivity
    c. lacks personal psychological insight
    d. remains on the symptom level
    e. is unable to participate in the group task
    f. finds that his/her contributions fail to match high group standards
    g. does not value or desire personal change
3. Intimacy: A member who has difficulty with self-disclosure usually has:
    a. maladaptive self-disclosure (too much/little)
    b. unrealistic demands for instant intimacy
    c. avoidant personality, silent, nonrevealing

    These members dread a constant, pervasive need to disclose. Some are threatened by the expression of feelings by others. It is difficult for these members to experience and express his/her own emotional reactions.
4. Fear of Emotional Contagion: Examples of a contagion are:
    a. fear of hearing the problems of other members. A sign of permeable (penetrate) ego boundaries and inability to differentiate oneself from significant others.

    b. intolerable fear of being alone and an irrational sense that one does not exist unless one is being observed and attended by others.
    c. projection. The disowning of undesirable personal traits and the development of strong negative feelings toward a person who serves as a reservoir for their feelings
5. Inability to share the therapist: A selfish need often indicative of a strong dependency need.
6. Concurrent Individual and Group Therapy: Some members learn to play one form of therapy off the other, thereby delaying improvement and commitment.
7. Early Provocateurs: This member can play several antigroup roles and sets up conditions where he or she can feel rejected and thus drop out of the group, whether by choice or request.
8. Inadequate Orientation to Therapy: The member did not understand what was expected of him/her or what was to take place in the session. The reasons can be external and internal. Example: A member may have planned to be on a vacation for three weeks and did not foresee how that would be detrimental to the group process.
9. Complications arising from subgrouping: Sometimes when the group is a size larger than desired, subgrouping occurs.
10. Subgrouping gives rise to factions that are not always resolved. Consequently, one or more members may quit the group under the pretense that the group is not right for them.

# OBJECTIVE 6A: Therapeutic Curative Factors in Groups

Bloch (1986) describes therapeutic factors as those elements that have an impact on the general condition of improvement for a client. A number of studies have been conducted which have attempted to isolate the factors or elements contributing to this improvement or healing for those members who participate in a group experience. The first published paper identifying such factors was by Corsini and Rosenberg (1955). Their list was composed of a nine-category classification, which included:

1. acceptance
2. altruism
3. universalization
4. intellectualization
5. reality testing
6. transference
7. interaction
8. spectator therapy
9. ventilation

Spectator therapy as a factor is the benefit a person receives by observing and imitating members within the group. These nine variables as well as the six elements developed by Hill (1957) listed below were shared and derived by group leaders:

1. catharsis
2. feelings of belonging
3. spectator therapy
4. insight
5. peer agency
6. socialization

The common therapeutic factors in these early publications were:

1. belonging (acceptance)
2. catharsis (ventilation)
3. spectator therapy
4. insight (intellectualization)
5. socialization (interaction)

Research that emphasized how group members saw therapeutic variables highlighted some additional and specific factors. Berzon, Pious, and Farson (1963) interviewed group members and came up with ten factors:

1. becoming more aware of emotional dynamics
2. recognizing similarity with others
3. feeling positive regard, acceptance, sympathy for others
4. seeing self as seen
5. expressing self congruently, articulately, or assertively in group
6. witnessing honesty, courage, openness, or expressions of emotionality in others
7. feeling warmth and closeness in the group
8. feeling responded to by others
9. ventilating of emotions

The following curative factors have been summarized from the work conducted by Yalom (1985) regarding curative agents in the group experience. This list was derived by synthesizing the results of 29 studies, in excess of 1, 023 subjects during the years 1970-1985. Adolescents value universality and cohesiveness as the two most important curative factors.

This list is in rank order:

1. Interpersonal Input: Interpersonal input refers to the individual learning how other people perceive him or her. It is the first step in interpersonal learning.
2. Catharsis: Catharsis is a sense of liberation, of acquiring skills for another time. The history of psychopathology provides reference to the effort to cleanse, from confessions to blood-letting. The high learners had catharsis as well as some form of cognitive learning. Catharsis has more value later in the group process than in the early course of the group.
3. Cohesiveness: Yalom (1985) reported that in 475 controlled studies it was found that 80% of the members were better off than those who did not receive therapy. Cohesiveness is a precondition for therapy. Cohesiveness enhances the development of other important developmental aspects of the group process. It is not the process of ventilation, nor the discovery of the other important problems similar to one's own that is important, but the affective sharing of one's own inner world, and then the acceptance by other members in the group. Cohesion provides the safety and support that allows members to explore themselves, to request interpersonal feedback, and to experiment with new behavior.
4. Self-understanding: Self-understanding is an intellectual understanding of the relationship between past and present. It is not just digging up information, but encouraging individuals to recognize, integrate, and give free expression to previous dissociated parts.
5. Interpersonal Output: Interpersonal output is a social behavior in how to be helpfully responsive to others. Individuals learn methods to resolve conflicts and are less likely to be judgmental when one learns to express accurate empathy.
6. Existential: The existential nature of a group fosters responsibility, basic isolation, contingency, and recognition of mortality, consequences, and how to conduct personal lives.
7. Universality: Individuals learn that their problems are not unique. Others have similar concerns. Members learn that they have unacceptable thoughts, problems, impulses, and fantasies similar to others. Yalom (1985) indicates that members in T-groups share secrets, and that they usually take one of three avenues: basic inadequacy, interpersonal alienation, and sexual secrets.
8. Instillation of Hope: The instillation of hope is a reflection of faith in a treatment mode (faith, optimism, placebo, etc.). People observe others improving. It is helpful to draw attention to this behavior. Yalom (1985), Corey (1990), and Couch and Childers (1987) suggest that the pre-group interview is the place to begin the instillation of hope. It is especially important during the early phase of the group process.
9. Altruism: Several philosophers viewed altruism as a reflection in love of others as oneself, survival of others at a cost to self, self-sacrifice, self-immolation, self-abnegation, self-denial, and self-destructive behaviors performed for the benefit of others. Seeking the welfare of others is the central core of altruism. Altruism provides support, reassurance, suggestions, and insight. The nature of altruism changes as the group reaches cohesiveness and matures. During group research Yalom (1985) identified individual participant statements as characteristic of altruism, helping others has given me more self-respect, putting others' needs ahead of mine, forgetting myself and thinking of helping others, giving part of myself to

others, helping others and being important in their lives. Giving part of myself to others was the highest in rank.

10. Family Reenactment: Yalom asserts that individuals who come to the group do so because of an unsuccessful first family experience. This can be a corrective experience of the primary family and can provide a sense of belonging. The family haunts the group.
11. Guidance: In the early life of a group, providing direction takes precedence. Guidance serves to function as initial binding until other therapeutic factors become operative.
12. Identification: MIndividuals can learn and change from observing and watching the process.

Yalom (1985) was convinced that the process of curing could take other forms. He referred to the term "corrective emotional experience." Franz Alexander believed that if an individual were re-exposed to a highly charged emotional experience he/she did not handle in his/her past, that repair was possible. This experience could be either positive or negative. This highly charged emotional experience was an event that occurred during the group or could be re-experienced in the group and, depending upon how it was processed and managed at the time; members have indicated its importance as a change agent. Yalom and Alexander believed that cognitive awareness needed to be accompanied by the emotional component and reality testing to be effective. In addition to the curative agents identified by Yalom, other factors contribute to the effectiveness of group counseling. Zimpfer and Waltman (1982) summarized research conducted by other writers and found factors related to the counselor and those related to the group.

## Counselor

1. Kellerman (1979) listed personality traits of simplicity, honesty, straightforwardness, tolerance, authenticity, trust, empathy, warmth, acceptance, understanding, spontaneity, maintaining distance, and sense of humor, to name a few as important variables.
2. External locus of control (Snyder, 1978)

## Group

1. Member's ability and adjustment
2. Groups composed of friendly, expressive, and people-oriented members (Jacobs, 1974)
3. Open-minded members (Conway, 1967)

Research identifying the curative agents is young in study; however, it appears that the counselor's experience, personality, style of counseling, and group composition are major determinants in the effectiveness of groups.

# OBJECTIVE 6A: Group Process

Groups are classified as going through stages, phases, cycles, and cybernetics although boundaries are vague. These categories do not fit all of the different types of groups. They are best adapted to personal growth groups.

## Development, Phases, Cycles and Stages

The authority cycle presents stages in terms of relationships between the leader and the members in terms of how authority is displayed, transferred and shared. The stages are dependence, counterinterdependence, counterdependence, and independence, interdependence (Posthuma, 1996).

## Socialization Stages

Society is viewed as a group and every child, irrespective of culture, is socialized during their development and according to his/her culture. Consequently, it is believed that all groups go through a socialization process. Moreland and Levine (1982) suggest a process in which groups experience socialization in a series of sequential stages. These stages are as follows:

INVESTIGATION: A cautious search for information wherein members engage in a reconnaissance. The group estimates the value of each member.

SOCIALIZATION: Group's view is accepted in place of old perceptions and views and members accept (assimilates) the group's norms, values, and perspectives.

MAINTENANCE: Role negotiation where members take on roles that are comfortable. The group may force members to take on roles they are not comfortable with (divergence).

RESOCIALIZATION: Members take on marginal role. This may stimulate a crisis in which the members are not contributory. The members may become dissatisfied; play a lesser role. The group may react to members who are not contributing and thus create a crisis. This crisis, if resolved, often finds the members recommitted (convergence).

REMEMBRANCE: Member reminisces about time together and the group validates contributions of members. From this process, a tradition will emerge an outcome, negative or positive.

This socialization process takes place in groups that typically have a shorter time span than a lifespan of socialization.

## Stages or Phases of a Group

The life of a group follows some ordered sequence of happenings similar to socialization. This sequence of events from the beginning of a group to the termination has been referred to as a group

process, life to death. Some authors see the process as occurring in sequential stages, while others call them phases, themes, and even a cybernetics hierarchy. The following illustration and chart is provided in order to develop an awareness of the universality of viewpoints regarding the progression of group movement and maturity. Like the individual counseling process there is an initial, middle, and final phase. Most stage theorists agree that the following occur during respective stages:

Stage 1: Introduction. An orientation reflecting concerns of trust, ambiguity, and personal sharing (self-disclosure), call for information, similarities between and among members (subgrouping), and norm setting.

Stage 2: Conflict. Some form or disagreement over authority, dissimilarities, and resistance.

Stage 3: Cohesion. Growing together of the group as a whole.

Stage 4: Work. This is a point in which the group is able to attend to the goals and accomplish the group task.

Stage 5: Termination.

Corey (2000) outlines a set of stages to include setting up. Briefly, the first stage is formation, which includes announcing and recruiting members and selecting and screening for membership. Stage two is the orientation and exploration that will include identity, trust, goal setting, responsibility taking, and structuring. Stage three is the time for resistance, anxiety, conflict, control, challenging the leader, and difficultly with members, a time of transition. Stage four includes cohesion, productivity, and therapeutic emerging factors. Stage five, the final stage, is one of consolidation and termination.

**Question 6-15:**
Ambiguity during the early sessions of growth groups tends to have which effect?

a. fosters competition for communication
b. exacerbates distortions, interpersonal fears, and stress
c. creates norms beyond the group's maturity
d. causes an increase in the dropout rate

Answer: b. exacerbates distortions, interpersonal fears, and stress

The following listing of authors and their respective process terms that denote stages or phases is intended to be descriptive of the life of a group. Although there are similarities in terms for many of the theories, there do exist several authors whose terms do not necessarily reflect a beginning and end, let alone a sequential process. In those cases, it is recommended that the reader recognize the uniqueness of the portrayal of a group movement.

## Stages/Phases of a Group

| Authors | Stage 1<br>Phase 1 | Stage 2<br>Phase 2 | Phase 3<br>Stage 3 | Phase 4<br>Stage 4 |
|---|---|---|---|---|
| Thelen & Dickerman 1949 | Forming | Conflict | Harmony Productivity | |
| Bales & Strodtbeck 1951 | Orientation | Evaluation | Control | |
| Bennis & Shepard 1956 | Inter-Dependence | Focused Dependence | Work | Productivity |
| Schultz 1958 | Inclusion | Control | Affection | |
| Tuckman 1965 | Forming | Storming | Norming | Performing Adjourning |
| Boston Model | Preaffliliation | Power&Control | Intimacy | Differentiation |
| Kaplan 1967 | Dependency | Power | Intimacy | |
| Fisher 1970 | Orientation | Conflict | Emergence | Reinforcement |
| Trotzer 1977 | Security | Responsibility | Work | Closing |
| Levine 1979 | Parallel | Inclusion | Mutuality | Termination |

PROCESS as defined by stages, phases, themes and cybernetics. If one were to arbitrarily speak of the process in three phases, that is, the beginning, middle, and end, the following authors and terms might be representative:

## Beginning/ Initial Session:

Thelen & Dickerman
Bales & Strodtbeck
Bennis & Shepard
Schultz
Tuckman
Boston Model
Kaplan
Fisher
Trotzer
Levine
Forming
Orientation
Dependence
Inclusion

| | |
|---|---|
| Forming | Orientation |
| Pre-affiliation | Security |
| Dependency | Parallel |

## Middle Sessions:

| | |
|---|---|
| Thelen & Dickerman | Conflict-Harmony |
| Bales & Strodtbeck | Evaluation |
| Bennis & Shepard | Interdependence, Focused Work |
| Schultz | Control |
| Tuckman | Storming, Norming, Performing |
| Boston Model | Power and Control, Intimacy |
| Kaplan | Power |
| Fisher | Conflict, Emergence |
| Trotzer | Responsibility, Work |
| Levine | Inclusion, Mutuality |

## Ending Sessions:

| | |
|---|---|
| Thelen & Dickerman | Productivity |
| Bales & Strodtbeck | Control |
| Bennis & Shepard | Productivity |
| Schultz | Affection |
| Tuckman | Adjourning |
| Boston Model | Differentiation |
| Kaplan | Intimacy |
| Fisher | Reinforcement |
| Trotzer | Closing |
| Levine | Termination |

The group stage theories of Tuckman and Jensen (1977), Corey (1990) and phase models by Fisher (1970) and Levine (1979) will be enlarged upon to provide a deeper understanding of the development of group process and dynamics.

## Tuckman and Jensen (1977)

Tuckman and Jensen developed four stages, later added a fifth. They view their stages as cutting across two variables, interpersonal relationships and the task to be performed. Below are abbreviated descriptions of those interpersonal characteristics and tasks to be performed.

1. Forming (inclusion)
    a. Discomfort of ego
    b. Caution
    c. ISSUE: In or out of group
    d. Usually a time of primary tension
2. Storming (control)
    a. Reacts to demands of what is to be done
    b. Questions authority, feels increasingly comfortable among group members
    c. ISSUE: Top or bottom
    d. A transition from primary tension to secondary tension
3. Norming (affection)
    a. Rules of behavior are appropriate and necessary
    b. Greater degree of order
    c. ISSUE: For or against
4. Performing (functional)
    a. Focuses energies on tasks, working through issues of membership, orientation
    b. leadership, and roles, climate of support
    c. ISSUE: Work or play
5. Adjourning
    a. Closure to task
    b. Changing relationships
    c. ISSUE: Fulfillment or bitterness

Tuckman and Jenson later added for each stage group behavior associated with interpersonal relationships and tasks.

1. Interpersonal Relationships
    a. Forming: Testing and dependency
    b. Storming: Tension and conflict
    c. Norming: Cohesion
    d. Performing: Functional role relationship
2. Task

a. Forming: Task definition, boundaries, exchange of functional information
b. Storming: Natural emotional response to task
c. Norming: Shared interpretations and perspectives
d. Performing: Emergent solutions

### Gerald Corey

Corey (1990, 1995) outlines four stages groups progress through, each of which is characterized by certain behaviors of the members and leaders. A brief outline follows:

## Stage 1: Initial Stage – Orientation and Exploration

Characterized: Anxiety and insecurity, a need for trust. Primary tension is associated with new surroundings and people.

Tasks: Tasks involve developing identity in a group and to determine how active a participant intends to be by his or her commitment.

Leader: The leader models to set tone and shape norms, assists in the development of group and individual goals, brings hidden agenda into the open.

Member: The member learns the fundamentals of group participation, becomes familiar with group expectations, engages in minimal risk and emotional exploration; atmosphere is one of superficial social acceptance determines position in the group and decides the degree of self- disclosure that will be attempted expresses insecurity and dependence on leader, conflicts between members avoided but display resistance toward leader formulates trust and mistrust.

## Stage 2: Transition and Resistance

Characterized: Cohesiveness (prime therapeutic factor in groups) and intimacy. Secondary tension is intragroup tension where member differences are felt and expressed. Typical dynamics are self-disclosure confrontation, and feedback.

Tasks:

1. working stage for behavior change
2. conflict and struggle for control

Leader: Reinforcement, caring, confrontation

Member:

1. interacts openly and directly
2. expresses some amount of risk with knowledge; respect will be forthcoming

3. resolves difficulties with sensitivity, not judgment
4. feels a degree of comfort and support, a sense of hopefulness

## Stage 3: Working – Cohesion and Productivity

Characterized: Exploration of problems and actions for change, issue development, productiveness.

Tasks:

1. cohesion development
2. risk-sharing

Leader:

1. reinforcement
2. search for common themes
3. interpretation, modeling
4. aware of therapeutic factors

Members:

1. shares issues
2. provides feedback to others
3. challenges and support members

## Stage 4: Final – Consolidation and Termination

Characterized: Depending on whether the group is open or closed the tasks may not be the same. Transferring what they learned in the group to their outside environment, consolidation of learning, summarizing, integrating, and interpreting the group experience.

Tasks:

1. separation anxiety
2. unfinished business

Leader:

1. termination issues unresolved
2. reinforce changes
3. feedback to others
4. applied learning

Members:

1. feelings of separation
2. generalize new learning
3. provide feedback

In conclusion, Corey, Corey, and Corey (2010) suggest that termination of group experiences are a time to deal with separation, compare early and later perceptions, deal with unfinished business, review group experience, practice behavioral change, carry out further learning, and to give and receive feedback.

# Recurring Phase Models

## Fisher's Model

Fisher's (1970) model will be briefly outlined as a phase model. These phases are as follows:

Phase 1: Orientation

1. establish common basis for functioning
2. communication oriented to each other
3. task dimension approached

Phase 2: Conflict

1. form opinions about their own position in group
2. compete for status within group
3. assert individuality
4. persuasive attempts at changing other's opinions

Phase 3: Emergence

1. group settles on norms
2. moves toward consensus via ambiguity
3. conflict continues

Phase 4: Reinforcement

1. sense of direction
2. consensus of opinion
3. group identity
4. genuine sense of accomplishment
5. reinforcement of group decisions

### Levine's Recurring Phases

Baruch and Levine (1979) proposed a phase model with integrated conflicts which are to be resolved. His theory is briefly outlined.

1. PARALLEL: This phase is drawn from the play of young children, where they play next to but not with each other. Members show increasing levels of trust in the therapist, other members, and the group situation in order to free their autonomous strivings and actions.

   Ia. Authority Crisis: A challenge to centrality and political power of the therapist.

2. INCLUSION: Inclusion is a decrease in centrality of the therapist in group relationships and an increase in member relationships. Affiliation of pairings and subgrouping (conflicts/power struggles).

   2a. Intimacy Crisis: Pair and subgroup (empathy becomes important dimension in cohesion).

3. MUTUALITY: The mutuality phase reveals the capacity for intimate relationships and a deepening of relationships.

   3a. Separation Crisis: Any phase. Inherent in authority and intimacy. Deal with loss or potential loss.

4. TERMINATION: Disengage

## Phases

Bennis and Shepard (1956) united their work on group process with Bales (1955) and Bales and Strodtbeck (1951) and developed six developmental phases for groups. These are:

| | | |
|---|---|---|
| 1. | Dependence | flight |
| 2. | Counterdependence | fight |
| 3. | Resolution | catharsis |
| 4. | Enchantment | flight |
| 5. | Disenchantment | fight |
| 6. | Consensus | validation |

## Themes

Cohen and Smith (1976) envision group development not so much in stages or phases, but rather in themes, which cut across most groups. It is their contention that the following five common themes exist:

1. Anxiety
2. Power
3. Norms

4. Personal Growth
5. Interpersonal Relationships

These themes can occur at any time and need to be resolved if the group is to mature. Leaders and member need to explore issues underlying these themes. Cohen and Smith believe that these themes are good for growth, self-study, and task groups.

## Cybernetic Hierarchy

Cybernetics is the science of control mechanisms and their associated communications systems (Chaplin, 1968). Cybernetics adapted to group work suggests that communication between input and output is feedback to members. This behavior is what allows or permits group members to change or adjust their behavior as a result of new information.

Hare (1976) identified four factors necessary for any group to survive. These factors are:

1. Develop a sense of common identity with values and purposes that are consistent.
2. Membership must be composed of skills and resources necessary to meet goals.
3. Rules and procedures develop to coordinate activities and permit feelings of interdependence and task effectiveness.
4. Leadership necessary to facilitate the process of execution (accountability and control). Areas in need of information will take precedence over areas of high energy. Members want to know what and how to do something before they will generate energy to do the activity.

# OBJECTIVE 6B: Leadership Styles and Characteristics

The fields of sociology, anthropology, and specifically social group work, group psychotherapy, and education have molded the development of groups and group work. As a result, a group definition has emerged. A few examples of definitions will suffice. A group is an aggregate of individuals standing in a certain descriptive relation to one another. The kind of relation depends upon the kind of group (Brodbeck, 1958). Shaw (1976) defines a group as "a number of people in interaction with each other. Two or more persons who are interacting with one another in such a manner that each member influences and is influenced by another person in the group" (p.11). Gladding (2003) defines a group "as a collection of two or more individuals, who meet in face-to-face interaction, interdependently, with the awareness that each belongs to the group and for the purpose of achieving mutually agreed-upon goals" (p. 3).

In summary, common among the definitions is the idea of two or more individuals who interact in some proximity to each other, recognize the other as a member in common with them, aware that each has some type of influence on the other, and share some type of goal.

Group Guidance: Group guidance is intended to prevent the development of problems. Generally, information is provided and group size is from 20 to 35. It consists of educational-vocational-personal-social information not otherwise taught in academic courses (Gazda, 1989).

Group Counseling: R. D. Allen (1931) is considered to be the first person to use the term group counseling even though his description of the group was later a definition for group guidance. Gazda (1989) describes group counseling as "growth engendering to provide the motivation for change and action" (p. 32). The process is interpersonal and remedial. "Group counseling is dynamic, interpersonal process focusing on conscious thought and behavior and involving the therapy functions of permissiveness, orientation to reality, catharsis, mutual trust, caring, understanding, acceptance, and support" (Gazda, Duncan, & Meadows, 1969, p. 39).

Group Psychotherapy: Corsini (1957, 1989) defines group psychotherapy much like group counseling; however it is more depth-oriented and rehabilitative. Moreno coined this term and the term "group therapy." It is educational, supportive, situational, problem-solving, involves conscious awareness, places emphasis on "normals," and is short-term. It is supportive, reconstructive, involves depth analysis, is analytical, focuses on the unconscious, emphasis on neurotics and severe emotional problems, and is long-term (Brammer & Shostrom, 1960). In summary, group psychotherapy is remedial, reconstructive, and helping clients with serious psychological problems through depth analysis.

## Types of Groups and Characteristics

A group type has a special type of focus and resembles a task-work emphasis, guidance-psychoeducational direction, counseling-interpersonal problem-solving, and psychotherapy-personality reconstruction (Gladding, 1995, 2003). Capuzzi and Gross (1992) summarize group type according to common writings by several group authors. These types are:

1. group psychotherapy
2. therapeutic groups
3. human development and training groups
4. and self-help groups

It should be recognized that these groups could overlap in purpose; however those stated purposes are defined at the beginning of each type of group. At least one example of each will be provided below and is represented by the number.

Psychotherapy Group (1): This type of group has as a goal a change in personality and interpersonal functioning. It is primarily clinical in emphasis, with the leaders trained in psychodynamic psychology and psychopathology. Group members tend to have chronic health problems. Stein and Kibel (1984), in describing psychotherapy groups, point out those emotional attachments between members in a group can be divided into three classes: autonomous reactions, dyads, and the group-as-a whole

phenomenon. Parloff (as cited in Stein & Kibel, 1984) described the application of group psychotherapy in terms of Stein and Kibel's three concepts of emotional attachment: interpersonal, intrapersonal, and integral.

Interpersonal: Individual therapy within a group. Individual theories and practices of treatment are applied to the individual.

Intrapersonal: A transactional group. Emphasis is on subgroups. The group becomes the field onto which the individual displays his or her uniqueness and ways of relating to others.

Integral: Group dynamics are emphasized. The group as a whole is studied. The individual is seen in interaction with the group entity.

Primary Group (2): A primary group was first defined by Charles Cooley as a face-to-face experience where intimate cooperation was the norm. This group was called a personal growth group. Members come together to develop personal insight, overcome personality problems, and grow as individuals from the feedback and support of others. The group experience involves personal learning and growth (Brilhart, 1982).

Sensitivity Group (2): Laboratory training. An educational method that emphasizes experience based upon learning activities. Learning by doing (Eddy & Lubin, 1989).

Encounter Group (2): An unstructured environment where members are responsible for building out of the interaction a group which can help meet their needs for support, feedback, etc. (Eddy & Lubin, 1989).

Structured Group (3): Social skills training with structure. Drum and Knott (1989) define a structured group as "a delimited learning situation with a predetermined goal and plan designed to assist each group member in reaching their established goal with a minimum of frustration" (p. 14).

Parents Without Partners (4): This type of group as well as Alcoholics Anonymous, Overeaters Anonymous, and others are voluntary groups who have a common problem or concern.

Not all groups fit nicely into a category but are a type of group. Some of these are:

Reference Group: "Any group to which an individual relates his attitudes. These attitudes are dependent upon, shaped by, or anchored in a particular group" (Cartwright, 1968, p. 53). A reference group has two functions. The first is a comparison function to the extent that behavior, attitudes, and circumstances represent standards or comparison points to use to make judgments or evaluations. The second function is normative, whereby evaluations of members are based upon the degree of conformity to certain standards of behavior or attitude (Kelley, 1952).

Task Group: This type of group can be any size and is often concerned about accomplishing a task or goal. Members come together to achieve some purpose such as finding a missing person, raising money, or political rally group in support of a candidate, and will disperse once the goal has been reached.

Self-Help Group: Self-help groups meet two needs, a basic need for help when in crisis and serious difficulties. A second need is for independence and autonomy that self-help groups foster. A self-help support-system type of group is one in which individuals with common problems and life dilemmas bind together and create a protective environment from psychological stress. The purpose of this type of group is to provide a safe shelter so that members will feel motivated to begin a change in their lives. These groups are frequently created by the members with similar concerns and are not usually serviced by professionals. Personal responsibility and action are two main themes.

Balint Group: A Balint group is named for the founders who originated with the work of Michael and Enid Balint at the Tavistock Clinic in London (Balint, 1957). They started working with family physicians. The purpose of this group was to use focused discussions whereby training students, residents, or physicians learned about when and how they did or did not respond empathetically to patients. In addition, the members learned about the psychosocial dynamics that were the basis of the patient's complaint.

Closed Group: This type of group begins with a set number of members and no new members throughout their commitment of time together.

An Open Group, frequently found in hospital settings, admits new members at any time during the duration of the commitment. There are advantages and disadvantages to both open and closed groups.

This brief presentation suggests the existence of many types of groups, and it is easy to recognize that additional group knowledge is necessary to understand all aspects of them. The purpose of a group will often dictate the membership, composition, structure, leadership, dynamics, and process.

## Ethics in Group

Corey (1995) and Gladding (1995) each devote a chapter in their books to the ethical and professional issues in group practice. Some of the key areas to be concerned about when leading or planning a group are: rights of members (informed consent) such as freedom to leave a group, freedom from coercion and undue pressure, issues in involuntary groups, equal treatment, and confidentiality (adults and minors); psychological risks, group leader actions such as personal relationships, socializing, and leader values; group leader competence and training; multicultural issues; group techniques employed; and legal liability and malpractice. It is important to remember that individuals join groups for different purposes. Membership in a group is voluntary or mandated. Problems that surface in groups tend to be unfinished issues with others, self-defeating behaviors and beliefs, crisis management, faulty information about themselves or a problem situation, and learning to manage developmental or life transitions (Ohlsen, Horne, & Lawe, 1988). The pre-interview will be given special attention because it includes several of the above issues, notably client rights and membership. The ASGW Code of Ethics defines and establishes guidelines for the major areas of orientation and information providing, screening members, confidentiality, voluntary/involuntary participation, leaving a group, coercion and pressure, imposing counselor values, dual relationships, techniques,

goal development, consultation, termination, evaluation and follow-up, referrals, and professional development (ASGW, 1990).

## Pre-Interview

The ACA and the Association for Specialists in Group Work (ASGW) emphasize the ethical considerations of the pre-interview. This pre-interview is primarily for psychotherapy groups where personal sharing and self-disclosure are important dynamics. For these types of groups, an individual interview is recommended for each applicant before joining a group. It is a time for the leader and group member to decide if that particular group is right for them. Depending upon the type (i.e., themes, etc.) of group, different information and questions may be necessary for that setting. However, some questions are relevant for all groups to determine if the person is right for the group and the group is right for the person. Some questions are as follows:

1. What is the person's motivation for seeking this group? Match the individual goal with the theme of the group. A therapist may have referred this person to a self-esteem group. The individual may be experiencing parenting concerns and self-refer to a group composed of parents seeking training.
2. What prior experience has this person had with groups? An experienced person in group work may not profit from joining a group of individuals having a first group experience. Will there be scheduling difficulties? This increases the number of dropouts and conflicts regarding time and location.
3. Are the members voluntary or involuntary? Is the group opened or closed? Have members had prior group experience. If so, what? Are the members in current crises?
4. Information consents are procedures to inform members of the risks, pros, and cons of group work, misconceptions, history of the group, confidentiality, release of information, working with minors, etc.
5. What are the leader qualifications? The leader is to share leadership experience, style of leadership, expectations, and theoretical orientation.

In summary, the pre-interview serves as an informed-consent procedure. That is, each member becomes aware of what is expected of him/her and what takes place in this type of group before it begins.

## How to Begin a Group

There are numerous suggestions about how to begin a group. It is the contention of several group authors that one should begin with how the group is advertised in attracting members. Beginning a task group may be very different than a personal-growth group. In all cases where possible, member introduction is important. This is not always feasible, as there may be large numbers in some groups like a self-help group. Thus, a group-type exercise that reinforces an awareness of who are the others

in the group is essential. Some on-going groups have a method for new members. Nevertheless, some statement and action is worthy.

An individual interview is recommended to determine if the identified goal is realistic for this potential member. The pre-interview elicits prior group experiences, behavioral deviations, an opportunity to express the "why" of this group, and an opportunity to meet the leader.

Informed-consent procedures are conducted during the pre-interview and the first meeting. This usually includes ethical responses, research possibilities, releases, scheduling, disturbances, risks, history of the group, curative factors, etc.

It is recommended for certain types of groups one or two pre-sessions to orient the members to each other and determine their fit. This may not be important for a task group as it is for a therapeutic group.

An opening statement is recommended, plus the purpose of the group, introduction of ground rules (norms), introduction exercises, content, dyad formation, and short sentence completion forms have been utilized to begin the socialization process (Moursund & Kenny, 2002).

Depending upon the type of group (task, here and now, self-help, etc.), the specific type of techniques will vary. In therapy groups, trust frequently is an issue, which needs to be introduced early. A second topic for a first session is a statement of an initial goal for being in the group.

In therapy groups, leaders will often utilize rounds to check in with the group members. This is a technique whereby the leader can identify where the group is and at the same time begin dyad establishment. An example of rounds is asking each member to respond with an adjective or feeling word to represent his/her feeling at the moment.

## Who will lead?

Leaders can be highly trained, or they can emerge out of the group composition. The type of group will often reflect the type of leader. That is, a self-help group will likely choose a leader. A leader may be someone with the same experience as the members, with a power base, liked by all (personal attributes), or even someone who takes control. A therapy group is likely to have a trained leader referred to as a professional leader. The following types of leadership will fit different settings. In addition, leaders do not always work alone; they have a co-leader.

## Co-Leaders

A co-leader is usually a professional who will share the leadership. A co-leader is frequently utilized when the group exceeds 12 or is comprised of couples. A major advantage in co-leaders is a replication of the parental model (modeling). A second advantage listed by several group writers is the ease in handling difficult situations during group process. Co-leading is not an easy task; however, if a good match is attained in all respects, the members will profit from this experience. One advantage of

a co-leader is that there is likely to be less burnout and a closer attention to group-member interaction (Nugent, 2003). Nugent suggests that if a male and female are co-leading gender concerns might be easier handled. Corey (1995), Gladding (1995), Kottler (1994), and Posthuma (1996) describe similar characteristics and beliefs regarding the advantages and disadvantages in co-leading groups. Some of these advantages and disadvantages are:

**Advantages**

Better group coverage

Compatibility

Pragmatic considerations

Sharing responsibilities

Differences in personality

Support for low-functioning members

Continuity of care

Role-modeling and role-playing

Feedback

Training

Shared knowledge

**Disadvantages**

Lack of coordinated efforts

Too leader-focused

Competition

Collusion (informal alliance)

Pacing (equivalent)

Leaders can act as rivals

Triangulation

In summary Gladding (2003) highlights the advantages in co-leaders from other group writers (e.g., Carroll, Bates, & Johnson, 1997; Corey & Corey, 2002; Jacobs, Masson, & Harvill, 2002) as ease in handling difficult situations, use of modeling, feedback, shared specialized knowledge, and pragmatic considerations.

Some disadvantages were lack of coordinated efforts, too leader-focused, competition, and collusion. Posthuma (1996) adds better group coverage, sharing responsibilities, support, continuity of care, role-modeling, and training. The disadvantages are competitiveness, need for control, dominant personalities, pacing, and relationship between the two.

When leaders emerge from within groups such as self-help groups, Beck, Dugo, Eng, Lewis, and Peters (1983) identify four likely types:

1. Scapegoat: This leader will act out, can be distracting or enriching as he/she adds diversity, helps others expand their narrow views, and may be destructive because he/she tends to abide by the norms and rules.
2. Defiant: The defiant leader will act out his/her ambivalence about being in a group, will take everyone else on, and is very difficult to deal with.
3. Emotional: The emotional leader is most concerned about his/her expression of feelings and in eliciting that from others. He/she will model openness, authenticity, and support. He/she is most likely to stimulate cohesion and intimacy. The negative side is he/she may make a group uncomfortable if it has not reached that stage of development.
4. Task: He/she becomes the authority of the group, sets norms, facilitates equitable interaction, clarifies goals, and will keep the discussion focused (p. 163).

## Leadership

Trained leaders meet the qualifications and standards established by ASGW. In addition leader attributes consist of self-confidence, responsibility, ability to listen, objectivity, genuineness, empathy, warmth and caring, respect, flexibility, creativity, enthusiasm, humor, clinical reasoning, and the ability to use self (Posthuma, 1996).

Forsyth (1990), in studying group leadership, has combined the work of several theorists and derived an interactional leadership. Interactional leadership is "reciprocal, transactional, transformational, cooperative, and goal-seeking, all of which motivates the others to attain individual and group goals" (p. 216).

1. Reciprocal: The leader, group, and setting all influence each other.
2. Transactional: Social interchange takes place between the leader and the member.
3. Transformational: The leader reinforces the change process by uniting members and changing their values, beliefs, and needs through the members' motivation, confidence, and satisfaction.
4. Cooperative: A legitimate use of power given by membership.
5. Goal-seeking: Leader organizes and encourages the direction of goal attainment.

Shapiro (1978) divided leadership into two styles, intrapersonally and interpersonally oriented. The intrapersonal style tends to reflect a one-to-one interaction with a focus on the intrapsychic or internal conflicts of the person. The interpersonal style focuses upon the relationships which are formed in the Here and Now.

The Minnesota Studies provide some understanding of how leadership will emerge in a group. First, the silent members are rejected, followed by the overly talkative and aggressive members. This will leave approximately half of the group, who will eliminate themselves because of various reasons. One

or two members will remain who will emerge as leaders. This process is known as the residual method. This group of studies suggests that leadership is based upon three variables. These are as follows:

1. Power: powers of reward, coercive, legitimate, referent, and expert. Referent power has the broadest range of powers.
2. Resources: the characteristics of the person (skill, ability, wealth, etc.).
3. Property: possessions such as property, some value.

## Trait Approach to Leadership

The trait approach tends to emphasize certain personal attributes and qualities of the individual as significant factors to cast them into the leader role. Stogdill (1974) listed the following personal attributes indicative of a leader:

1. drive for responsibility and task completion
2. vigor and persistence in pursuit of goals
3. venturesome and originality in problem-solving
4. drive to exercise initiative in social situation
5. self-confidence and sense of personal identity
6. willingness to accept consequences of decisions and actions
7. readiness to absorb interpersonal stress
8. readiness to tolerate frustrations and delay
9. ability to influence the behavior of others
10. capacity to structure social systems according to the purpose at hand

Forsyth (1990) has compiled several research leadership studies and grouped them according to physical characteristics, gender, intelligence, personality traits, task abilities, and participation rates. Below is a brief statement regarding their summary research:

1. Physical characteristics: Group members appear to associate leadership with height and weight. Leaders are larger and heavier, thus giving an appearance of power.
2. Gender: Men outnumber women as leaders in small groups and unstructured groups.
3. Intelligence: Groups tend to prefer leaders who are more intelligent.
4. Personality traits: Stogdill (1974) found leaders to be higher in achievement orientation, adaptability, ascendancy, energy level, responsibility taking, self-confidence, and sociability.
5. Task abilities: Stogdill (1974) found groups prefer leaders possessing skills and abilities valued by the group and enhancing their chances of achieving success.
6. Participation rates: The person who talks the most is apt to become the leader.

## Influence Styles

The theories associated with influence style indicate that a reciprocal relationship exists between the leader and the members. There is an exchange or transition between the leader and followers. Behaviors expected are that both give and receive in return, thus each influences the other. The leader receives status, recognition, and esteem, while the followers obtain resources and the ability to structure the group activities toward the goal. While the leader provides structure, direction, and the resources, the members provide the deference and reinforcement (Johnson & Johnson, 1997).

## Situational Styles

Situational Leadership Theory is a model based upon task and interpersonal dimensions. The theory suggests that the best leader is one who meets the needs of the group. An important point is that flexibility develops as the group matures over time.

The person who attempts to lead must be aware of what function is needed and how confident he or she is in taking the initiative to perform that act. This type of leader must be able to alter behaviors from situation to situation. The underlying theme is that different situations require different types of leadership.

The Managerial Grid Model is based upon a concern for people and a concern for results (Blake & Mouton, 1964). This model utilizes a rating scale (1-9) along both dimensions. The rating of high relationship-high task is most effective. Hersey and Blanchard (1969) developed a four-quadrant life-cycle theory reflecting two variables, task and interpersonal functioning. If the leader carries out these two different roles, the group will progress from immaturity to maturity. At this point, the leader will end up reflecting low task and low relationship functions.

The Ohio State University Leadership Studies, among others, have grouped leadership into two categories (Halpin & Winer, 1952). These categories are relationship and task. Some descriptors of each category are as follows:

**Relationship**:

relationship-oriented

socioemotional

relation-skilled

supportive

employee-centered

group maintenance

**Task**:

task-oriented

work-facilitative

administratively skilled

goal-oriented

production-centered

goal-achievement

The Interaction-Process Analysis method supports the notion that social interaction will determine the emerging leader. The person who talks the most will become a leader. In a group, the most functional leadership will be when one member assumes the task role and a second one assumes the social-emotional role. Robert Bales is best known for the development of these two roles.

Fiedler developed a Situational Theory of leadership in which he divided effective leaders into those who were task-oriented and those who were maintenance -oriented. Task-oriented leaders were geared to structure, good terms with the members, and tended to be high on authority and power. The maintenance leader encouraged member participation. Fiedler's Contingency Model indicated that effectiveness is based upon the personal characteristics of the leader and the nature of the group situation (Fiedler, 1978).

## Styles Approach

Participatory leadership was advocated by Kurt Lewin, Ronald Lippitt, and Ralph White (1939), who conducted the classic study on leadership styles with 10- and 11-year-old boys who worked on hobbies. Three styles of leadership were alternated within the groups; autocratic, democratic, and laissez-faire. The autocratic leader allowed no input from the group members. The democratic leader allowed for input from the members and encouraged the members to make their own decisions. The laissez-faire leader was not involved and allowed the members to make decisions without supervision. The first three leadership styles were an outgrowth of this study. Some examples of these styles are provided:

AUTOCRATIC: Self-centered "I" and a need for power and prestige. This type of leader often fosters hostility and dependence. Where an urgent and quick decision is needed, the autocratic method would be the most effective. This leader likes control and to be in charge. Members in this type of group tend to be unaware of what is expected of them. Goal attainment for this leader is for the group and not necessarily the individual members.

DEMOCRATIC: This is a problem-solving style. A "We" concept in the development of a group leads to better decisions because of a desire to serve the group. Power is derived from the group, while responsibility and authority are shared. The leader is motivated by persuasion and tolerance. The leader will guide rather than direct. The process is to create a safe environment and to involve all members. The leader will guide rather than direct, be receptive to member participation and ideas, leave decision-making to the membership and occasionally offer suggestions.

LAISSEZ-FAIRE: This is a non-leader style with complete freedom. Rarely does the leader take part in discussion. Members make all decisions. This type is a passive or anarchy-type leader, an active listener.

This leadership method may be effective if all members are committed to a plan. In therapy groups, this type of leadership will surface increased anxiety among the members.

DIPLOMATIC: This leader is interested in personal gain and will manipulate the members to achieve that end. Some descriptors of this method are manipulator, personal gain, recognition, and hidden agenda.

BUREAUCRATIC: This type of leadership is utilized in social groups. The leader will use a fixed set of rules and tends to be impersonal and rule-centered. As a result, this leader tends to avoid interacting with the members, yet demands loyalty.

**Question 6-16:**
Which style of leadership in a small interaction group is associated with member satisfaction?

a. Autocratic
b. Bureaucratic
c. Democratic
d. Laissez-faire

Answer: c. Democratic. Democratic style of leadership tends to be highest in satisfaction in small, interaction groups.

**Question 6-17:**
A group with a laissez-faire style of leadership will generally find members experiencing:

a. increased anxiety levels
b. increased individual power
c. identification with the leader
d. personalized problem attention

Answer: a. increased anxiety levels

## Group Conflict

According to Forsyth (1990), conflict is disagreement, discord, and friction among members. The behavior is one of resistance by one or more members to beliefs, emotions, and/or actions of one or more members of the group. Stresses and strains erupt because of the push and pull of task roles and socioemotional roles played out by different members. Competition in some form is at the center of the conflict. The interpersonal style of interacting members becomes the source of conflict. Forsyth (1990) quotes several authors who view members as cooperators and competitors. The descriptions for cooperators and competitors are such that if members from both categories are in a group, conflict is likely to occur. The conflict usually manifests itself in one of several forms. Forsyth cites several of these behavioral forms to be attribution, entrapment, arousal and aggression, and reciprocity.

1. Attribution: Individuals make assumptions about causes of behavior and situations. Heider (1958) suggests that group members will make an intuitive hunch about some particular situation or event. Conflict will result if the members feel or think that their disagreement is fostered by other members' stubbornness, lack of competence, and personality characteristics.
2. Entrapment: This type of conflict escalation occurs when the participants invest more energy into the original disagreement than is necessary. In a sense, it becomes out of control (Pruitt & Rubin, 1986).
3. Arousal and Aggression: Members are unable to reach their goal and become frustrated. The frustration leads to a motivation to act, often in an aggressive manner. The situation continues to escalate, often ending in hostility.
4. Reciprocity: A type of sustaining conflict. The members believe in fair play. If some members treated one unfairly, that person feels that he or she is deserving of unfairness and allows the conflict to persist.

Bion (1985) indicates that there are three conflicts that will affect group function. These are:

1. The desire on the part of the member for a sense of vitality by total submergence in the group. This submergence is parallel to a desire to have a sense of independence by repudiating the group.
2. A conflict between the group and the member who desires a goal which is contrary to the group goal or group need.
3. A conflict between the problem-oriented work group and the basic growth-oriented group.

The studies referenced by Forsyth (1990) for Bion's three conflicts can be explained by several different theories. Cooperation and competition are central factors of study in Social Interdependency Theory. Although Kurt Koffka and Kurt Lewin were early formulators of the theory, Morton Deutsch further refined the theory and developed two types of social interdependency, cooperative and competitive and individualistic efforts as the absence of interdependence. It was his contention that there were two continua. The first continuum at opposite ends was two types of goals of interdependency: promotive and contrient. Promotive is when the goals are positively linked so that the probability of one person obtaining his/her goals are positively related to the others obtaining their goals. Contrient is a negatively linked probability of one person obtaining his/her goal that is negatively linked with another member obtaining his/her goal. At the ends of the second continuum are found two types of action. At one end is effective action where a member's chances are enhanced in obtaining his/her goal and the other end of the continuum is bungling where there is a decrease in his/her chances of achieving his/her goal. The combination of these two continua created the three processes of substitutability, cathexis, and inducibility. The dynamics of social interdependency theory for group work reveal many opportunities for the lack of this cooperation and for the dynamics of competition to surface, creating challenges for group leaders.

For the most part, group problems arise in goal conflicts, physical facilities, cohesion, personal conflicts, leadership, and network interference. Cohesion, personal conflicts, and leadership,

respectively, account for the majority of conflicts. Edelwich and Brodsky (1992) identified several common problems to be:

1. physical flight (absences or lateness to session)
2. non-participation (silence and withdrawal by members)
3. extended focus (blaming and gossiping)
4. ventilation (grievances and anger)
5. monopolizing (attention-seeking and rambling)
6. intimidation (emotional blackmail and verbal abuse)
7. seduction (helplessness and eroticism)
8. red crossing (rescuing and avoiding conflict)
9. intolerance (peer pressure and prejudices)

Rose (1989) cited a list of common problems for adults that include both members and process. They are:

1. low cohesion
2. overly-dominant member
3. member withdrawal
4. excessive off-task behavior
5. destructive coalitions
6. over-dependence on the leader
7. active conflict
8. problematic group norms

Because conflict is common in most groups, one leader function is to manage this conflict. According to Simpson (1977), conflict can be managed by one of the following five actions:

1. withdrawal
2. suppression
3. integration
4. compromise
5. power

**Question 6-18:**
Different group processes can lead to the leader being attacked. Which one of the following is not one of them?

a. risk-taking and sharing
b. subgrouping

c. fear of intimacy

d. extra-group socializing

Answer: a. risk-taking and sharing

**Question 6-19:**

If a group leader should find himself/herself under attack, it is recommended the leader:

a. play devil's advocate.

b. ignore the attack.

c. see it as an opportunity to shape new norms and promote group movement.

d. attempt to determine the underlying feelings the group members have by this attack, interpret and give feedback.

Answer: c. see it as an opportunity to shape new norms and promote group movement. Answer d. is a viable option; however, without more information this behavior may be premature.

**Question 6-20:**

Marian has been leading a human-potential growth group for the past ten weeks, meeting for two hours each session. The group has been experiencing a number of conflicts with partial resolution to issues in varying intensity and importance to the group members. A critical issue has recently surfaced which needs to be resolved in order that the group is able to continue movement. Marian urges the members to reexamine the issues and locate points of agreement in the conflicts. Marian is using which technique of Simpson's to manage this conflict?

a. suppression

b. integration

c. compromise

d. power

Answer: c. compromise. Consensus is the core behavior for integration, while suppression plays down conflict, compromise is giving up a part of what one wants, and power is to impose one's will on another.

**Question 6-21:**

Mary has decided to enlist the services of a co-leader for a small-group experience in self-esteem. Which one of the following reasons would justify her decision?

a. collusion

b. competition

c. feedback

d. too leader-focused

Answer: c. feedback. Leaders stimulate each other, assist in avoiding burnout, and provide twice the feedback. Collusion, competition, and too leader-focused are limitations of co-led groups.

## Leader Behaviors and Membership Roles

Possible questions regarding problem situations in a group should be anticipated. These problems will be in the form of difficult people or roles, procedures, processes (impasse), and first-time behaviors. Some of each category will be illustrated so the reader will consider responses for each type. If there were one response for all situations that would be appropriate, it most likely would be to shift the responsibility to the members or plan in advance by including the behavior in the contractual goals, thereby a shared ownership. Without question, when a safety issue is the situation, the leader is to take control. Different group situations warrant different responses. Some suggestions for leader techniques are included. Gladding (1991, 1995), in researching problem members for groups, combined the work of several writers and listed six common problem members. These are:

MANIPULATOR: The manipulator attempts to use his/her feelings and behaviors to weaken the leader's function. Gladding (1995) indicates anger and control are often the causes of this behavior for the manipulator. This member thrives on tension, conflict, hostility, and chaos.

Leader Technique: Reframe or block this action. It is recommended for some manipulators' concurrent therapy (individual and group). Confrontation becomes the response for most manipulation that continues.

RESISTER: The resister attempts to remain out of exercises or involvement of the group. He/she will stand in the way of the group forming.

Leader Technique: Affirm these members, confront and interpret what is happening, invite him/her to participate

MONOPOLIZER: The monopolizer attempts to capture the group's attention. Gladding (1995) suggests this person may have underlying anxiety. Kottler (1994) uses the term "entitled member" to refer to the monopolizer and overly talkative one. He views this member as attempting to control and keep the focus on him/ herself. He/she is frequently rigid and will sabotage help. He/she will come late or miss sessions and is needy and demanding.

Leader Technique: Confront this behavior and interpret how this behavior affects interpersonal behavior within the group and is self-defeating. Cutting off is appropriate.

SILENT MEMBER: The silent member may be nonassertive, reflective, and shy. Or the silence may represent some underlying behavior such as hostility. This member usually lacks trust in the leader, or the behavior is an inadvertent style based on an inadvertent state of mind. Silence can be attributed to family background or culture.

Leader Technique: The leader should determine the reason for the silence. Inviting some members to speak by asking questions that can produce information can do this. Respecting silence by some members is appropriate, unless the silence is utilized to avoid participation. Kottler (1994) and Corey (1995) suggest at times confront, create structure which is more conducive to working with a silent member, and even pursue an individual session.

SARCASM: The sarcastic member utilizes sarcasm in an attempt to hide anger and is utilized by some who find it difficult to express their feelings.

Leader Technique: The leader can interpret what is happening (how the sarcasm is being used) and encourage members to promote feedback. The task is to help the person recognize and effectively deal with his/her masked feelings.

FOCUSING ON OTHERS: The focuser focuses on others in an attempt to take on the leader's role. This member will ask questions, give advice, and remain out of the helping process as though he/she is not one of the group members. This member may also have difficulty with self-disclosure.

Leader Technique: The leader can help teach the person that personal involvement through some level of self-disclosure is more helpful than the role of leader.

There is some consistency in terminology regarding problem members, yet some response differences exist. So several different lists will be presented. Yalom (1985) described many different types of problems that frequently surface in groups. Some of these are: monopolist, schizoid, silent person, boring person, help-rejecting, complainers, righteous, moralist, psychotic, narcissistic and borderline person.

Probably the most often roles cited for group members are those offered by Benne and Sheats (1948). These roles fall under group task roles, group building and maintenance roles and individual roles.

**Group Task Roles**

1. initiator-contributor
2. information seeker
3. opinion seeker
4. information giver
5. opinion giver
6. elaborator
7. coordinator
8. orienter
9. evaluator
10. energizer
11. procedural technician
12. recorder

**Group Building and Maintenance Roles**

1. encourager
2. barmonizer
3. compromiser

4. gatekeeper and expediter
5. standard setter
6. group observer and commentator
7. follower

**Individual Roles**

1. aggressor
2. blocker
3. recognition
4. playboy
5. dominator
6. self-confessor
7. arguer

Kottler (1994) lists 14 difficult group member types, mostly similar to the debilitated listing of Ohlsen, Horne, and Lawe. Berg, et al. (1998) listed 17 problem members many similar to other listings but in several situations used different descriptors such as avoiders, withdrawers, alienators, naiveté, Pollyannas, dependents, harmonizers, coordinators, problem solvers, poor me, special interest pleaders, attackers, resisters, and super-helpers. Ohlsen, et al. (1988) identified several specific behavioral problems exhibited by different group members. These are:

1. Emotionally Debilitated: Those who fear the intensity of emotional expression.
    a. Chronic Suppression: A group member does not understand the depth of difficulties or hurt (hopelessness).
    b. Emotional Episode: When a client has a debilitating emotion such as anger, hate, grief, etc., and wants to blame others for this condition.
    c. Griever: The individual is obsessed with a love object.
2. Anxious Client: When an individual doubts his/her ability or coping skills and interferes with effective action.
3. Hostile: Ohlsen, et al. (1988) suggest that this member is often one who has been badgered, over-disciplined, and abandoned. He/she often reveals hostile feelings in a group.
4. Depressed: This group member often internalizes responsibility and blames himself/ herself for failures in his/her life and an inability to control his/her external events.
5. Learning Disabled: This individual member has a disorder or is developmentally in delay.

OTHER-CONTROLLED: This member makes an undue effort to meet the needs of others. This member tends to go with what other members deem important. As a result, the other-controlled member often feels used and thus resentful (Ohlsen, et al., 1988). Assertiveness training is a recommended

treatment. These authors describe other-controlled as the silent or withdrawn (empathic silence, slow-moving, hostile silence, observer), scapegoat, socializer, dependent, and the advice giver.

RELUCTANT MEMBER: Reluctance may be an aspect of the counseling process and, as such, fear of the unknown and suspicion are common behaviors of the reluctant member. The most common type of group member who manifests reluctance is the referred member. Ohlsen, et al. (1988) identified five types of reluctant members: nonclient, disruptive, drug-addicted, monopolist, and the acting-out person. Group members who are reluctant tend not to interact in open discussion regarding their problems.

Capuzzi and Gross (1992) cite a prepared list by Dyer and Vriend's problem members in a group. The below list is a combination of their list and Corey (1990, 1995), and Jacobs, Harvill, and Masson (1994).

1. Noncontributor: Seek a smaller group. Ask questions about strengths. Give time and play it safe.
2. Chronic talker: This person talks out of habit and dislikes silence. Form dyads and pair the talker with the leader or a confident member who will provide feedback. Use positive direction in communication and stop the member and state "let's make sure everyone has commented, etc." The chronic talker can be:
    a. Nervous: Talks to hide feelings and control self. This person is usually the first to answer questions and provides information and advice. Focus on the information side of communication to be followed by gradually effective sharing.
    b. Rambling: Talkative person with long and drawn-out tales. Once this has been shared, the leader can request him/her to paraphrase and reduce what he/she related.
    c. Show-off-Clowning: Insecure and wants to impress. Ignore the behavior and should it persist, point out how it might have been helpful early in the group, but at this stage of development it serves another purpose.

    To influence the non-contributor to share and the chronic talker to listen more the leader can use different strategies. Dyads will help the non-contributor to share with another person. Specific dyad assignments will require the chronic talker to listen to the other person.
3. Wanderer: The purpose is not always clear. Maturity may be an issue. The leader is to provide structure. Norming is very effective using verbal or nonverbal cutting off: a comment like, "restate that statement as it relates to you."
4. Slow to learn: Often lacks insight to group process and his/her role. The leader may need to provide clear, distinct instructions or even place the member in a homogeneous group. Structure is needed.
5. Rescuer: Smoothes out or over negative feelings. This prevents members from resolving problems. As the group progresses, draw this behavior to the attention of the member. Train the group how to be therapeutic.

6. Fighter: Enjoys the disruption. Most effective behavior adjustment is through the peer group. Allow the group to solidify and encourage members to talk to each other. Norm-setting is another effective way to handle the fighter.
7. Negativist: The negative member complains about the group or disagrees. Attitudes and behaviors run counter to the leader and group goals. Do not confront head-on. Talk outside of group and ask for help from the member. Identify allies and avoid eye contact when the member is being negative. Later, through emphatic responding, reflect on the behavior. It is usually an error to confront the negative member about his/her negativistic behavior. Recommended by several authors is to avoid making direct eye contact with a negative person. Sometimes this behavior will intensify the feelings and behavior.
8. Resistant: Let member share feelings in the group. Use dyads to break resistance, sometimes pairing the resistant member with the leader, providing the opportunity to talk in confined privacy. Jacobs, et al. (1994) recommend encouraging the resistant member to share his/her feelings in the group. If progress is not being made, then talk with the member after a group meeting. Identify allies and direct questions to them. Recommended by several authors is to avoid making direct eye contact with a person exhibiting resistive characteristics or behaviors.
9. "Get the leader:" This behavior has been defined as an attitude of wanting to sabotage what the leader is doing. Shift the power struggle away by refocusing. Try to understand why the leader is the target. Turn this over to the group and solicit help in understanding (Jacobs, et al., 1994).
10. Silent: Corey suggests modeling respect for the silent member. Allow the group to initiate interest in the silent member and his/her readiness to draw him/her out. Initiate the topic of silence and allow others to say what they are able about being silent. The topic of feedback can be a means to reflect to the silent member the importance and impact his/her silence has on those who have shared.
11. Monopolizer: Cutting off and shifting the focus are helpful techniques. Corey suggests that giving feedback in the form of humor can be effective. Let the group struggle with the monopolizer.
12. Sarcastic: Elicit feedback from other members. Teach members how to be emotionally honest and present with one another.
13. Focuses on others: Encourage members to get something from the group for him/her.

The first time a behavior occurs for a leader and for a group is problematic. How and what is said, as well as the response to these concerns, can set the norm for future interactions. Kottler (1994) identified a number of firsts to be: first impressions, unequal participation, superficial concerns, small talk, collective silence, functional deafness, angry outburst, giving advice, power struggle, acute anxiety, prejudicial incidents, boredom, and resistance.

Kottler cites Brown's (1992) suggestions as to the importance that the leader get these behaviors out in the open to all members, so that members can learn to hear non-defensively, learn to interpret accurately, develop skills in the practice of giving feedback, become more perceptive in his/her

cognitions, collect data about one another, and learn to become accepting and flexible in his/her perceptions.

**Question 6-22:**

During the second session of a personal growth group, a member began to cry and continued intermittently for some time. This was the first time anyone in the group cried. The sharing by different members was a rounds type of activity in that everyone was giving a brief history of his/her origin. Nothing shared at this point appeared to be of emotional magnitude to prompt such a response. What should the leader do?

a. ignore the behavior out of respect and continue with the rounds activity
b. suggest to the person to take a break for some water and return when he/she is ready
c. create a break for the group and take the person aside privately and speak to him/her
d. do not focus on the person; create dyads with an assignment such as what group experiences each has had in the past and what his/her reaction was to the experience

Answer: c. create a break for the group and take the person aside privately and speak to him/her. Of the options available this choice might be preferred because this is a second session and members are not that well acquainted. Thus, members might be reluctant or uncertain of group behaviors to move toward the member. In addition cohesion, according to theory, would not be established whereby membership would likely take control and members would seek to support with sensitivity and respect. To avoid focusing on the member (option d) could intensify the uncomfortableness in the group as well as the member. What was disturbing to the client to evoke the crying could be something recent that took place before the group or something from the rounds that triggered her response.

**Question 6-23:**

Group interaction occurs on two levels. The first is an interaction that is conscious and the purpose is known (public) in the group and is public agenda. The second is hidden agenda. All of the following are signs for the leader when hidden agenda might exist in a group except:

a. emotions overtake logical thinking
b. personal attacks, scapegoating, grumbling
c. withdrawal into silence
d. lack of coalitions and cliques

Answer: d. lack of coalitions and cliques. Hidden agendas may not exist in some groups but when they do hidden agenda refers to aims of some members to achieve or accomplish personal goals but not make them known to the group. The individual hidden agenda may be conscious or unconscious but likely to impede group process. The group as a whole can also have hidden agenda.

**Question 6-24:**

In question 6-23 (hidden agenda) assuming the hidden agenda is a group hidden agenda what strategy might the leader utilize to understand and move through the hidden agenda?

a. challenge the group regarding the resistance
b. use a specific technique to bring the hidden agenda to the surface
c. maintain control of the group or it is likely to dissolve
d. leader ask self-questions such as "what does this mean", "am I pushing too hard", "is this about me"

Answer: d. leader ask of self-questions such as "what does this mean", "am I pushing too hard", "is this about me". The leader may want to assess whether the hidden agenda is conscious or unconscious in the outcome thus the response is likely to be different dependent upon that assessment.

# Specific Techniques

Leader techniques and skill development for the most part involve timing and effective communication for dealing with membership involvement, conflicts, and client issues. Some areas for leader or client work involve breaking eye contact, redirecting, last-minute input, monopolistic behaviors, recognition and gatekeeping, taking turns, nonverbal contact, confrontation, apathy, tension, nonparticipation, eye contact, agreements (dis), asking for opinions, direct questions, silence, disturbed individuals, and termination.

## Cutting Off

The goal in cutting off a member is to stop what is occurring or to refocus but stay with the member. Cutting off is often called blocking or intervening. Jacobs, Harvill and Masson (1994, 2002) indicate that the most important time to cut off is when the member is:

1. rambling
2. sharing comments which conflict with the group's purpose
3. saying something hurtful
4. saying inaccuracies
5. rescuing
6. arguing
7. session is nearing the end (2002, p. 161)

Timing is crucial for intervention. It must be optimal. That is, action or interventions too early may cut off communication and involvement. If cutting off is too late a behavior may have generated its own energy and take on dynamics calling for leader involvement. Cutting off can be used when the leader wants to shift the focus. Jacobs, et al. (2002) indicate that cutting off can proceed in three directions: cut and stay with the person, cut and stay with the topic, and cut and leave the topic and person. Cutting off can be effectively carried out through the use of voice, clarifying the interruption, nonverbal expressions, and the refocusing method.

**Question 6-25:**

A personal growth group has been on-going for four sessions. One of the nine members has been monopolizing much of the time for most of the four sessions. The two leaders were concerned because it appears as the sessions have progressed more members appear to be involved less, are not listening, and some degree of apathy exists when the monopolistic member starts to talk. The group has not reached cohesion yet and cohesion appears to be slowing down. The co-leaders have decided that they should do something before charging the membership to deal with the spacing for everyone in the group. What might be a positive step for the co-leaders to take to begin the process without alienating that member?

a. One of the co-leaders to sit beside the monopolistic member
b. Take the member aside and ask him/her to help the leadership involve more members to participate
c. Ask the group what they think of everyone's involvement
d. Open up a topic about how much involvement each member might want in the group

Answer: a. one of the co-leaders to sit by the monopolistic member. This technique is good for someone (member) struggling with impulse control or reality. A few non-verbal behaviors can be associated with the proximity of sitting next to the member. The co-leader may not want to solicit a leadership request from this member because it may set a precedent for this member to be apart (separate) from the rest of the group especially if he is not considered a leader by the members.

**Question 6-26:**

A process group has been together for several months. In this particular session, two members have been arguing for some time. The leader decides to use the cutting-off technique and suggests one of the following:

a. asks the two members to continue the discussion but to tone down remarks
b. asks two of the non-arguing members to discuss the argument
c. discuss the issue calmly herself (leader)
d. shift the focus to a new issue

Answer: All answers would be examples of cutting off. Jacobs, et al. (1994) state that arguments can only be harmful to a group as they affect cohesion and should only be allowed to continue if they in some way are productive for the group. Shifting focus to the group to reflect on the interacting can be feedback for the two arguing members.

**Question 6-27:**

A member appears to be rambling, and it has gone on for an extended period of time. In fact, the leader has noticed this in previous sessions. What is one of the cues that may be an indication for the leader to recognize that he or she should cut off the member?

a. when redundancy begins to set in with the member
b. when other members begin to argue with the rambler

c. when silence becomes noticeable within the group

d. rely on the leader's experience and feedback from other members

Answer: a. when redundancy begins to set in with the member. From an informational standpoint, redundancy is a good cue that cutting off is in order. Letter d. is also an effective behavior; however the leader can create new and effective behaviors if he or she cuts off.

## Pacing

Jacobs, et al. (2002) refer to pacing as the rate at which the group moves. This is influenced by the leader or members' rate of speech and pattern. This pattern includes tone, pitch, volume, and rate. If a group moves too slowly, members will lose interest, become bored and frustrated, and tend to wander. The voice is the key to pacing.

## Setting Tone

Setting the tone is conveying and setting a mood for the members, the setting or disposition that is expected for them. The voice, as it implies messages of softness, firmness, and lightness, will often convey to the group whether the setting is one of sensitivity, seriousness, or freedom of direction. Jacobs, et al. (2002) identify several possible tones to be serious, social, confrontive, supportive, formal, and on-task.

## Linking

Nelson-Jones (1992) describes linking as the connecting of the meaning of what one member says or contributes in a session to what another member shares in a session. Linking is insightful gathering of common themes and feelings that different members are demonstrating.

**Question 6-28:**
A member of a growth group has been silent from the beginning and for the better part of several sessions. The leader wants to draw the person into the group. What action might the leader take to draw this person into the group?

a. call on two or three members and through the use of the leader's eyes determine if the silent member will speak; the leader should keep in mind to always provide an out for the member

b. ask the silent member what he or she thought about the topic that another member just shared

c. look directly at the person you would like to see share more (subtle non-verbal shift)

d. speak to the person saying that the group would like to hear more from him or her; stress that the group is interested and would like for the person to feel a part of the group

Answer: b. ask the silent member what he or she thought about the topic that another member just shared. The silent member may be more comfortable speaking or reflecting outward before he or she reflects from within. This allows the member to receive validation from the other members as to how

they evaluate what is presently occurring, thus increasing his/her acceptance and confidence level. If the statement had indicated that in the early part of the group the person had spoken perhaps a different answer would be suggested.

## Focus

Jacobs, et al. (1994, 2002) highlight two other group-leader concerns or skills to acquire: holding/establishing the focus and responding to rescuing. Focusing skills to be developed include establishing a focus, holding the focus, shifting the focus, and deepening the focus. The application of these different skills may be different as the group matures. Rounds and dyads are often utilized to focus a group. Holding the focus is keeping the attention on the content or topic and is an important skill. Focusing is usually centered on a topic, person, or exercise. Several questions are relevant for focusing:

1. When to hold the focus: First, decide where the focus is centered (person, content, exercise). If the focus is on a topic, decide if it is relevant, if the members are interested, how long the group has been on the topic, and if the topic has been discussed before (redundancy). In addition, decide if the information flow or interpersonal additives are meeting the goal(s) of the individual or group. If the focus is on a person, decide if the person is benefiting, and ask whether it benefits the group. If the focus is on an exercise, process the activity in relationship to the goals and, when silence or redundancy sets in, the focus should shift.
2. How to hold the focus: This depends upon the type of group or content of the focus, but the upper limit is considered to be 30 minutes (Jacobs, et al., 2002).
3. How to hold the focus: The main skill when the focus begins to shift is the use of cutting off, making rounds, or forming dyads. Other skills are to use an exercise for focusing. Jacobs, et al. (1988) believe that the essential behavior is to act quickly, not to wait.
4. When to shift the focus: Jacobs, et al. (1988) recommend shifting the focus when the focus has been on one person, topic, or activity for too long. In addition, a shift should be made when the focus does not match the purpose or when a new focus is needed. Shifting of focus can be from a topic to a person, topic to an exercise, person to person, person to topic, or from a person to an exercise (p. 109). Observing membership involvement is another form as members withdraw from the interaction or more become involved (interest).

**Question 6-29:**
When a member is rescuing another member, he or she is:

a. providing answers for the focused person, who is unable to provide the answers.
b. smoothing over negative emotions that someone else is experiencing.
c. creating a situation where a focused member will have to deal with a real-life situation within the group.
d. cutting off the focused member from the exploratory phase of the process.

Answer: b. smoothing over negative emotions that someone else is experiencing. Rescuing is not a behavior that the leader should reinforce. At the same time, a leader wants to exercise caution in cutting off a member. Rescuing occurs most often in mutual support, self-help, and growth groups. Some of the dangers of cutting a member off inappropriately are likely to diminish sharing by all members, not clarify why the interruption has occurred, shift the focus away from the topic, and shift the focus away from the person to a topic.

## Drawing Out

Jacobs, et al. (1988) describe drawing out as a specific technique for the leader. Drawing out is "a skill to elicit group members' comments" or involvement (Jacobs, et al., 2002, p. 170). The reasons to draw out a member are varied; however the group goal is to elicit more involvement. More involvement will generate more ideas, information, and interpersonal interaction, and reinforce the concept of sharing. A person who has a difficult time talking in a group can, in a caring atmosphere, learn to talk in a group. A final reason is to achieve greater depth in exploration. The silent, timid, unprepared, bored, uncommitted, intimidated, non-present member is often the one who experiences drawing-out techniques.

There are several methods for drawing a member out. Corey (1990) suggests the use of rounds, direct and indirect methods. Rounds are short stimulus statements/questions in which each member responds. These can be specific words, phrases, homework, adjectives, feelings about how they are at this time in the group, and feelings about a topic. The direct method uses direct questions, while the indirect method can come about through the use of dyads, rounds, written expressions, and role-playing. Jacobs, et al. (1994) suggest that a skillful method is to use the leader's tone of voice and caring, accepting attitude as vehicles for inviting and giving permission to speak.

**Question 6-30:**
You are a leader in a personal-growth group. There are nine members in the group who are committed to their own group goal(s). You are in the sixth two-hour session covering ten weeks. One of the members begins to silently cry and is affected. The leader notices, but there is very little time remaining in the session. The leader should do which of the following?

a. shift the focus to this member and find out what brought on the tear
b. exercise patience and allow the group to respond to the member
c. probe the member and find out the cause of the trouble
d. break into dyads and pair yourself with this member; assess what has troubled the member

Answer: b. exercise patience and allow the group to respond to the member. This group is in the 12th hour of the process and likely in the working stage where cohesiveness is established. If the leader has shifted the responsibility to the group, members will likely attend to the affected member with sensitivity and support.

### Rounds

Another leader technique is considered a useful and versatile way to involve everyone is rounds. To conduct rounds as an exercise is to request that each person reflect verbally on a topic. Some groups use rounds as a way to check-in. Checking in can be in the form of a descriptive word describing a feeling state at the beginning of the group. A leader uses rounds to redirect, focus in on a topic, draw out members, center upon differing thoughts or feelings, and energize a group. Rounds can bring out information quickly, focus members, and at different levels involve members. Trotzer (1989) cites three reasons to utilize rounds. They are to complete loose thoughts, end on a positive note, and ensure that each person is participating in the group.

Designated words or phrases, word or phrase, and comment are three types of rounds commonly used in groups (Jacobs, et al., 2002). Rounds can be a designated word or a number to reflect the here and now. This will give the group members a sense of where they are in relation to everyone else. A word or a phrase is another form of rounds and is usually a reaction to an exercise or a dilemma. Finally, a comment round is a summary response for a topic covered by the group and is to capture what stood out to each member. Summary comments can be used to start a session reflecting upon last week's session.

## OBJECTIVE 6C: Group Theory

The principles of counseling within each theory, whether individual or group, with exceptions appear to be similar. Theory questions typically have been found to occur in the theory section of the examination. It is recommended the examinee be knowledgeable about group theory principles, techniques, etc., but recognize that few questions have come from this theory section. The following outlines for ten group theories are provided to reinforce your knowledge base.

### PERSON-CENTERED: Carl Rogers (Encounter Groups)

Encounter groups are open to a wide range of concerns and are often referred to as a personal growth experience. Person- or client-centered therapy is also known as intensive experiential group therapy (Rogers, 1967).

Philosophy: Individuals strive to become fully functioning and self-actualized. This attitude and set of behaviors become internalized and allow the person to be ever expanding and attaining his/her full capacities. Rogers believed that each person has an internal drive to become a whole person. The theory relies on the natural ordering tendencies of life. Each person is aware of his or her incongruence and is capable of reorganizing to achieve congruence. Maladjustment is when a person distorts or denies one experience and therefore is in a state of incongruence between self-concept and experiences.

Key Terms: empathy, concreteness, respect, trust, genuineness, immediacy, formative tendency, readiness, and facilitator.

Method: Therapist gives up professional role. Individuals grow in awareness as relationships are reinforced in the group. Their inner wisdom and trust is to allow the formative tendency to operate. The leader does not force change but encourages the here and now of experiencing. Group procedures reinforce the self-knowing and understanding of others.

Rogers (cited in Burke, 1989) indicated that the therapist utilizes three attitudes - genuineness, unconditional positive regard, and empathy - to assist the person in the formative tendency. Rogers saw the powerful inducements for change were being present with the person (presence) and being congruent.

Stages: Rogers did not outline his therapy as progressing in stages although described in that manner by several authors. Rogers saw individual and group therapy progressing as a process, free flowing from one 'stage' to another. Rather, it is an evolution in development, which reflects more of a sequencing of events and process. Posthuma cites Roger's analogy of rain drops falling on a window pane (separate is each) and if a person touched one drop and moved that drop down the window pane it will link up with another and form a larger raindrop. The leader or another member has to be insightful and synthesize a common bridge of understanding. Jacobs, et al. (2002) refers to this behavior as typing together. Rogers (1967) saw group process evolving in 15 'stages' beginning with milling around and concluding with behavior change. The following 'stages' are offered to be suggestive of a process (Corey, 1990, p. 300-301; Gladding, 1995, p. 321-323):

1. milling around
2. resistance to personal expressions/ explorations
3. descriptions of past feelings
4. expression of negative feelings
5. expression/exploration of personally meaningful material
6. expression of immediate interpersonal feelings in the group
7. development of healing capacity
8. self-acceptance and beginning of change
9. cracking of facades
10. feedback
11. confrontation
12. helping relationships outside group
13. basic encounter
14. expression of positive feelings/closeness
15. behavior change in group

Role of Leader: The leader is called a facilitator and is interpersonally effective in creating a climate of acceptance and non-judgment. The leader brings alertness and willingness to the group. The relationship is important for promoting growth and change. The leader reflects warmth, acceptance,

respect, caring, and empathy. The leader provides understanding meanings and intents, conveys acceptance and provides linking. The leader participates as a member, giving up authority, devotes a willingness to recognize that others in the group are able to lead, self-discloses when appropriate, strives for personal influence, and believes members are capable of moving in their own direction.

Role of Member: No specific guidelines  in selecting members. Ground rules are made up by the membership. Goals: Self-awareness and awareness of others.

## GESTALT: Fritz Perls

Philosophy: Gestalt group therapy is composed of existential, experimental, and phenomenology. The basic philosophy is that much of what each person needs to live in the world is outside of his/her ego boundary. To bring the material through the ego boundary, the person needs to be aware of the need and to expend the energy to bring this transportation about to completeness, wholeness to a gestalt. The basic drive is denial aggression. Bringing something through the ego boundary is called contact.

The person is born with the capacity to cope with life. The child's development is interfered with and must introject, project, retroflect, repress, and suppress instinctual strivings to be normal.

Key Terms: denial aggression, impasse, contact, figure, rehearsal, background, awareness, here and now, unfinished business, introject, personality (multilayered), cliché, playing, impasse, implosive-explosive, genuine, I-Thou, closure, elasticity, proactive, rounds, role reversal, empty chair, top-dog/ underdog dialogue.

Method: All members are seen in individual therapy to assess the degree and severity of disturbance. In addition, the members' attitudes and willingness to participate are assessed.

The goal is to move from environmental support to self-support. The curative process is centered upon awareness.

With awareness, clients are able to recognize blocks and impasses. Therapy is an effort to assist the client to discover within himself/ herself the resources to resolve these blocks and impasses. The client proceeds to recognize parts and integrate into a whole. Other issues are the here and now, recognizing and accepting polarities, and re-experiencing business in the present.

Stages: Everything is based upon the Here and Now. The past and future do not exist except in relationship to the Here and Now. The Gestalt Institute of Cleveland has suggested a stage evolution of trust and safety, establishing norms, exploration, confrontation, confluence, and working. They view each event as composed of a cycle that includes centering, sensation, awareness, energy, action, contact, resolution, and withdrawal (Gazda, 1989).

Role of Leader: The leader is to challenge members, confront and encourage while in the Here and Now. The leader is a facilitator and provides feedback, perceptions, attitudes, and feelings. The leader is a model in the I-Thou relationship and determines much of what will take place with whom and when.

Role of Member: Active contact, interactional, self-awareness, and willing to re-experience contact.

Techniques: Action-oriented, language exercises (it talk, you talk, questions, qualifiers, shoulds, oughts, can't), nonverbal, take responsibility, matching rounds, fantasy, rehearsal, reversal, exaggeration, exercises, dream work, first person (Corey, 1995).

Goals: The outcome is for members to have more awareness of themselves in the Here and Now. Each member will remove layers of neurosis (phony, phobic, impasse, implosive, and explosiveness).

## ADLERIAN: Alfred Adler - Rudolph Dreikurs (Primary Group Developer)

Philosophy: Basic assumption is the social nature of humans and based upon the holistic view of man. Adler believed in family education. His approach is called socioteleological. The primary motivations are social forces. The individual is striving for significance, that is, to achieve a unique identity and to belong to a group. A key term is inferiority, which is the motivating force for individual's goal-orient for mastery, power, and perfection.

Key Tenets: social development, cooperation, and education.

Key Terms: holism, autonomy, creativity, choice, teleology, lifestyle, phenomenology, inferiority, identity confusion, ego integrity, family constellation, basic mistakes, earliest recollection, psychological disclosures, personal identity.

Method: The group is the setting in which inferiority can be challenged. The mistaken beliefs and values can be uprooted and affected by the group. These mistaken beliefs and values are the foundation of social and emotional problems. It is within the group that members can feel a part of a larger group and attain a sense of belonging. The individual will overcome helplessness through compensation.

Stages: Adlerians such as Dreikurs, Sonstegard, and Bitter view Adlerian counseling in phases. Gazda (1989) and Gladding (1995) view the process as developing in the following four phases:

Phase 1: Developing a relationship

Phase 2: Analysis and assessment

Phase 3: Insight

Phase 4: Reorientation

The group process is linked through the interpretation of a person's early history and the individual, interpersonal, and group process goals.

Role of Leader: Interpret and guide for change by understanding present behavior; monitor group process; establish structure and guidelines; challenge client's beliefs and goals; and encourage therapeutic conditions (Corey, 1990). The leader is a participant in the group, and an effective personality is important.

Role of Member: Provide support for other members; assist in interpretations for others; open to alternatives, attitudes, and beliefs.

Techniques: Interview regarding family constellation for atmosphere and early recollections; look for significance in birth order; lifestyle assessment; early recollection; interpretation; confrontation; encouragement.

Goals: The desired outcome is the active growth and actions of the person within the group. The individual should experience a more socially oriented and goal-directed growth. He/she should come more in contact with his/her family or origin and achieve social adjustment.

## REALITY THERAPY: William Glasser

Philosophy: Glasser's basic concept is "success identity," whereby each person has an internal force that drives him or her toward this success identity. A behavioral change will produce a change in one's identity. This theory is active, directive, and didactic. The theory advocates helping people take control of their lives in the form of choices. The individual attempts to meet his/her psychological and physiological needs. Choice theory as a part of reality therapy explains how the brain works.

Key Tenets: Glasser (1984) states that all behavior is "generated within us for the purpose of satisfying one or more basic needs" (p. 323). Glasser maintains that one of the five internal needs of belonging, power, freedom, and fun, and the physiological need of survival, bring individuals to counseling.

Key Terms: belonging power, freedom, fun, doing, thinking, feeling, physiology, success identity, involvement, value judgment, present vs. past, commitment.

Method: Cycle of counseling is a rational process and not necessarily procedural. Involves the environment; counselor attitudes; exploring wants, needs and perceptions; focus on current behavior; evaluating self; plan and act; and commitment. Glasser rejects the term "mental illness," emphasizes the present, is unconcerned with transference or the unconscious, stresses evaluating one's own behavior in light of personal and societal values, and finding a better way to assuming responsibility.

Stages: There are no stages. There are only eight steps. Glasser stresses that his choice theory is a process and does not to attempt to fit it into a procedure. The steps are: develop a meaningful relationship, emphasize the present behavior, stress the client actions that are getting them what they want, plan positively, establish a commitment to the plan, accept no excuse, apply no punishment, and never give up (Gladding, 1995).

Role of Leader: Active and directive, involved, maintain control, challenge, model, relationship development, leader of discussion, teach, set limits, connect real life with learning, confront excuses, and encourage strengths.

Role of Member: Supportive, encouraging, creating relationships with other members, setting goals, making commitments, acting.

Technique: Questioning; self-help procedures, humor; paradoxical techniques, interviewing, no excuses for failure, contract method, role playing, discussion, involvement, structured, cognitive, behavior-oriented.

Goals: To move beyond self-defeating behavior and to become unstuck. Group members realize they can take control of their lives.

## PSYCHODRAMA: J. L. Moreno

Philosophy: The total involvement of all group members through their expression of feelings in a spontaneous manner. This is achieved through a drama enacted via role-playing. The aim is to free people up from old feelings that are irrational. This is a holistic approach that reinforces spontaneity and creativity. Moreno believed that humans have the capacity to encounter one another in an open, honest manner.

Key Beliefs: Spontaneity and creativity, the situation, tele (total feelings between feelings), catharsis (end products of spontaneity and tele), insight (new perceptions,) dealing with the present, surplus and reality.

Key Terms: Encounter, spontaneity, tele, creativity, protagonist, auxiliary.

Method: Emphasizes enacting or reenacting events, role-play with warm-up process, action phase, and discussion. The psychodrama experience is a holistic interaction of the protagonist in his/her encounter. This encounter is a physical and psychological contact of persons in the Here and Now.

Three phases:

Phase 1: Warm-up - designed to alert and inform participants about the experience. This phase will elicit goals and willingness to trust others in the audience to participate. The scene is developed and members are told that they reveal what they want to share.

Phase 2: Action Phase - when reenactment takes place. The members and group work through focusing on the exploration. Interpersonal issues are worked through.

Phase 3: Discussion Phase/Integration Phase - when the action is shared and discussed. Observations and reactions are provided to stimulate understanding for all members. This is a personal and nonjudgmental sharing.

Role of Leader: Producer, catalyst, facilitator, analyzer, debriefer. The director has a direct responsibility to the members.

Role of Members: To be auxiliary egos and protagonists.

Techniques: Role-play, self-presentation, role-reversal, soliloquy, double technique, mirror technique, magic shop, future projection.

Goals: The desired outcome is the release of the natural human spontaneity and creativity. The individual works through past, present, and anticipated events.

## RATIONAL-EMOTIVE BEHAVIOR THERAPY (REBT): Albert Ellis

Albert Ellis Any one of three theorists could describe a cognitive behavioral group therapy. Aaron Beck and Donald Meichenbaum provide models that reflect the cognitive structures of the client, although each of the three emphasizes different perspectives. Albert Ellis attacks underlying belief systems that have been reinforced by the client. This theory is well known for the three basic "musts." They are: "I must," "You must," and "Conditions must" (Donigian & Hulse-Killacky, 1999).

Philosophy: The basic personality theory assumptions hold that humans are capable of rational and irrational thinking (dual nature). These ways of thinking are the cause of emotional reactions, and resultant behaviors. When self-defeating behavior is replicated, people become dysfunctional. Cognition and feelings are interlocked. REBT is a cognitive approach that assumes each person has the potential for rational and irrational thinking.

Key Terms: ABC Theory, "musterbation," self-indoctrination, confrontation. Four types of thoughts (positive, negative, neutral, and mixed) and three feedback modes (cognitive, imaginal, and behavioral).

Method: Teaching and feedback in which an active directive intervention uses the ABC approach; a) activating event, b) belief system, c) emotional consequences, d) dispute, and e) effect method.

Stages: There are no emphasized stages. Instead, the above ABC process is enacted, which takes into account interviewing, motivating, problem-solving, and action.

Role of Leader: The leader role is both active and directive, confronting, and active. The leader serves as a teacher, illustrating how a person connects emotions and behavior. Many people have conditioned themselves into "musts." The leader will encourage members to dispose of musts, shoulds, and oughts, using activity-oriented exercises.

Role of Members: To realize his/her faulty thinking, to self-rate, establish goals, and solve problems.

Techniques: Disputing, ABC, self-statements, homework, humor, shame attacking, imagery, role-playing, and feedback.

Goals: Ellis (1982) said the goal of REBT is to "stop awfullizing, catastrophizing about life's misfortunes and frustrations and to accept oneself and others as being fallible and human" (p. 288). The desired outcome is to learn how to think rationally; overcome irrational beliefs using the ABC model, better knowledge of REBT and personal understanding of the change process (Gladding, 1995).

## EXISTENTIAL: Victor Frankl and Ludwig Binswanter

Philosophy: Yalom (1985) points out that existentialism is founded upon freedom of choice and is based upon four concerns: freedom, death, isolation, and meaninglessness. Each person is encouraged to lead a fully authentic life. An example of existential thought is Victor Frankl's logotherapy (Corey, 1995).

Key Terms: authenticity, I-Thou, freedom, choice, self-awareness, aloneness, death, existential, anxiety.

Method: The group is a place to discover existential concerns. The members' subjective experiences are brought to their awareness through their own doings. Members are encouraged to shed their superficial beings and replace this with an authentic way of life.

Stages: There are no clear stages rather a process of phases that represent self- awareness. There are no rules; therefore, this therapy can be a painful process for members. The initial concern is what roles members should play. As this concern is discarded, members begin to question how they perceive and interpret their existence. The focus is on what other people 'make' them feel. The middle phase is a deeper self-exploration of their value system for new insights. The final phase is learning what each member learned and transmitted to action.

Role of Leader: Major role is to be with the client. There are no specific techniques for being a leader of an existential group. The leader will encourage members to be open, participate, share, and develop the therapeutic alliance. The leader will challenge members to change positions, look for opportunities from failures, be creative for the future, and study their defensive styles.

Role of Members: Offer illustrations of their conflict strategies. Accept responsibility for themselves, be open and participating.

Techniques: No real techniques. Relationship development and challenge.

## BEHAVIORAL: B.F. Skinner

Corey (1990) contends that behavioral theory is not a single theory. Rather, it covers a broad array of techniques and understandings rooted in learning theory. Behavioral therapy reinforces experimental methods and documentation of observable behaviors. The acquisition of data is important. Lazarus, a multimodal therapist, proposes a theory referred to as BASIC ID for group work.

Philosophy: The basic assumption is that individuals have learned those behaviors that are being expressed as problems. These problems are composed of behaviors, cognitions, and feelings. The second assumption is what the client expresses is the problem. Behavioral groups are either interpersonal or transactional. The interpersonal groups are didactic and have specific goals for self-improvement, while the transactional groups are heterogeneous and have broader goals.

Key Terms: Shaping, modeling, learning theory, systematic desensitization, contingency management, positive reinforcement.

Method: Assessment and tabulation of results, problem solving, treatment planning, and action.

Stages: There are no stages. Rather, there is a sequencing of activities according to specific techniques. Stages could appear to be assessment, charting, program planning intervention, reinforcement, and action checking.

Role of Leader: Interview, assess, technique application, model, reinforce, teach problem-solving, and create a climate of trust and respect. The leader uses contracts, cognitive restructuring, and modeling.

Role of Members: Contracting, listing behaviors, problem-solving, learning new skills, reporting progress, yielding feedback, role-playing, participating in various techniques.

Techniques: There are numerous behavioral techniques, depending upon the specific behavioral orientation of the author. Some examples are stress inoculation, assertiveness training, modeling, reinforcement, diagnosis, cognitive restructuring, etc.

Goals: The desired outcomes are many, such as becoming aware of specific behaviors that need to change and how that will be accomplished. The members will learn how to assess their changes and learn new ways to alter their behaviors, and will understand the power of reinforcement.

## PSYCHOANALYTIC: Sigmund Freud

Philosophy: As in individual psychoanalysis, group therapy attempts to restructure the individual's personality. The bringing to the unconscious to the conscious level is a major goal. The family of origin is central to the therapy in resolving problems. A group resembles the original family and the leader and members act in similar ways. This allows the analysis to regress and restructure the personality. The needs not met in childhood seek outlets in the adult life. The main aims are insight and adjustment.

Key Beliefs: Freeing unconscious thoughts, making unconscious conscious, and use of specific techniques. A major assumption is the interaction of the id, ego, and superego and passing through four stages of psychosexual development.

Key Terms: Unconscious, fixation, defense mechanisms, psychosexual stages, dream analysis, interpretation, insight, alternate session, transference, condenser phenomena, mirror phenomena, counter transference, and catharsis.

Method: Making the unconscious conscious. The individual attempts to resolve conflicts of the psychosexual stages. The leader is not always looked upon as an ego ideal, members are not always passive and dependent, and members can create group standards.

Stages: Psychoanalytic therapists view this change as a process. The process is composed of recreating, analyzing, discussing, interpreting, and defense mechanism, restructuring and working through similar stages such as those of Erikson's Psychosocial Theory. This process is either a regressive-reconstructive or repressive-constructive approach.

Leader's Role: The leader is not necessarily a member of the group; however, will attempt to create a climate for exploration, support and expression. The leader may set limits, provide resistance interpretation, interpret meaning, process intragroup conflict, transfer leadership, and use transference interpretations.

Member's Role: Each member establishes a similar relationship to those in birth family. Examine defense mechanisms, share insights, and interpret member dreams and expressions.

Techniques: Free association, alternate session, dream analysis, insight.

Goals: Pass through the desired stages successfully.

### TRANSACTIONAL ANALYSIS: Eric Berne and Robert Goulding

Philosophy: This is a method of changing our way of thinking, feeling, and behaving. We are responsible for thinking, feeling, and behaving as it pertains to our life. Individuals are programmed or scripted early in life and are capable of change.

Key Beliefs: TA is similar to REBT in cognition and participatory learning.

Key Terms: Injunctions, structural analysis, stroking, counter injunctions, games, life scripts, contamination, transactional analysis, ego states, parent-child-adult.

Method: This is a didactic and cognitive model. The recognition of the ego state and how the individual communicates determines how the person has set up his/her life plan. This in turn determines his/her actions.

Stages: A process is reinforced whereby the individual engages in a contract with established goals. Authors have different approaches to the therapy. Goulding has three stages, while Berne may utilize four techniques, such as structural analysis, transactional analysis, game analysis, and life-script analysis.

Role of the Leader: A teacher, trainer and resource person. The relationship is important so that the group can be a place for learning. Important transactions are those between a leader and a member and less so among members. The leader roles are protection, permission, potency, and operations.

Role of Members: Develop inner resources, make contact with members, develop contract, and be in the process.

Techniques: Game analysis, structural analysis, transactional analysis, life-script analysis, rackets, etc.

Goals: The desired outcome is for everyone to adopt an "I'm Ok" stance. A desired goal is for everyone to think, feel, and behave differently. They are to be freed from old parenting messages.

## OBJECTIVE 6D: Evaluation

Planning the evaluation is critical for goal assessments throughout the life of the group. There is to be evaluation plans for the entire group as well as the individual members. The evaluations can take the form of written goals assessed with a rating scale or instruments. Suggestions for process note taking during the course of the group experiences will assist in memory recall for smaller details to emerge and become a part of the outcome. A follow-up will provide feedback should the membership be homogeneous or heterogeneous.

The best practice guidelines 2007 revision within the scope of practice (A.3., C.3) specifies assessment to include group workers assessing their knowledge and skills and ecological awareness. Ecological assessment refers to the needs of the community, agency or organization resources, organization

mission, staff competency, attitudes regarding group work, professional training levels of group leaders, client attitudes regarding group work, and multicultural and diversity considerations (Thomas & Pender, 2008). Section C.3 evaluation and follow-up state that group workers evaluate process and outcomes and to conduct follow-up contact with group members.

Interaction process analysis is a method of observation developed by Bales (1950, 1955) although later identified as a system for the multiple level observation of groups (SYMOG) (Bales, Cohen & Williamson, 1979). In this system observations are conducted for positive social/emotional areas, negative social/emotional areas and neutral task areas. A formal method of evaluation is to use forms for group development or diagrams that include topics of unity, self-direction, climate, leadership distribution, responsibility, problem solving, methods for resolving disagreements, basic needs, activities, depth of activities, leader-member rapport, role of leader, and stability. Depending on the type of group and group goals items can be deleted or added.

# OBJECTIVE 6E: Group Leadership Standards

In 1992, ASGW published standards for leader qualifications. These standards were revised in 2000 and recommend at least one group course at the master level training however, one course may not be enough when that course includes both content and experience (ASGW, 2000). The 2000 revision specifies the content and clinical instruction for the course work objectives in knowledge and clinical instruction for experiential requirements and skill objectives. The 2000 standards mirror the CACREP objectives for this unit of study regarding knowledge and skill requirements.

ASGW standards specify two levels. The first level is core knowledge and skill competencies. There are nine knowledge competencies, 17 skill competencies, and specified hours for group work that are supervised in group counseling. The skill acquisition mandates learning how to open and close session work, model appropriate behaviors, display appropriate self-disclosure, give and receive feedback, and help members attribute meaning to experiences, help to integrate and apply learning, and apply ethical principles in the group (Corey, 2000). During the skill acquisition, the standards recommend 20 hours of core supervised experiences with a minimum of 10 hours for supervised experiences. The second level, advanced specialization, is to specialize in one of four types of group psychoeducation, task/work group, group counseling, and group psychotherapy. Task/work group requires a minimum of 30 clock hours of supervised practice, group psychoeducation 30 minimum clock hours, group counseling 45 clock hours, and group psychotherapy 45 clock hours.

Multicultural and social justice competences are included under three categories, awareness of self and group members, strategies and skills, and social justice advocacy. Social justice competencies include respecting worldviews, language development, specific knowledge and information, understandings of race, ethnicity, gender, culture, sexual identity, age, SES, and shared cultural experiences, model relationships, group needs and goals, and target populations. If groups should be culture-specific, communication styles, pre-group screening, time impact and communication, and referring are important (Singh, Merchant, et al., 2012).

Group supervision is essential for effective feedback for the leaders and in accomplishing clinical goals for the group members. Supervision can include blind supervision (leaders describe session work), one-way mirror (observation behind a mirror), videotape (review verbal and non-verbal work together), and audio tape (verbal reporting with leader input). In each situation ethical requirements are for permission requests to be made for each situation where the client is a part of the taping, video, and mirror experience and under informed consent the leader is to inform members of supervision involvement.

**Question 6-31:**
Which one of the following is not considered a developmental theme or deficit for those who experience an eating disorder?

a. sibling rivalry
b. avoid femininity
c. over embrace femininity
d. lack separation and differentiation
e. exhibit younger styles of reasoning
f. desire to remain a child

Answer: a. sibling rivalry

**Question 6-32:**
Which type of group has been recommended for those who experience eating disorders?

a. Gestalt
b. person-centered
c. cognitive-behavioral
d. psychoanalysis

Answer: c. cognitive-behavioral

**Question 6-33:**
Research by Elizabeth (1983) in comparing group treatment methods found which therapy to generate higher levels of anxiety among group members?

a. psychoanalytic
b. person-centered
c. rational-emotive
d. gestalt

Answer: a. psychoanalytic

**Question 6-34:**
The term that Janis (1972) described as a deterioration of mental efficiency, reality testing, and moral judgment that results from in-group pressures is:

a. groupthink.
b. emotional contagion.
c. deindividuation.
4. SYMLOG.

Answer: a. groupthink (see TERMS for definition).

**Question 6-35:**
A research based personality and group dynamic which allows a rating on three dimensions (dominance vs. submissiveness, friendliness vs. unfriendliness, and instrumentally vs. emotionally expressive) and 26 roles found in groups is:

a. NGT.
b. SYMLOG.
c. synectics.
d. cohesion.

Answer: b. SYMLOG. System for the Multiple Level Observation of Groups. NGT is a nominal-group technique, a six-step procedure to help nonworking groups become productive.

# Unit 6 - Terms

AUTOCRATIC LEADERSHIP:
A form of leadership in which the leader uses directive forms of group therapy and maintains control of the group. This type of leadership will usually inhibit the process of differentiation and recapitulation. This leader usually demands conformity and obedience, gives advice, and sees himself/herself as expert. The leader is usually charismatic and is most effective during times of crisis.

BALINT GROUP:
A Balint group is a special group developed by Michael and Enid Balint for family-practice physicians who are concerned about understanding and improving the doctor-patient relationship (Balint, 1957). In addition, those doctors who view the curative process to include the doctor-patient relationship are more effectively able to elicit client motivation and involvement in his/her own cure.

BLOCKING:
A leader technique used to counteract nonproductive group work. Leader blocking must be done with sensitivity and skill in order not to come across as attacking the individual. The leader should focus on the behavior and not on the person. Corey (1995) indicates that scapegoating, group pressure, and questioning are behaviors in which blocking is appropriate. Breaking confidence, invading privacy,

giving undue amounts of advice, storytelling, and gossiping are behaviors for blocking. Blocking is not to be confused with the blocker role, which is the tendency to be negativistic and socialization groups.

BOSTON MODEL:
A group of social-work theorists from the Boston University School of Social Work developed a five-stage model of group development. These stages are: pre-affiliation, power and control, intimacy, differentiation, and termination. This model was developed and suggested for supportive treatment and socialization groups.

CAPPING:
A term used to denote the easing away from emotional interaction and toward cognitive reflection. Gladding (1995) identified this as one of three methods used to assist the leader in the termination process of a group. The other two methods are setting time limits and modeling appropriate termination skills in closing a group.

CHARISMATIC LEADER:
This type of leader develops an irrational devotion by followers. This leader has an unusual amount of referent and legitimate powers. Followers of charismatic leaders are trusting and tend to worship them without reference to any social norm. Charismatic leaders tend to appeal to large groups who are dissatisfied with some element of society or the environment.

CO-LEADERSHIP:
A term frequently reserved for professionals who have been trained to lead in tandem and to replicate the parental structure. Several advantages and disadvantages for co-leading a group are given in the chapter. Gladding (1995, 2003) and Vander Kolk (1985) indicate that co-leading is desired at all times; however, when group membership exceeds 12, it becomes almost imperative.

CONFORMITY:
Through group social influence there is a change in beliefs or actions. Conformity usually improves the functioning of a group. Asch (1952) conducted the most noteworthy study on group pressures.

CONTAGION:
This is the transmission of cues triggering behaviors in others that may be similar to the one transmitting. It often causes members to follow suit. Spontaneous pickup imitation (Redl, 1949).

CRITICAL INCIDENTS:
Gladding (1995) defined a critical incident in a group as "an event that has the power to shape or influence the group positively or negatively" (p. 448). Kottler (1994) summarized content writings of several authors who use terms such as a group problem, problem behaviors, critical issues, and critical first-time behaviors to illustrate a critical incident. Donihian and Hulse-Killacky (1999) believed that critical incidents occur naturally out of the development of a group.

DYNAMICS:
Group dynamics is the study of behavior in groups regarding the nature of groups and group development. It is a term to denote the interrelations of individuals in a group.

EMERGENT-NORM THEORY:
One of the theories to explain the group mind. This theory suggests that a powerful norm emerges in a group and becomes the standard for behavior. These are atypical norms, and what is conveyed is a sense of urgency transmitted through a crowd by means of mood, imagery, and actions. These moods and actions are considered right by the group, and members conform. This theory also asserts that members are highly suggestible. These are norms that become relevant at the time, based upon the makeup of the group. This type of norm emerges out of what is occurring and the Group Mind.

EMPOWERMENT:
Empowering an individual is to make him/her feel worthy. Johnson and Johnson (1972) describe two methods to empower an individual. The first is to be open to negotiations and to be flexible with the option most liked. The second is to give power through the choice.

ENCOUNTER:
Encounter is an existential term that entails a physical and psychological contact in a group context. The encounter is usually referred to as encounter experience and is of an intense nature between individuals. A result is a sensitivity training in which individuals gain deep interpersonal intimacy with one another. Members are in a small group experience, which fosters personal growth, intrapsychic and interpersonal issues sharing through expression and sensory exploration (Eddy & Lubin, 1989; Lieberman, Yalom, & Miles, 1973).

ENTITATIVITY:
Campbell (as cited in Forsyth, 1990) suggests it takes three components to make up a unified entity (group): common fate, similarity, and proximity. Entitativity is framed in a place in which all members experience the same outcome while displaying similar behaviors, yet are close enough to one another (proximity) to appear together.

FAREWELL PARTY SYNDROME:
A behavior demonstrated by some members of a group who desire to avoid what they have learned in a group. These members tend to accentuate the positive aspects of what occurred in a group.

FIRO:
Fundamental Interpersonal Relations Orientation (F1RO). William Schutz developed his instruments on the basis that people orient themselves toward people or away from them. These instruments are called the FIRO-B and the FIRO-F for behavior.

FISHBOWL:
One method of the fishbowl is to form subgroups to monitor each other's behavior. Each member on the inside circle is matched with a member on the outside circle. The outside member will be observing to provide feedback; to conduct interchanges, serve as an auxiliary fishbowl is used to increase the awareness of group members to the process of the group.

GROUP MIND:
Gustave LeBon, in publishing his study, The Crow; made reference to the group mind, which appears as the antisocial behaviors of impulsiveness, irritability, incapacity to reason, and exaggeration of

sentiments. It was his opinion that members who feel anonymous and invulnerable will succumb to behavioral contagions, passing emotions from one another in a group and are suggestible to a collective mind. There are several different theories that attempt to explain these phenomena, such as convergence theory, emergent-norm theory, and deindividuation theory (LeBon, 1895/1960).

GROUPTHINK:
A term coined by Janis (1982) to reflect a decision-making process in which defensive avoidance is the norm. Groupthink is the collective striving for unanimity that overrides group members' motivation to realistically appraise alternative courses of action (Johnson & Johnson, 1997). Janis believes this type of thinking leads to a mental inefficiency and an ignoring of external information inconsistent with the favored course of action. Janis used the Bay of Pigs, Pearl Harbor, and the Vietnam War to illustrate how groupthink led to these outcomes (Janis, 1982).

HERE AND NOW:
Irv Yalom teaches and leads groups in present experiencing utilizing the self-reflective loop composed of self-disclosure and feedback.

ICEBREAKER:
Icebreakers are introductory exercises or techniques designed to develop communication between two or more individuals. These techniques are desired in that they allow members to orient themselves to the others and to the group before sharing of deeper intimacy is required.

LEVELING:
In communicating, the person receiving the message will reduce the amount of information he/she has to receive by remembering less of the message. As a result, the message becomes shorter and shorter, thus concise and easier to grasp and retell. Details are omitted.

LEWIN, KURT:
Trained at the University of Berlin, Lewin worked and associated with Max Wertheimer, Kurt Koffka, and Wolfgang Kohler, who were gestalt psychologists. He was interested in what motivated individuals and while at the University of Iowa he studied group dynamics. Lewin is credited with the term "group dynamics."

MANDATE PHENOMENON:
An individual will go against the leader-authority when he/she feels the power of the group behind him/her (Clark & Sechrest, 1976).

MINDLESSNESS:
Elmes and Gemmill (1990) credit Langer and Piper with coining the term "mindlessness," which refers to the "tendency of an individual to process information sluggishly and to adhere to a rigid frame of reference that is inappropriate and inadequate for coping with emerging issues" (p. 29). Langer and Piper studied the effects of television viewing on the cognitive processes. It was their contention that for cognitions that did not fit the group mind, the collective group would deny and distort the inner and outer realities. This repression and suppression (social defense against anxiety over complexity

and turbulence both inside and outside a group) of one's individuality and yield to a group mind was a part of the writings of Freud.

NORMS:
Behaviors that structure and regulate the performance of the individual's behaviors and judgments. Norming has developed when members have a "We" feeling and subscribe to those rules both overt and covert. Several different types of norms exist, such as prescriptive and proscriptive. A parity norm is an equity norm suggesting that the payoffs should equal the amount of input to the task.

POWER:
Power refers to the amount of influence or force a person can exert on a second person, divided by the resistance the second person can apply to that force (Lewin, 1951). Power in groups is most often applied to leadership type and style. Forsyth (1990) refers to the basic power types as referent, expert, coercive, and legitimate. Each of these types has associated power tactics.

PREMATURE TERMINATION:
Premature termination can be described as a time in which a goal is not reached. There are various reasons why members abruptly leave counseling without informing the counselor. Skills need to be developed to respond to prevent premature terminators.

PRIMARY GROUP:
A primary group is a small group in which there is face-to-face interaction where the members adhere to interdependency and identify with each other.

RINGELMANN EFFECT:
As a group increases in size, it will become less productive (Steiner, 1972).

SELF-HELP GROUP:
Self-help groups are developed by the membership to respond to a multitude of common concerns. The primary purpose is to provide support and protect members from psychological stress and urge them to change their existing conditions. They are often leader-centered and can be of any size. Mothers Against Drunken Drivers (MADD) is a good example of a self-help group.

SOCIOMETRY:
A term developed by J. L. Moreno describing a technique for measuring the social relationships linking group members. A sociogram is constructed from the responses of group members (Forsyth, 1990).

STEINZOR EFFECT:
An interpersonal communication pattern of a group member speaking immediately after the person across from him/her has spoken (Forsyth, 1990).

T-GROUP:
T-groups started at the National Training Laboratory in Bethel, Maine, and are considered to be a part of the human potential movement. T-groups and the purpose for them was the development and understanding of theory, group dynamics, and group work.

TASK ROLE:
One set of roles in which members set about to reach the goal of the group. These role functions are more interested in the task accomplished than the emotional aspects of the interactions.

UNIVERSALITY:
Universality is one of the curative agents identified by Yalom that is important in the early phases of a group. Individuals learn they are not unique in the sense that they are the only ones to have a problem, which problem is or is not as severe as another, and that people do get better.

# Unit 6 - References


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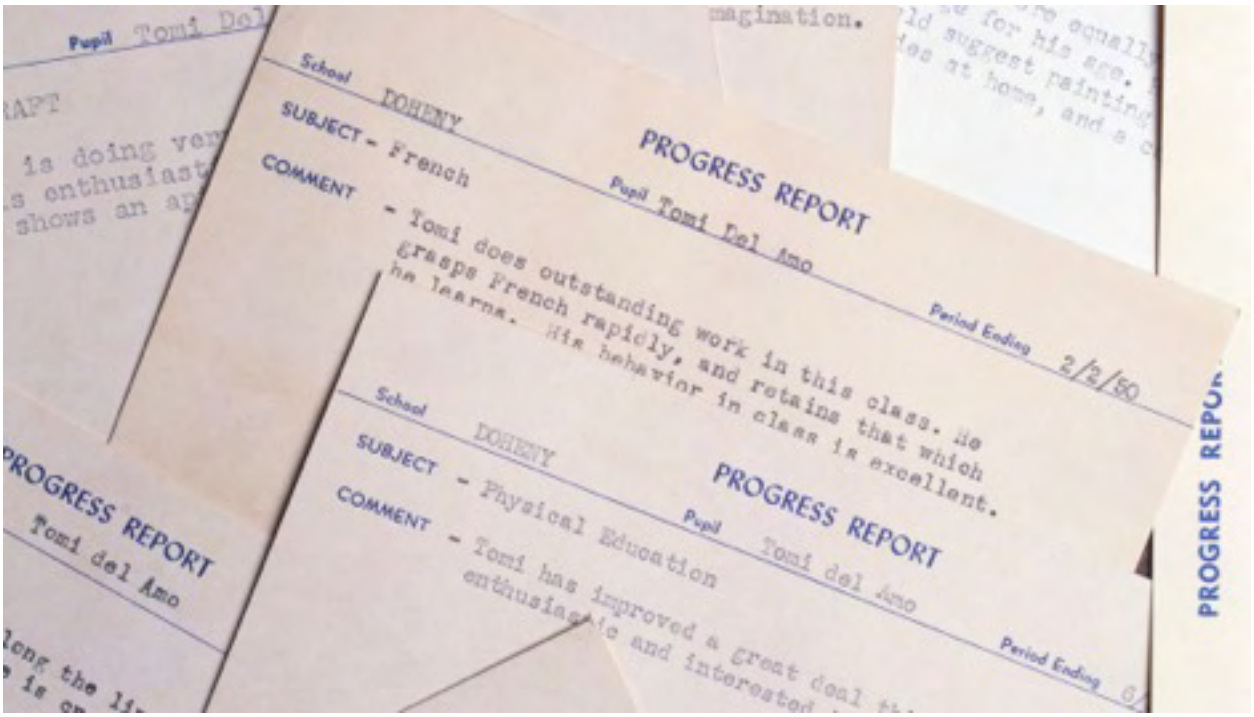



# UNIT 7 - Assessment

## Introduction

It is important for all counselors to understand the importance of assessing individuals. This involves understanding different theories of testing, instrument construction, testing procedures, and interpretation practices (Gladding, 1996; Newsome & Gladding, 2014). Developing a foundation in mental measurement and assessment does include terminology, understanding and applying information about test administration and scoring, standardization methods, measurement error, and statistical techniques.

A reasonable approach to acquire this understanding is to begin with the functions and usability of test and non-test data in measurement and assessment. Understanding individual similarities and differences, historically, has been used as the basis for determining human functioning. Historically, these differences have been studied and interpreted through the use of sensorimotor, physical, mental, and brass instruments.

Be familiar with score reports to the extent that you are knowledgeable about the normal curve and the application of test information. Interviewing techniques such as the social intake, mental status examination, and sociometrics are included as a means of gathering data.

Basic principles of assessing are stressed throughout the examination. These fundamentals include reliability, validity, norming, variability, and a variety of correlations. Computer technology as it is

applied to testing, scanning answer forms, data storage, and retrievable test interpretation and dissemination have become ethical and sometimes legal issues. Section E of the ACA Code of Ethics should be reviewed.

Finally, in preparing for questions from this chapter, be aware that approximately 25 test questions, of which 20 count toward your total score, come from the core area of individual assessment.

# CACREP Objectives

Assessment objectives have been abbreviated to serve as an over-view and the full objectives for CACREP standards 2009 are to be located at www.cacrep.org.

A. historical perspective and meaning of assessment;
B. standardized, nonstandardized, norm-referenced, criterion-referenced, environmental, performance, inventories, psychological testing, and behavioral observations.
C. scales of measurement, statistical concepts, central tendency, variability, shapes, correlations
D. reliability, measurement error, models and application
E. validity, types, relationship between validity and reliability
F. social and culture factors and specific populations
G. legal and ethical is issues

**Question 7-1: (Objective A.)**
Sir Francis Galton was credited for several constructs, terms, and evaluative tools. Which of the following did he make a partial contribution?

a. correlation
b. normal curve
c. ratio IQ
d. descriptive statistics

Answer: b. normal curve. The normal curve (bell curve) is referred to as the Gaussiun curve and named for Carl Gauss.

**Question 7-2: (Objective B.)**
The technique most closely associated with behavioral observations of a social nature of individuals in a group task is:

a. round robin
b. sociometric
c. social observation
d. t-test

Answer: b. sociometric. A sociometric is a qualitative method to measure social relationships (alliances, hidden beliefs, agendas, stars, isolates of a group).

**Question 7-3: (Objective B.)**
What type of instrument is used for assessing an assault of the brain?

a. Stanford Binet
b. Bender Gestalt
c. Halstead-Reitan
d. Rorschach

Answer: b. Bender Gestalt. After the Korean War the Bender Gestalt was used for treating and diagnosing brain damage. It has been used as a screening tool for brain damage for ages 4-85. Errors are calculated for rotation, overlapping, difficulty, simplication, fragmentation, retrogression, preservation, collision, impotence, closure difficulty, angulation, and cohesion, time (15"). Error rate from 9-12 is considered strong evidence.

**Question 7-4: (Objective C.)**
The distribution of a set of scores with a mean of 58 and a median of 61 can be described as a:

a. perfect distribution
b. positively skewed distribution
c. negatively skewed distribution
d. t-distribution

Answer: c. negatively skewed distribution. Mean is to the left of the median.

**Question 7-5: (Objective D.)**
What model of reliability is administered twice but with different but equal forms?

a. construct
b. test-retest
c. coefficient alpha
d. parallel

Answer: d. parallel (or alternate)

**Question 7-6: (Objective E.)**
In the analogy reliability is to standard of measure and validity is to standard error of:

a. consistency
b. criterion
c. estimate
d. relevance

Answer: c. estimate

**Question 7-7: (Objective F.)**
It is important when using achievement instruments with specific populations to:

a. secure signed releases
b. use norm included instruments
c. use age adjusted norms
d. use only raw scores

Answer: b. use norm included instruments

**Question 7-8: (Objective G.)**
The resource guide most useful for technical information when selecting an assessment instrument is the:

a. Test in Print
b. Test Manual
c. Technical Test Manual
d. Buros Mental Measurement Yearbook

Answer: d. Buros Mental Measurement Yearbook. Instruments in the MMYB have been reviewed by a minimum of three experts who comment on the research, validity, reliability, usefulness, strengths, weaknesses, age usage, and other specifics of the instruments.

**Question 7-9: (Objective G.)**
When administering and interpreting results it is important that:

a. a manual is to be present
b. a supervisor is present
c. a set of answers is to be scored more than one time
d. stylistic scales are understood by the client and the administrator

Answer: a. a manual is to be present

# Terms

Several terms relating to individual analysis and testing are listed. Definitions are found at the end of this chapter.

Achievement
Aptitude
Coefficient Alpha
Confidentiality
Constant Error
Convergent Validity

Criterion Referenced
Crystallized Intelligence
Cultural Equivalence
Discriminant Validity
Expectancy Table
Factor Analysis
Fluid Intelligence
Flynn Effect
Forced Choice
Formative Evaluation
Guttman Scale
Halo Effect
Item Analysis
Likert Scale
Mainstreaming
Mesokurtic
Omnibus
Power Trust
Public Law 94-142
Q-Sort
Regression
Reliability
Semantic Differential
Sociometry
SOMPA
Standard Error Measure
Standardization
Stem and Leaf
Summative Evaluation
Truth in Testing
Validity
Variability

# Ethical Observations

The ACA Code of Ethics for assessment has 14 sections devoted to assessment, client welfare, competence, appropriate use of instruments, decisions based on results, informed consent, recipients of results, release of data, diagnosis, cultural sensitivity, social prejudices, refraining from diagnosis, instrument selection, referral, conditions for administration, favorable conditions, technological administration, unsupervised assessment, multicultural issues, scoring and interpretation, insufficient empirical data, services, security, obsolete assessment and data, construction, forensic evaluation, obligations, consent, evaluation prohibited, and potentially harmful relationships (ACA, 2014).

## OBJECTIVE 7A: The History of Assessment

CACREP objective for assessment 7.a. identifies the need to understand the historical perspectives concerning the nature and meaning of assessment (2013). Drummond and Jones (2010) use the definition for assessment offered by the American Educational Research Association which is a systematic procedure for collecting information that is used to make inferences or decisions about the characteristics of a person. This provides a clearer definition for assessment and for testing. Testing is often a single act requiring an interview, a test, an observation or a self-report. The comprehensive task is to integrate the information from a multitude of data collecting tools or methods. The methods represent three groups: interviews, tests, and observations. It is the purpose of the assessment that determines the method, screening, diagnosis, intervention, and monitoring for outcome. Interview

methods include data gathering styles using open, structured, motivational, unstructured, and semi-structured types. Tests are standardized, inventories, checklists, questionnaires, projective, work samples, environmental, and monitoring. Observation include rating scales, event and duration recording, time sampling, raw notes, and anecdotal records (Drummonds & Jones).

Currently testing and assessment have added another approach and tool to gather data. Some of these advancements are computer-based which include automated test scoring, computer-generated reports and narratives, computer-adaptive tests and simulations. With these innovations new ethical dilemmas have emerged regarding confidentiality, examinee expertise in the use of test format, and packaged reports often taken at face value. Internet-based assessments have opened up different pros and cons. There is immediate availability and scoring, cost efficiency, and for some an administrator is not required. The limitations include receiving feedback at face-value without a counselor to assist in the understanding of results.

Though the history of testing can be traced to the ancient Chinese, it was during the late 1800s that interest in measuring individual differences became pronounced. With the rise of scientific psychology in Germany and the writings of Charles Darwin in England, the field of mental measurement became a new frontier to be explored. Early test development was led by individuals such as Wilhelm Wundt, Francis Galton, Carl Brigham, James McKeen Cattell, Charles Spearman, Lewis Terman, Robert Woodworth, Edward Thorndike, and Alfred Binet (Aiken, 1997). Wilhelm Wundt, who developed one of the first psychological laboratories, proposed assessing individuals according to uniformities. Sir Francis Galton, an English biologist and cousin of Charles Darwin, established a psychometric laboratory where he assessed and compared individual differences through the use of physical-sensory and intellectual devices. He pioneered the testing movement through his research on the hereditary basis on genius. Besides his book, Hereditary Genius, Galton's contribution to the field of testing includes the rating scale, the questionnaire, and the observation of co-relation.

## Intelligence Testing

One of Galton's assistants, American psychologist James McKeen Cattell, was responsible for furthering the testing movement and was the first to use the term "mental test." Alfred Binet, a French psychologist, spent many years researching approaches for measuring intelligence. These approaches included such things as analyzing handwriting and measuring cranial and facial forms. Finally, when Binet and his colleagues came up with a test that would identify mentally retarded children in the French public school system, they developed the first Binet-Simon Scale (Anastasi, 1988). The 1908 revision introduced the concept of "mental age," and the 1911 revision extended the test to the adult level (Aiken, 1997). In America the most famous revision of the Binet-Simon test was the Stanford-Binet developed by Lewis Terman in 1916. This was the first test to use the concept of "IQ," or ratio between mental age and chronological age (Anastasi, 1988).

During this time, a student of Terman, Arthur Otis, devised a group intelligence test, which used a multiple-choice format. This item type was one of Otis's major contributions to group testing. His intelligence test later served as the basis for the Army Alpha and Army Beta test developed by Robert Yerkes. These instruments were first used during World War I to screen military personnel and were

eventually released, after many revisions, for civilian use. It was at this point that IQ testing was widely applied.

## Aptitude Testing

New statistical methods such as factor analysis were developed, and as new developments in trait theory were evolving, widespread use of intelligence tests and limitations of test use became evident. Thus, the multiple aptitude battery was developed. Charles Spearman, T. L. Kelly, and L. L. Thurstone were all influential in aptitude testing. This type of a test measured a number of traits and yielded a separate score for each trait, as opposed to one global score such as the IQ. Nearly all aptitude batteries have been constructed since 1945 as a result of the intensive research by military psychologists during World War II. Today, multiple aptitude batteries are still used in the armed forces as well as educational and vocational counseling, personnel selection and classification, etc. (Anastasi, 1988). Some specific examples include the General Aptitude Test Battery (GATB), the Differential Aptitude Battery (DAT), and the Armed Services Vocational Aptitude Battery (ASVAB) (Gladding, 1988, 1996).

## Achievement Testing

Another developing field in testing at the turn of the century was the standardized achievement test. E. L. Thorndike was a pioneer in achievement testing as well as T. L. Kelly, Giles M. Ruch, and Lewis Terman (Anastasi, 1988). In 1923, the first achievement test battery, the Stanford Achievement Test (SAT), was published. By 1930, it was generally accepted that the new objective achievement tests, which could be scored by machine, were less time-consuming and more reliable than the oral and essay tests formerly given students. By 1917, the Educational Testing Service (ETS) was formed out of the testing divisions of the College Entrance Examination Board (CEEB), the Carnegie Corporation, and the American Council on Education. Educational Testing Service (ETS) became the primary agency in developing national testing programs for institutions of higher learning (Anastasi, 1988). One of these tests, the Scholastic Aptitude Test (SAT), has incurred much criticism since the 1960s despite its exceptional design and high reliability and validity as a predictor of college achievement (Gladding, 1988).

## Personality Testing

Still another area of testing is concerned with the measurement of personality. During World War I, the Woodworth Personal Data Sheet was developed to screen out seriously neurotic military candidates. This questionnaire was the first standardized personality inventory and served as a prototype for subsequent tests. Besides questionnaires, personality was measured through performance or situation tests such as those used during World War II in the assessment program for the Office of Selective Service. Also, projective techniques such as the Rorschach in 1921, sentence-completion, and Murray's Thematic Apperception Test in 1931 have been developed for clinical use in personality assessment (Anastasi, 1988).

## Interest/Vocational Testing

In 1927, the Strong Vocational Interest Blank (SVIB) was published. Several revisions have been conducted with the SVIB until today it is known as the Strong Interest Inventory (SII). The Strong Interest Inventory is one of the most widely used and researched inventories currently published for professional and semi-professional occupations (Gladding, 1996). John Holland's theory, particularly his categorization of occupational stereotypes, has been incorporated into the instrument as a way to understand the personality and environment interactions (fit). Other interest inventories are the Kuder series (vocational, personal, and occupational), the Jackson Vocational Interest Survey, and the Vocational Preference Inventory, to name a few.

## Observational Testing

Rating scales, checklists, behavioral charting, anecdotal records, and interviews are often used as a means to measure behavior. These observational techniques are subject to error in assessment. Some errors include: lack objectivity, halo error, personal response tendencies, being obtrusive, failure to observe behavior more than once, lack of training, and observer agreement or disagreement. A form of observational assessment that is done through student demonstrations similar to classroom behaviors is known as authentic or performance testing (Drummond, 1996). Observations that take place at work, play, school, and social settings are natural. When observations are made in a laboratory they are referred to as analogue assessment.

One example of an observational scale is The Vineland Adaptive Behavior Scale, which utilizes observational testing to assess intellectual disability. The Vineland is used for diagnostic evaluation and program planning (Newmark, 1989).

## Computerized Adaptive Testing

Powell (1994) indicates that computerized adaptive testing (CAT) is an alternative to the traditional pencil-and-paper testing. Computerized adaptive testing is statistically supported through item response theory. Strength of adaptive testing is in building item banks and individualizing the test to suit the needs of each test taker. An adaptive test always attempts to provide questions that are near the difficulty level of the examinee's achievement level. There are three procedures that can be implemented. Questions can be selected at random from an item pool; examinees can choose the level of item difficulty before the examination; and the examinee's response can guide the level of difficulty based upon the last question. Generally, the testing procedure is to present a more difficult item after a correct answer and a less difficult item after an incorrect answer. When the examinee's estimated achievement level can be ascertained the examination is curtailed. Adaptive testing usually reduces testing time, yields a more precise measure of the assessment, and has a higher correlation with an external criterion.

## Summary

Historically, the popularity of testing in assessment has varied. The two periods of most prolific testing in America were the 1930s and the 1960s. The 1930s witnessed widespread use of vocational tests to combat the unemployment woes of the Great Depression by attempting to match people and jobs. Then, with the passage of the National Defense Education Act in 1958 and Title V of that legislation, the 1960s became an era of increased funding for testing in schools to identify children capable of careers in the sciences (Gladding, 1988, 1996). The decades of the 1970s and 1980s can be characterized as an "anti-testing" era that led to a critical look at the use of tests. As a result, many instruments were extensively revised and improved, and professionals became increasingly sensitive to their proper use.

Finally, the field of testing has grown and developed as a result of a need to measure individual differences or similarities. From its initial purpose to identify the mentally retarded, testing has broadened its use to include the selection of military personnel, the enhancement of self-understanding and personal development, and the advancement of basic research. Test uses tend to vary, however generally they are selected for purposes of classification, diagnosis, self-knowledge, program evaluation, and research (Gregory, 1996).

The following section identifies some of the basic concepts in appraisal that are common to all of these types of tests.

# OBJECTIVE 7B: Basic Concepts of Assessment

The art and science of understanding, measuring, and making decisions about the psychological characteristics of people are the essence of this unit. Several major terms are important to begin this unit of study. These are:

MEASUREMENT: Ward and Murray-Ward (1999) define measurement as a "process of determining the amount, extent, or other category of a variable" (p. 59). Variable is an important term in this definition because it is usually a characteristic. Mehrens and Lehmann (1984) briefly define measurement as broader than a test (set of stimuli). Measurement can be through observations, rating scales, and interviews, and will yield a score of some description. This score is then compared to an accepted standard, norm-referenced or criterion-referenced. The process utilized to obtain this information is also measurement.

EVALUATION: To continue with Mehrens and Lehmann's (1984) definition of evaluation is even more encompassing decision-making, as a judgment is conducted between the performance on the test and the objectives. Mehrens and Lehmann make a significant point when they emphasize that a person is never measured or evaluated. Rather, what is measured are the characteristics or traits of people. Evaluation results in answers to qualitative questions—How well does Mark know the state capitals?

PSYCHOLOGICAL ASSESSMENT: Maloney and Ward (1976) define psychological assessment as a process of solving problems utilizing psychological tests as a method to collect information. Gregory (1996) defines psychological assessment of an individual through the accumulation of data and personal information collected in order to evaluate the person's psychological functioning in an area and to "predict behavior" (p. 36). The critical elements of psychological assessment are the problem, data collection, and interpretation of the information. Sattler (1990) views psychological assessment in terms of the unique characteristics and circumstances of the person. The purposes of assessment are for screening, diagnosis, counseling, and rehabilitation. This measurement or process is predicated on the idea that behavior can be assessed quantitatively. Therefore, the quantitative concepts are IQ, GPA, %, etc.

QUANTITATIVE: This term refers to how much of an attribute a person has in a segment of knowledge (algebra). Frequently this is presented as 36 correct out of 50 items, or 72% of the questions were answered correctly.

QUALITATIVE: The question becomes how good are the 36 correct results. Frequently the answer is conducted by comparing it to some standard (norm or criterion). It could be said this person surpassed the criterion number correct score to pass on to the next lesson or this person ranked at the 50% level when compared to his eighth-grade classmates at his local school.

STANDARDIZED TESTS: Standardization is defined as a uniform procedure in the administration and scoring of the test. There are many specific facets to be fulfilled in order for a test to be considered a standardized test. Therefore, a psychological test is an objective and standardized measure of a sample of behavior (Anastasi, 1988). These tests are standardized upon a sample, which meets the characteristics of the population.

STANDARD SCORES: A standard test will yield raw scores that will convert to representative scores through the use of a bell-shaped curve with an established mean and standard deviation (Classical Measurement Theory). This process is called a transformation. These scores are now comparable to other members of that population norm group.

## Ethical Factors to Consider in Assessment

Almost any textbook that has to do with psychological testing will systematically present the training needs and safeguards for the consumer because of score contamination, user qualifications, error variances, inadequacies in instrumentation sophistication, and ethical considerations in the application and interpretation of tests and test scores. A few such examples will be provided for review.

1. Invasion of privacy: Several court cases have evolved because the stimuli statements were found to be an invasion of human rights. The area of personality testing calls for improvement in a theoretical base (E.3.b., E.10. security).
2. Heredity vs. environment: The controversial report by Dr. Arthur Jensen regarding the raising-lowering of IQ based upon coaching and the differences in IQ in races have generated many

questions yet unanswered. This debate continues with the publication of The Bell Curve by Richard Hernstein and Charles Murray.

3. Clinical vs. statistical: Statistical predictions have proven to be more reliable than clinical predictions. Clinical judgment is based on experience, intuition, and textbook knowledge (Gregory, 2000). Statistical or actuarial prediction is based on a research-based formula.
4. Demographic differences: Some facts from research reports are included, but not for memorization for the NCE to illustrate that sex, ethnicity, and geographical differences appear to exist. Continued replication and instrument development are needed before generalizations can be made. Women and men have attained different results on the SAT over the years. Men have tended to outscore women on both parts since 1972 (Cordes, 1986). Differences are also noted for ethnic backgrounds with whites scoring highest on SAT-M while Asians score highest on SAT-V (Trombley, 1986). Thus, gender and race bias is known to exist.
5. Coaching on test scores: Coaching is teaching of test-taking skills to improve test performance. Mostly inconsistent and negligible findings are noted for some types of test performance. Yet Messick (1988) concluded that SAT results could be improved by as much as 10 points with 8-10 hours of study. Thirty-point differences have been found with 260 hours of study for the SAT-V and 45 hours for the SAT-M. Because coaching has gone beyond teaching, it has become known that the Lake Wobegon effect has inflated test scores. This has taken place because of inappropriate assistance in time, altered answer sheets, gaining access to answers, receiving copies of tests, and teaching directly to the questions (Cannell, 1989; Ward & Murray-Ward, 1999).
6. Need for cultural and ethnic diversity (E.5.b., ACA, 2014): These differences include values, language, family interaction, nonverbal communication, etc., and yield different results in acquired knowledge for different groups. Cultural sensitivity in the use of tests begins with developing instruments that meet the criteria for culture-fair tests. Cultural equivalence can be established in a test when functional, conceptual, linguistic, and psychometric properties have been assessed and met. The term functional refers to when test scores measure psychological characteristics that occur with equal frequency with different cultural groups. Conceptual refers to the extent that different groups are equally familiar with the content of test items and have similar meaning for the content. Linguistic refers to the language used in the test. Do the words have the same meaning for different cultural groups?

## Classification of Tests

The ACA Code of Ethics cautions users to be aware of the established procedures, relevant standards, and current professional knowledge for assessment, design development, publication, and utilization of assessment techniques (E.12., construction, ACA, 2014).

Tests can be classified in several ways. Some of the more common methods listed by Aiken (1997) are some of the following dichotomies.

Standardized vs. Nonstandardized: A standardized test is one that has been administered to a sample from the population it is intended to represent. Norms have been computed from these scores, and they are the basis by which later scores are interpreted. A standardized test has set instructions for administration and scoring, and professional test constructors create it. A nonstandardized test is usually constructed by a teacher in an informal manner and is usually intended for only one administration.

Individual vs. Group: Individual tests are administered to one examinee at a time, and group tests can be administered to more than one examinee at a time. Group tests usually are multiple choice, more objective, and have better established norms.

Speed vs. Power: A speed test has many easy items, but there is a limit on the time the examinee has to answer the questions. A power test has a generous time limit, but the items may be more difficult.

Objective vs. Subjective: An objective test can be scored by anyone, and the results would be the same no matter who scored it. Examples of objective tests are multiple choice, matching, or true/false. Subjective or nonobjective tests require the scorer to make a judgment. The results may vary depending on who scored the test. Personality tests and essay tests are examples of subjective tests.

Cognitive vs. Noncognitive: Cognitive tests measure mental ability. Achievement tests and aptitude tests are examples of cognitive tests. This type of test is also called a Maximum Performance test.

Typical Performance Test: Noncognitive tests measure interests, attitudes, and other noncognitive attributes of personality. Projective tests and personality inventories are examples and referred to as a Typical Performance Test.

Performance vs. Paper and Pencil: A performance test requires the examinee to manipulate objects, such as in a typing test. This type of test can be called a psychomotor test. A paper-and-pencil test requires the examinee to write answers on paper. An oral examination is similar to the paper-and-pencil test.

Norm vs. Criterion-based: Many of the early classroom tests were norm-based or referenced tests. The goals to be accomplished by testing change and as a result norm-referenced tests did not satisfy the users, therefore criterion-based and domain-referenced tests came about.

In a norm-referenced test, the person's performance is compared to the performance of others in a well-defined norm group. Often, the purpose of these tests is to group students, select special students, evaluate programs, and assign high or low performance. Comparisons are usually conducted with standard scores (z, t, etc.) (Anastasi, 1988).

Norm-referenced scores compare how well a person did when compared to a group score and interpreted as a ranking.

Anecdotal records are brief usually in a narrative form charted after the behavior has taken place. Anecdotal records often are of a single observation or event, objective, written in phrases and immediately after the event, listing sequences of behavior, direct quotes, and recording positive and negative statements (Drummond & Jones, 2010).

A criterion-referenced test is designed to measure the outcomes of instruction. The student's performance is compared to a standard defined by the instruction. There is an absolute standard often characterized as a criterion level, cutting score, pass-fail, go no go, which is a passing standard (Glaser, 1963). Often the term domain-based is used with criterion-referenced tests. In the domain-based, a universe of items has been created and the test is based on this domain. It is the core of criterion-referenced tests. In comparison to norm-referenced, criterion-referenced is a more narrow interpretation such as mathematics (norm) and criterion may be larger in scope (intelligence).

Criterion-referenced norms

Criterion-reference scores are results from criterion-referenced tests and norms and measure how well a person mastered a certain skill such as mathematics. These scores are interpreted when there is a reference or a criterion for a standard of performance and are interpreted using percentiles, scale scores and performance categories.

Testing often is applied to different domains. Domains are cognitive, affective, psychomotor, nonverbal, and component behaviors and are listed in a sophisticated hierarchy known as taxonomies. Depending on the purpose of assessment, one or more of these domains will be tested. Component parts of the cognitive domain taxonomy are knowledge, comprehension, application, analysis, synthesis, and evaluation. The purpose for which the scores are to be used should determine whether a norm or criterion-referenced test is used. If the purpose of testing is simply to rank order the examinees along some achievement continuum, norm-referenced is appropriate. If the scores are to be used as the basis for deciding whether to prescribe remedial work in a skill area or to pass the student along to the next unit of learning, a criterion-referenced test is appropriate.

## Taxonomies for Testing

Test development is generally based upon different levels of learning. Depending upon the purpose of the test, taxonomies may or may not be a part of the assessment process. From a developmental perspective it is easy to see how the cognitive taxonomy is intimately involved in the schooling process, diagnosis, and treatment planning for different age levels. The affective taxonomy may be a part of certain scale construction in personality, interest, attitude, communication, maturity, and instruments that provide some level of attainment. Psychomotor taxonomy is a part of the performance sections of intelligence, aptitude, and achievement subtests. Special areas such as rehabilitation and neurological testing concern themselves with behaviors acceptable to normal performance.

The Affective Domain consists of dimensions of personality that include attitudes, motives, emotional behavior, temperament, and personality traits (Krathwohl, 1964).

The Cognitive Domain consists of dimensions of perceiving, thinking, and remembering. Cognitive domain levels are knowledge, comprehension, application, synthesis, analysis, and evaluation. A brief definition for knowledge and comprehension is provided:

Knowledge is the ability to recall or recognize information in the form it was presented (remembering). Comprehension means understanding and the ability to use previously acquired information to solve a problem (translation and interpretation). Translation is the ability to paraphrase a communication or present it in a different form or to recognize the changes in symbolic form; interpretation-ability to make an inference based on information, explain the meaning, or summarize the information.

The Psychomotor Domain emphasizes psychomotor developing as individual behavioral objectives. Harlow developed a taxonomy that utilized classification levels and subcategories to classify behaviors (Harrow (1972).

Various types of tests will be described below using the dichotomous classification of cognitive versus noncognitive.

# Cognitive Tests

## Achievement Tests

An achievement test measures a person's achievement, or degree of learning already obtained in a particular area. An achievement test can be teacher-made or standardized. It is used for selection, classification, placement, or instruction. It is difficult for examinees to tell the difference in aptitude and achievement items if the purpose is not known. The reliabilities of achievement tests are usually in the .80s or .90s (parallel forms preferred), and they have content validity. Some examples of achievement tests are the Iowa Test of Basic Skills (1TBS), a Spanish test constructed by a high school teacher, or the National Counselors Examination (NCE).

Type-Aiken (1997) identifies the following instruments representing a match for instrument to purpose:

Diagnostic: Identifies specific difficulties in learning a subject. An example is the Diagnostic Reading Scales.

Single Subject: Yields one overall score in a single subject and makes no determination of causes of high and low scores. An example is a teacher-made math test.

Survey Batteries: A group of subject tests that measures a person's standing in several different subject areas. An example is the Metropolitan Achievement Test.

Prognostic: Predicts achievement. Examples are the Stanford Achievement Test or a reading readiness test.

## Aptitude Tests

Aptitude tests measure what a person is capable of learning in the future. They indicate a person's ability to profit from training in an area. Aptitude tests usually have split-half reliabilities in the .80s or .90s, and have predictive validity.

Aptitude tests are considered by some to be a type of achievement test in that they do not measure innate abilities, but rather the product of a lifetime of environmental and hereditary factors (Aiken, 1997). Aptitude tests measure achievement and achievement tests predict future accomplishments, thereby qualify, as aptitude measures (Aiken). For this reason, some have suggested that both aptitude and achievement tests be called ability tests or cognitive ability tests.

## Intelligence Tests

Several definitions exist for intelligence tests, however most include judgment, understanding, and reasoning capacity. Gregory (1996) reviewed thirteen definitions of intelligence by various theorists and found agreement that intelligence is composed of the capacity to learn from experiences and to adapt to one's environment. Theorists such as Thorndike, Otis, Guilford, Spearman, Cattell, Thurstone, Wechsler, and Binet have developed instruments to assess the aptitude for scholastic work and successful performance of duties. These are either individual or group tests. It is meaningful to remember that intelligence tests attempt to measure intelligence and do not necessarily define intelligence. Gregory (1996) delineates a critical difference between an operational definition and a real definition. An operational definition for intelligence is circular while a real definition for intelligence is the true nature of intelligence, something we have not been able to determine.

The first useful scale was the Binet-Simon Scale, which in 1916 became the Stanford-Binet Intelligence Scale. The Stanford-Binet yields a ratio IQ, which is mental age divided by chronological age and multiplied by 100, a term first introduced by Stern in 1914. Stern recognized that being retarded had different meanings at different ages. The basal age of a subject is the highest year level at which all subjects are passed, and the ceiling age is the lowest year level at which all subjects are failed.

Another set of popular intelligence scales is the Wechsler intelligence scales (WAIS-R, WISC-IIIR, and WPPSI-R). The Wechsler yields a deviation IQ, which is computed by multiplying the z score equivalent of the raw score by the standard deviation and adding 100 to this product. A deviation IQ has a mean of 100 and a set standard deviation usually 15 or 16. Three kinds of Intelligence Quotients (IQ) are reported by this test: Verbal, Performance, and Full Scale.

Several tests yield these three scores. For the most part the Verbal Scale is likely to refer to functions of the left-brain hemisphere and the Performance Scale to right-brain hemisphere functioning. The left hemisphere components control for verbal functions, memory, language and logical-sequential learning while the right brain for expressive and creative tasks. The below list is not exhaustive, however, contains a majority of the functions.

| | |
|---|---|
| Left Hemisphere | Verbal functions |

| | |
|---|---|
| Memory | Nonverbal |
| Language comprehension | Perceptual |
| Analytic, sequential | Spatial visualization |
| Sequential-serial | Visual learning |
| Ideas Holistic-gestalt | Visual-motor organize |
| Temporal analysis | Holistic-gestalt |
| Right-left orientation | Intuitive problem solving |
| Sequential processing | Humor |
| Conceptual | Creative associative |
| Motor functions | Sound |
| Field-dependent | Fluid thinking |
| Crystallized thinking | Field thinking |
| Speech-writing | Incidental learning |
| Right Hemisphere | Impersonal orientation |

The above functions have been adapted from the work of Sattler (1990) and Berent (1981). The reporting of IQ scores must be given special consideration. These scores should never be reported without interpretation to parents and/or students because they are sometimes misinterpreted as being measures of the capacity for learning, which has been replaced with academic aptitude (Sax, 1974). Grade norms should not be used in counseling with parents (Sax, 1974), and methods of reporting student progress should be objective, continuous, reliable, and valid.

Models of Intelligence: An overview of a few select models of intelligence theories will be provided. Galton, Cattell, and Brigham attempted to develop early theories which would measure intelligence, not define it.

Faculty Theory: During the 18th century, it was believed the mind was made up of separate and distinct faculties, such as memory, concentration, reasoning, etc. It was thought that these functioned independently of one another and that any of them could be strengthened through appropriate kinds of exercise. This is the doctrine of formal discipline and has very little basis.

Multifactor Theory: There is no such thing as general intelligence or general mental ability. There are only specific connections between stimuli and responses. Every mental act involves a number of these elements operating together. Differences in intelligence are due to the number and kinds of connections in the individual's neurological system. Thorndike devised a test composed of four subgroupings: sentence completion (C), arithmetical reasoning (A), vocabulary (V), and following directions (D)—CAVD.

Two-Factor Theory: An English psychologist, Charles Spearman, differed from Thorndike. Intelligence includes a general (g) element or factor, and one or more specific (s) factors. The general factor is a kind of mental energy (power) common to every mental act. Essentially, it is the ability to perceive relationships. Although the amount varies from person to person, everyone has some. Specific factors

are abilities to do particular things. They vary from person to person, and the quality determines intelligence of each. Spearman believed that the differences in the g have to do with apprehension of experience, determining relations, and determining correlations.

Group-Factor Theory: L. L. Thurstone arrived at the conclusion that intelligence is composed of a number of groups or families of closely related abilities. To these he gave the name Primary Mental Abilities. He believed he successfully isolated seven:

V—Verbal: the ability to understand ideas expressed in words

N—Number: the ability to compute arithmetically

S—Spatial: the ability to visualize in spatial relations

W—Word Fluency: the ability to speak or write with ease

R—Reasoning: the ability to solve problems

M—Memory: the ability to achieve rote memorization

I—Inductive reasoning: the ability to compose a rule for the whole from only part of the information

Vernon's Hierarchical Theory: Vernon's hierarchical model of intelligence identified four levels of factors making up intelligence. The first level includes the g factor that is known as general or cognitive intelligence. Below the g factor are two major groups, verbal-educational and mechanical-spatial-physical. Vernon's theory has had the most impact on understanding or inferring adult intelligence. According to this model spatial and number ability appear to decline with age while verbal comprehension, word fluency, and inductive reasoning do not (Gregory, 1996). This model presents a conceptual way of including the general intelligence dimension of Spearman's work and the multifactor approach identified by other intelligence theorists such as Thorndike, Thurstone, and Guilford.

Guilford's Model of Intelligence: This model is a multifactor approach to understanding intelligence known as a structure of intellect (SOI). Guilford (as cited in Drummond, 1996) proposed a three-dimensional model that includes five operations, four types of content, and six types of products. Operations are the intellectual operations of the test such as cognition, memory, divergent production, convergent production, and evaluation. Content refers to the nature of the information presented by the format of the test such as visual, auditory, symbolic, semantic, and behavioral. Products refers to the different types of mental structures the brain produces to derive the answer such as unit, class, relation, system, transformation, and implication. The terms convergent productions and divergent productions refer to the development of a single answer to a question and many correct answers to a single question respectively. The model contains 120 cells (Drummond, 1996). Guilford's operations include:

1. cognition
2. memory

3. divergent thinking
4. convergent thinking
5. evaluation

Cattell's Fluid versus Crystallized Intelligence: Cattell's theory is one of the better-known theories and continues to influence those who study intelligence. It is better identified as a theory of many intelligences. Cattell identified two different types of intelligence: fluid (gf) and crystallized (gc). Fluid intelligence is mostly a nonverbal form of mental ability and does not require exposure to a specific culture. This factor refers to the capacity of the person to learn and solve problems. Fluid intelligence is an adaptation function which is considered an innate ability to perform and reflects more unstructured and casual learning. This intelligence is used when a person is adapting to a new situation. Crystallized intelligence is culturally dependent and requires a learned or habitual response. This crystallized intelligence stems from what one has already learned and acquired through fluid intelligence (as cited in Aiken, 1997). Subtests on major individual intelligence tests assess crystallized intelligence though verbal comprehension and social relations (Whiston, 2000).

Piaget's Cognitive Development-Adaptation: Piaget studied intelligence through observation of children and conceptualized a theory of intelligence basically for children. He formulated a theory of cognitive development which included four major stages of cognitive development: sensorimotor, preoperational, concrete operational, and formal operational. He used terms such as conservation, equilibration, accommodation, and assimilation to explain his intelligence theory for children. Conservation was a developmental construct in which Piaget was able to observe changes in how a child altered his/her cognition. A schema is developed which is an organized pattern of behavior that brings about learning how to do things.

Multiple Intelligence: Gardner's Theory of Multiple Intelligence was developed from a brain-behavior relationship. Gardner (as cited in Drummond, 1996) believed that there are several independent human intelligences. He referred to this as autonomous intelligence and isolated seven natural intelligences or forms. They are:

1. linguistic
2. logical mathematical
3. spatial
4. musical
5. bodily kinesthetic
6. interpersonal
7. intrapersonal

Personal intelligence is composed of both intra-and-interpersonal accessing of one's own feelings as well as others. Bodily kinesthetic refers to skills of the artistic environments such as athletes, dancers, etc.

Confluence: Zajonc believed firstborn children were brighter. The number of brothers and sisters reduces the intellectual environment of the family (Zajonc, Markus, & Markus, 1979). His model was used to explain and predict the decline and rise in the SAT scores during the 1980s.

Arthur Jensen presented a theme that genetic influence accounted for the majority of differences in test scores when races were compared. This prompted the genetic-environment issue of intelligence differences in races.

Neurological Examinations:  A neurological assessment is conducted when there is a need for a diagnosis or treatment for anyone suspected of a brain dysfunction. Neurological tests are different than other types of tests in that they attempt to derive inferences regarding the location (site), type, and/or degree of impairment in the brain. These impairments can be open-or close-head injuries. These impairments can be from birth, accidents, and diseases such as Alzheimer's.

The function of a trained examiner is to understand the anatomy of the brain to include the central nervous system as well as the peripheral nervous system.

At times, counselors will refer individuals through a physician for a neurological examination. This referral is due to suspected or known brain dysfunctioning. This type of examination includes a clinical history, mental status, and an analysis of the cranial nerves, motor functions, coordination, sensory functions, and gait. In addition, some neurologists may include some laboratory procedures such as the computerized tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), electroencephalogram (EEG), and spinal tap (Sattler, 1990). The results of these tests are categorized as soft and hard signs. Hard signs are definite indications of abnormalities in cerebral functioning. Soft signs are associated with more complex behaviors such as mental activities, coordination, and sensation (Sattler, 1990).

The term lateralization is designated to specific portions of the cerebral cortex such as cognitive, perceptual, and sensory activities. When it comes to higher levels of learning (cognitive) and perceptual processing, different hemispheres and specific functions are identified.

The Nebraska Luria, Halstead-Reitan, and Bender Gestalt are example instruments that are utilized as a part of an assessment procedure to derive important brain functioning.

## Noncognitive Tests

Noncognitive instruments are of different types and development. The following material will provide the reader a method in which to categorize type and makeup of tests.

Makeup: Noncognitive tests can be structured or unstructured. Structured tests are those in which there is a question (stem-stimulus) and alternatives (answers, foils, leaves) from which to select an appropriate response. An example of this type of inventory may be the Strong Interest Inventory and the 16PF. Unstructured tests provide a stimulus from which the respondent creates the answer from his/her frame of reference. Examples of the unstructured instrument might be the Rorschach and Thematic Apperception Test (TAT).

Type: Noncognitive tests may be self-reports, observations, and sociometric in their format. Self-reports are those in which the respondent may answer questions about his/herself such as the 16PF, MMPI, and an assortment of inventories.

Observations are those behaviors of a subject in specific situations and evaluated by others. Examples of observational inquiries may be situational tests in which the respondent is evaluated by an observer or him/herself. The assessment may be to observe how many times a student gets up from his/her desk in a five-minute time period. Certain nonverbal behaviors are observed in elevators, such as nearness to one another as passengers enter the elevator.

Sociometrics is a form of evaluation in which others make ratings or judgments. Sociometrics was researched extensively in group work by Moreno where group members reflected upon each other regarding behaviors such as attraction, repulsion, warmth, and non-warmth from which a sociogram was developed. Generally, a quantitative statement can be developed for each member regarding each type of observation such as attraction vs. non-attraction.

Construction and Keying: Constructing and keying (answering) a noncognitive test will be presented together. Constructing noncognitive tests generally is found to be logical (non-empirical), homogeneous, and empirical. Keying or scaling is assigning numbers to answers on a test so a person can be rated as having more or less of a certain construct.

Logical construction employs a rational basis for development rather than an empirical one. The author determines the skills or traits for the test and then constructs appropriate items for answers. The author usually scores the answers according to his/her perception of the theory being tested.

Homogenous construction begins with a large number of items and is organized to fit the identified clusters through a technique called factor analysis. The unique aspect of this type of development is the intercorrelation of the items which runs throughout the subscale(s) and with the total scale score.

Empirical construction, often called criterion construction, makes no assumptions about the trait being assessed. The author attempts to create items and thus scales which will discriminate those who have the trait from those who do not. Faking is more difficult to achieve with this type of construction and keying.

Scaling Methods: Assigning numbers to responses

1. Equal appearing intervals—Presenting as many items, which are in a polarity, position (true/false) to a specific number of experts on the trait(s) and utilize statistical techniques to develop an interval scale for various levels of the trait. This method was developed by E. L. Thurstone.
2. Absolute—scaling for absolute item difficulty for different age groups. Frequently this method is used for cognitive achievement and aptitude tests.
3. Expert—This type of scaling is a behavioral ranking by those who are known to be experts in that trait or concept. Their compiled lists are then ranked for a level of severity.

4. Likert Scale—This scale refers to a summative scale that uses five responses ordered on a continuum. A continuum may reflect a scaling of strongly agree, agree, undecided, disagree, strongly disagree.
5. Guttman Scale—This type of scale differs from the Likert Scale in that when a respondent agrees with one statement the respondent is in fact agreeing with all of the other items, which are milder.
6. Empirical Scale—This type of scale is developed based on how a certain criterion group (engineers) responds in comparison to a normal sample (all occupations). Similar to empirical construction discussed above.
7. Rational Scale—All items are correlated with each other and with the total score of that scale. It is similar to logical construction previously discussed under construction.

## Personality Tests

These tests give a composite of mental abilities, interests, and other variables that characterize a person's individuality (Aiken, 1997). Personality tests are governed by the nomothetic approach (general laws of behavior individuality) and ideographic approach (every person is considered a lawful, integrated system). Personality theories sharing many identifying characteristics yet can be vastly different. Some attempt to describe personality according to type (body), traits, phenomenological characteristics as well as individual preferences for color and flower essence. Instruments or inventories provide one method to assess personality. Personality observations are usually conducted through one of the three following procedures:

1. what individuals say about themselves (self-report)
2. what others say about the person (sociometric)
3. what the individual does in a situation (observational)

## Interest Inventories

Purpose: The purpose of an interest inventory is to report a preference for certain types of activities, topics, and occupations over others. Frequently this type of inventory is used to identify occupational preferences. The outcome for some interest inventories such as the SII is to measure satisfaction, not success.

Types: It may be construed that interest is developmental and can be assessed using all four of the indices below.

1. Expressed: What the person indicates he/she wants to be. As a child one often heard from others "What do you want to be when you grow up?" Although the answers do change over time, it is thought a fiber of this early interest is maintained.
2. Manifested: Manifested interest is a demonstration of an interest through involvement. If the expressed interest is maintained or another developed, it is believed the person will begin to

become active early in life in some small way regarding aspects of the occupation or environment. The person may do summer jobs or tasks, subscribe to journals, develop hobbies, and more or less participate in activities that have elements of that later occupation. In a small way he/she becomes a part of the expression by learning more about the skills and abilities in that work.

3. Inventoried: Responses to noncognitive instruments such as the Strong Interest Inventory (SII).
4. Tested: Responses to inquiries regarding information about a specific occupation.

## Response Style

Non-cognitive instruments tend to be sensitive to different response styles. Response style is the tendency for subjects to respond to personality items in a fixed manner that is independent of the content and has frequently been referred to as response sets, response bias, response style, or suppressors. These styles represent either nonsubstantive or substantively irrelevant components of response to structured personality items. Some authors believe that much of the variance in results is stylistic rather than substantive in nature.

There are several scales (terms) that will reflect the response styles of an individual. Impression management is an intentional and conscious alteration of responses (Edwards, 1970). Edwards defined impression management as the tendency to fake good and fake bad. Some terms considered to be similar are response bias, motivational distortion, and suppressors.

Absolute response deviation is a departure from a statistically expected distribution, such as a normal curve. An example is that about 80% of subjects will call "heads" on the first toss of a coin. This response clearly deviates from the statistically expected percentage of 50%. Another example is that three out of four people at entrances to theaters will turn right, even though both paths arrive at the same point.

Relative deviation is when a subject answers differently from the majority. For example, 95% of a group of normal subjects answered false to the item: I hear strange things when I am alone. An answer of true to this item is therefore a deviant response, with reference to the population of normals used as a baseline against which to evaluate. The infrequency response scale on some instruments attempts to provide this type of information.

Acquiescence is the tendency to agree rather than disagree on, for example, a true/false test. This is an example of a response style.

Social desirability is of most concern in noncognitive measurement. It is the tendency for people to describe themselves or to choose items on a test that describe themselves in socially acceptable ways, and to avoid choosing items that would describe their true nature. Some instruments refer to this scale as faking good or Good Impression (Gi-California Psychological Inventory).

Forced Choice format is designed to reduce response styles. A forced choice is usually a yes/no, true/false with only two choices, in contrast to the Likert Scale, which allows for continuous scaling or answering.

## Attitude Measures

An attitude is a "learned predisposition to respond positively or negatively to a certain object, situation, institution, or person" (Aiken, 1997, p. 251). Attitudes are descriptions of how people feel about certain social statements or objects. This is contrasted with what they know or can do (achievement, accomplishments). For the most part, attitudes are inferred from behavior. It is thinking and reacting behavior. The most frequent methods of measuring attitudes are through observations and self-reports. Of the two, self-reports tend to be more valid and reliable than observations. It is far more difficult to see a certain attitude than it is to know you possess that attitude.

The Semantic Differential scales were developed by Osgood, Suci, and Tannenbaum (1957) as an alternative way to measure attitudes. An inherent belief for this method is that there are two meanings for every object, denotative and connotative, and are rated independently. The Guttman Scales were developed to better understand the separate dimensions for the answers given to attitude questions (Guttman, 1944). The Guttman Scales are unidimensional, that is, if the examinee chooses the most extreme answer he or she agrees with all of the milder responses.

## Values

Rokeach (as cited in Gregory, 1996), psychologist, defined a value as a shared, enduring belief about ideal modes of behavior or end-states of existence. A value is the "usefulness, importance, and worth attached to particular activities or objects" (Aiken, 1997, p. 259). Like attitude assessment, values are easier to define than assess. Some examples of values instruments are the Rokeach Value Survey, Gordon's Survey of Values, and Educational Values Inventory. Rating scales used for attitude and values assessment, however, are less precise but popular. Examples are in the form of numerical, graphic, standard, forced-choice, and behavioral-anchored types. Q-Sorts or card sorts are a method of sorting out a set of statements (adjectives) into piles of most to least characteristic. A final type of assessment is through the checklist that is a self-report instrument. The subject checks words in a list that describes whatever or whoever is being assessed on that value or attitude.

# OBJECTIVE 7B: Assessment Phases

## The Interview

Interviewing is a process in which one or more individuals interacts with another individual with a structured or unstructured set of stimuli in order to secure information. If the data are objective or scoreable they are often called biodata (Gregory, 1996). Frequently, the data is not objective but more

so in the form of attitudes or subjective in nature. Whether two or more individuals possess the exact skill to secure the same information has been studied by numerous researchers. Just as training two individuals to conduct a standard procedure is difficult, so is the process of interviewing another person. When two individuals are trained to administer the same test or evaluate the same interviewee's response no two people do this alike. Inter-rater reliability is an index of agreement between two people as to how much alike they see things or a response that is given by an examinee.

Thus, there is error in this process of determining the quality of an answer. Sources of error in appraisal are of different types, such as the halo effect, rater bias (leniency and severity error) and criterion contamination. The halo effect is an error in receiving a high or low evaluation on all dimensions based upon some global impression usually passed on by another. Rater bias also causes rating errors based on the extremes such as being too lenient or too severe.

Criterion contamination errors are frequently found in the world of work when an evaluator or supervisor includes in the evaluation factors that are not part of the person's job. Interviews include verbal and nonverbal assessment. An example of a test to assess the non-verbal skill of the evaluator is known as the Profile of Nonverbal Sensitivity (PONS).

When counselors engage in the process of counseling the first step is to conduct a clinical or a bio-social interview. Some agencies develop a clinical interview set of questions to fit their particular practice; however, most agencies use a clinical interview that will elicit responses to similar questions. Some agencies such as a feeding and eating disorder clinic, no doubt, would expand and/or focus clinical questions that are directly related to the eating disorder.

The interview is the main ingredient of the assessment and good interviewing skills are critical for the evaluation process, as a number of authors have described: Lazare, Putnam, and Lipkin (1995) suggest three functions of the interview: 1) determine and monitor the problem, 2) develop, maintain, and conclude the therapeutic relationship, and 3) provide client education and implement a treatment plan. The interviewer collects data for diagnostic purposes, responds to the client's emotions, and provides a means to educate and modify or cure symptoms. Truant (1998) describes the assessment process as consisting of three components: 1) a diagnostic interview consisting of historical facts, symptoms, diagnoses, and treatment options; 2) a psychological-psychodynamic assessment; and 3) an estimation of the client's ability to engage in the therapeutic process. In all diagnostic interviews, the examiner should keep in mind an overall structure to follow so that all pertinent information can be included.

Phase I: During the initial interview, the interviewer will need to look for the major personality characteristics, traits, and chronic symptoms typical of the client's long-term functioning. However, it is sometimes difficult to tell the difference because abnormalities in cognition, affect, behavior, and motor activity may be manifestations of more than one disorder. In other words, personality related cognitive impairment, affective dysfunction, and personality or behavioral abnormalities also can be symptoms of clinical depression, anxiety, or panic disorder. Yet most personality disorders are readily apparent. For example, emotional distress and physiological manifestations of stress (i.e., cardiovascular and gastrointestinal symptoms) are more often seen in anxiety disorders, mood disorders, and somatization symptom disorders than in personality disorders (Everly, 1989). On the

other hand, personality disorders are typically manifested by a lack of overt distress. Thus, the interviewer can clarify the difference by determining if subjective distress is present or absent and if modulation of affect is acute or long-standing.

Phase II: Typically, personality-disordered clients maintain an attitude of denial about their own disturbed character traits, finding it much easier to blame other people or external factors for their problems (arrests, job losses, broken relationships) than to be honest and acknowledge any faults. Thus, the interviewer's task is to look for symptoms and behavioral characteristics that may not be obvious. To bring these to awareness (attention), the interviewer will need to confront or bypass the client's defensiveness, denial, avoidance, projection, and distortion. Widiger, Frances, and Trull (1989) recommend indirect questioning techniques that can bypass the client's defenses and tendencies toward dishonesty or evasiveness in order to elicit honest and accurate information the disordered client would rather hide.

## Personality Assessment

The first phase of the interview may take or include a focused questioning regarding a personality issue. The DSM-5™ (APA, 2013) lists ten personality disorders, which result in impairments in social and occupational functioning. This diagnostic category uses a polythetic approach that utilizes taxonomy for diagnosis, which is based upon a clustering of traits. According to the DSM-5™, personality disorders are defined as "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is inflexible and has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment" (APA, 2013, p. 645). This maladaptive pattern of behavior is of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

How does the interviewer make an assessment of a personality disorder? Fong (1993, 1995) describes the clinical interview as a progression of steps: making initial broad observations and screening, looking for tentative symptom clustering, and asking focused, diagnosis-specific questions. While this process is pertinent for all disorders, the latter (e.g., a personality disorder) may take more than one interview to accurately diagnose, using techniques about which many counselors are untrained (Richie, Piazza, & Lewton, 1991.

To differentiate pathological from nonpathological personality traits, the interviewer may utilize a polythetic list of criteria of many types of symptoms, emotions, cognitions, and behaviors with threshold requirements for each personality disorder that differ from normal personality traits. For example, it is relatively normal for most individuals to maintain self-esteem by avoiding acknowledgment of their faults, yet be willing to take constructive criticism from trustworthy friends.

In contrast, an individual with a narcissistic personality disorder maintains absolute denial of his or her own shortcomings, is predictably self-absorbed, verbally denigrating or abusive, always blames others when things go wrong, and always denies his problem in the face of evidence to the contrary. One of the differentiating features of a personality disorder from other disorders is the degree of ego-

syntonicity. For example, an individual with a clinical disorder other than a personality disorder may see the problem as egodystonic and unwanted ("I'm depressed and I want help.").

An individual with a personality disorder has an egosyntonic "problem" which he or she is unable to perceive or take responsibility for, ("If I ever get angry, it's because she provokes me and deserves what she gets. It's not my problem, it's her problem.")

According to the DSM-5™ typical behaviors for individuals with a personality disorder are rigid, inflexible, repetitively nonfunctional, destructive or self-destructive, and tends to be the same coping behaviors over time. Individuals with personality disorders suffer from cross-situational maladaptive patterns of behavior, which have become stable over time (Fong, 1995). As a result, such individuals suffer from chronic difficulties, either directly or indirectly, caused by repeated destructive or nonfunctional coping behaviors, leading to impairment in occupational and social functioning.

Turkat (1990) estimates that at least 50% of clients who have a personality diagnosis concurrently have another disorder. In assessing a personality disorder, behaviors must be manifested by abnormalities in two or more of the following: a cognitive, interpersonal functioning, affect, or impulse control. In addition, there is an inflexibility and pervasiveness to the disorder, which has to cut across personal and social situations. Finally, a resulting impairment in functioning is to be noted in social, occupational, and other important areas of life. An important goal in assessing for a personality disorder is to determine whether the symptoms are a state (transitory feeling, i.e., fear or worry) or a trait-enduring characteristic, (i.e., the way one individual differs from another) (Gregory, 2000). Fong (1993, 1995) points out two other features necessary in the diagnosis of a personality disorder. The first is to determine if the problem is perceived by the client as egodystonic (not part of self) or egosyntonic (integral part of self). The second feature is to determine if the personality disorder reveals a dysfunction in occupational or social functioning. Finally, Overholser (1989) notes that clients with personality disorders will repetitively utilize the same maladaptive coping skills.

PERSONALITY: According to the DSM-5™ (APA, 2013, pp. 649, 659, 672) personality disorders are organized by clusters based upon a descriptive similarity of traits. According to Bergin et al. (1997), Clusters A, B, and C are patterns of inner experiences and behaviors.

Cluster A (Individuals appear odd or eccentric)

1. Paranoid – often argumentative, tense, and humorless; a pattern of distrust and suspiciousness
2. Schizoid – detachment in social relationships and restricted range of emotional expression
3. Schizotypal – acute discomfort in social relationships, cognitive and/or perceptual distortions.

Cluster B (Individuals appear dramatic, emotional, or erratic)

1. Antisocial – originates in childhood or early adolescence as a conduct disorder
2. Borderline – is characterized by an instability in a variety of personality dimensions
3. Histrionic – draws attention to self, charming, warm, and viewed by others as shallow
4. Narcissistic – self-importance, self-absorbed

Cluster C (Individuals appear anxious or fearful)

1. Avoidant – shy and avoids new and old situations as well as people, feelings of inadequacy and hypersensitive to negative evaluation
2. Dependent – will allow others to make decisions, lacks self-esteem, submissive, and clinging behaviors
3. Obsessive-Compulsive – will strive for perfection, preoccupation with orderliness, and control

## Clinical Interview and Categories

Identifying information: Name, age, gender, and demographic variables, contact information, address, telephone, medical doctor

Chief complaint: Description of symptoms that brought the client to seek help, their intensity and duration, duration of existence, cause for concern, when most affected, and changes in quality or quantity

Presenting illness: Onset of symptoms, precipitating factors and modifying factors, extent of disability, degree of worsening, effect on job, social relationships and family, efforts taken to modify or control, first noticed

Past psychiatric history: Previous psychiatric symptoms or disorder, including possible substance abuse and treatment received

Medical history: Any medical issue that might have a bearing on the presenting problem such as a thyroid condition, obesity, diabetes, and heart condition, last physical, medications, compliance, past physical illnesses, particularly those that have affected emotional, behavioral, or mental status; all medications, food supplements, or herbs that the client has taken previously or continues to take

Mental history: Previous therapy receptivity, hospitalization

Family history: History of emotional, behavioral, or substance-abuse problems within immediate and extended family members, family members, siblings, predispositions and relationships (v-codes, anxiety, eating, medical, etc.), attachments

Education history: Achieved degree level, course preferences and non-preferences, achievements, majors, solving problems, strengths-weaknesses

Social history: Number and types of associations to include close personal friends and/or acquaintances, relational, group or individual oriented

Dating/sexual history: Age of first date, intimacy in communication, sexual disorder, diseases, HIV, vulnerability

Work history: Relational, accountability, skills-engagements, disability

Substance history: Use (past, present, how often, how much) -- Disorder types (alcohol, prescription, recidivism, family predispositions, treatment, hospitalization, individual therapies

Suicide history: Ideation and/or attempts history: (methods, attempts, reason for the behavior)

The annotated diagnostic interview format is broader in scope with six categories (Cullari, 2001).

1. Informed consent
2. Presenting problem/chief compliant
3. Psychosocial history
4. Treatment history
5. Critical topics
6. Ending the interview

## Assessment and Mental Status Examination

During the initial interview or at some later time it may be necessary to administer the mini-mental status or the full mental status examination (MSE). The MSE is not a psychometric instrument rather a set of diagnostic cognitive, affective, behavioral, and observation diagnostic interviewing probes. This interview requires observations of subtle and detailed wording and behavior that accompany a client's thoughts, mannerisms and non-verbal behavior. The full MSE is for objective and subjective data.

The assessment can take many forms such as a social intake, problem identification, structured interview, referral sourcing, and a diagnostic evaluation based on the DSM-5™ diagnostic criteria. The interview is not complete until a mental status examination has been conducted; a detailed profile of a client's

1. appearance, attitude, and activity
2. mood and affect
3. speech and language
4. thought process, thought content and perception
5. cognition
6. insight and judgment (Trzepacz & Baker, 1993).

In many cases, this information is readily available without systematic questioning. On the other hand, information necessary for the diagnosis of conditions such as neurocognitive disorders, delirium, Alzheimer's, or head injury may require a structured mental status examination. An effective interviewer has learned how to weave pertinent questions into the interview, which will allow for a more fluid assessment. When conducting a mental status examination, the interviewer should consider dividing it into two components: observation of behavior and cognitions (Morrison, 1993).

The behavioral or observational part includes attitudes, appearance and demeanor, mood, psychomotor behavior, and flow of thought, while the cognitive portion contains content of thought, perception, cognition, insight and judgment. Another method is to categorize according to appearance and demeanor, orientation/ attention/ cognition, speech and language, mood and affect, thought content and process, and judgment and insight (Culleri, 2010).

## Mental Status Categories: Cognitive Functioning

1. Orientation: The individual aware of the time (day, month, and year) place (where they are located at this time—office, city, and state), person (awareness of his/her own name), and purpose (the reason why the interview is taking place).
2. Fund of Knowledge: Questions are usually based upon or taken from individualized intelligence tests such as the Weschsler Adult Intelligence Scale (WAIS) or Weschler Intelligence Scale Children (WISCR)(how many days in a year, month, president of the United States, etc.). The interviewer also should determine if the client has had a sufficient amount of information from personal experiences to be able to communicate. Making this determination also serves as a check on memory.
3. Concentration: Attention span and concentration can be assessed in a number of ways limited only by the examiner's creativity. A typical example is to have the individual count backward in serials of nine or six.
4. Memory: Long-term, intermediate, and immediate memory can be assessed in a variety of ways. The interviewer can recite a string of numbers forward and backward, identify a number of objects in the room, and request the client to immediately repeat these objects and again later in the interview. Acquiring this type of feedback is important in the assessment for such disorders as senile dementia, amnesia, or normal aging.
5. Abstraction: Typically the client is asked to provide his or her understanding of the meaning of a proverb.
6. Judgment: This portion of the assessment reflects the capacity of the client to make sound decisions. The interviewer will ask the client to indicate what he or she would do in a particular situation.

## Mental Status Categories: Observational

1. Orientation: The traditional orientation assesses whether or not the client can relate to the present with awareness to time, person, and place, that is, the date and time of day, place he or she is in, and his or her name.
2. Speech: Does the client speak coherently, normally, in progression, spontaneously, and understandably? What should be observed are the speed, flow, volume, nature of speech, and any impairment. If not, does the client's speech appear incoherent, pressured, mute, mumbled, slurred, slow, loud, soft, emotional, nonstop, hesitant, argumentative, dramatic, or stuttering? In addition, the client may be experiencing a few of the following deficits in speech:

a. Circumscriptions: limitation of meaning, talking around.
b. Clang associations: type of thinking in which the sound of the word gives direction, punning or rhyming.
c. Dysprosody: difficulty pronouncing vocal sounds.
d. Echolalia: parrot-like repetition of overheard words.
e. Neologism: new word or old word used in a new sense.
f. Paraphasic: inappropriate words (misuse of words).
g. Verbigeration: stereotyped and seemingly meaningless repetition of words or sentences.

3. Thought Processes: This part of the mental status examination assists in determining if there is a thought disorder present. This disorder is often found in psychotic behaviors and organic dysfunctioning. Speech is assessed along with the thought processes as the client responds to questions from the interviewer. An observation is made as to whether the client is slow to respond, changes topics, falls into sudden silences, blocks, or has a flight of ideas.

   Some other observations may be:

   a. Blocking/derailment: sudden stoppage of thought or action because of emotional distress.
   b. Circumstantiality: characteristic or pattern of speech (of language) that proceeds indirectly to its goal (delayed) because of excessive or irrelevant detail or parenthetical remarks. Client returns to the original point.
   c. Flight of ideas: disjointed ideas and speech expressed by patients unable to organize their thoughts.
   d. Impoverishment: depleted capacity to speak other than limited words or phrases, with little emotional integration.
   e. Associations Loss: loses point, fragmented and disjointed thoughts that remain logically unconnected. Frequently found in psychotic patients such as schizophrenia.
   f. Nonsequitur: an inference that does not follow from the premise.
   g. Palilalia: repetition of words or phrases.
   h. Perseveration: continuing repetitiously in an activity (e.g., irrational repetitions of words or phrases).
   i. Tangentially: replying to a question in an oblique or irrelevant way.

4. Psychomotor Movements: Observe any unusual movements, mannerisms, or levels of physical activity. Some examples might be pacing, slowed responses, stiffness, tics, tremors, uncontrolled body parts, hyperactivity, disconnected, Parkinson, etc.

   Athetotic: slow, recurring, weaving motion of arms and legs/facial grimaces

   Choreatic: jerky, involuntary movement, spasms (muscles)

5. Sensory Perceptions and Hallucinations: A distortion of sensory perceptions can include hallucinatory experiences and imagery. Hallucinations can include auditory, visual, tactile, and olfactory senses associated with psychotic states.

   Mood and Affect: Mood is the patient's subjective expression of how he or she is feeling. This statement can include words or expressions of highs, lows, sad feelings, sleeplessness, and suicidal thoughts.

   Affect is the interviewer's observation and description of the client's appearance and emotional expression. Some words to describe affect are detached, flat, blunted, tearful, despondent, euphoric, hyperphoric, inappropriate, and depressed.

# OBJECTIVE 7B: Behavioral Assessment

Behavioral instruments are employed to assess the behaviors of subjects who are about to undergo behavior modification in order to establish a baseline, to determine the antecedents and consequences of the target behaviors, and to get a social learning history (Aiken, 1997).

## Method

Aiken (1997) describes several methods for measuring behaviors for this modification. They are:

Observational: Information about target behaviors which can be recorded by teachers, parents, nurses, etc. A few examples are the Attention Deficit Disorders Evaluation Scale, Connor's teacher/parent forms, Parent/Guardian-Rated DSM-5™ Level 1 Cross-Cutting Symptom Measure-Child Age 6-17(APA, 3013), DSM-5™ Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult, World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).

Self-Observational: The person is taught to monitor self-behavior. This in itself often affects the behavior. The person is requested to write down the exact time of day he/she smoked, what happened just before he/she made the choice to smoke, and what occurred just after the smoking. Example: sleep log.

Behavioral Interviews: A clinical interview is a behavioral set of questions geared toward obtaining information in order to plan a program of behavior modification. An example of this interview could be the mental status examination or even a performance review.

Rating Scales and Checklists: A list of behaviors is presented for the stated concern (Attention Deficit Disorder) and responded to by a teacher or parent. Examples are an Alcohol Questionnaire, Reinforcement Survey Schedule, and the ADHD-H Comprehensive Teacher's Rating Scale.

Projective Tests: Projective tests were credited to Laurence Frank. Projective assessment techniques provide for an unstructured or vague stimuli, such as pictures, music, or inkblots, and require the subject to respond by relating what he/she is thinking or feeling about the stimuli. Projective tests are developed in such a manner to seek deeper layers of personality functioning (unconscious desires,

motives, conflicts, unexpressed or out of awareness). Instrument development is derived from the projective hypothesis or psychoanalytic theory. It is believed that when a client is presented ambiguous material, he or she will project hidden aspects of his or her personality onto the material by way of the response to a picture or inkblot. The typical response forms are categorized into five groups: inkblots or words, construction of stories or sequences, sentence completions or stories, arrangement or selection of pictures of verbal choices, and expressions with drawings or play (Gregory, 1996). The main theme of all five forms is freedom of expression. The Rorschach Inkblot Test and Thematic Apperception Test are examples of projective tests.

Family Assessment: Includes diagnosis, treatment selection, and treatment in evaluation. The purpose of assessment is to assist therapists in organizing their thinking so the complex family patterns can be understood and an accurate assessment of the pathology that may be hidden can take place.

## Case Conceptualization

When a case consultation is a part of the counselor's treatment strategy a case conceptualization is shared. The ACA Code of Ethics (2014) informs the counselor sharing information in a consulting relationship that is written or oral. Every effort is made to protect the client identity and to avoid invasion of privacy (B.7.b.). When the identity of the client is made known during consultation it is only with prior consent of the client or organization. The disclosure is limited to what is necessary for the purpose of the consultation (B.7.b.).

The next step is to form a case conceptualization to set up treatment. There are some 20 case conceptualization models in the literature not all of which are focused on a diagnosis but are applicable to treatment plans. Case conceptualization is the process of using theoretical frameworks to organize interview data, observational data, and assessment data to formulate hypotheses that explain the underlying dynamics of a presenting problem, in order to formulate an accurate treatment plan. That is to understand what personal, interpersonal or systemic dynamics are driving and maintaining a client's behavioral or emotional issue or problem. A clinical case formulation, according to Prieto and Scheel (2002), is "a conceptual scheme that organizes, explains, or makes clinical sense out of large amounts of data and influences the treatment decisions." The case conceptualization is the treatment plan presented with the rationale and justification for the plan. The case conceptualization includes:

1. symptoms or problems that need to be changed.
2. large amount of information that needs to be organized.
3. conceptual scheme that provides an explanation.
4. treatment decisions that lead to specific procedures.

The case conceptualization is communicated with the client, with team members if in a hospital setting and with case managers. Most case conceptualization models begin with the presenting problem, followed by gathering data, defining problems clearly as data, not as a diagnosis, listing problems, specifying goals, and assessing for a problem or a diagnosis. Once the diagnosis is agreed

upon a treatment plan with identified interventions along with a time table to accomplish goals is constructed or planned. Finally, monitoring for improvement and progress notes to document the session work is completed.

## Models of Case Conceptualizations

### Steven-Morris Model

This model is an atheoretical based on a cognitive schema framework. Data gathering includes background information, presenting concern, verbal content, verbal style, nonverbal behavior, client emotional experience, counselor's experience and personal reactions, client-counselor interaction, test data, diagnosis, inferences and assumptions, goals for treatment, and evaluation of outcome (Steven & Morris, 1995).

### Inverted Pyramid Model

The inverted pyramid model was developed as a supervision and teaching model for student counselors. It is a stepwise method to identify and understand client concerns with a diagram that visually guides and clarifies the conceptualization process. The emphasis is for early assessment and treatment planning. The model has four steps outlined with three to four actions taking place at each step (Schwitzer, 1996).

### Linchpin Model

The concept of the linchpin is to organize all of the key factors around one causal, explanatory source, frame the problem in terms of factors amendable to direct intervention and finally to be shared with the client focusing on the benefit. The three steps are to organize facts around a "linchpin", target factors amendable to interventions and share the data with the client (Bergner, 1998).

## Records: ACA Code of Ethics, Section B.6. and SP 13

Ethical code B.6. records and documentation and standard of practice SP 13 pertain to the confidentiality of records. Section B.6.a. acknowledges creating and maintaining records and documents to render professional services. Counselors are to provide a safe containment for the records and only authorized persons are to have access (B.6.b.). If a recording or observations take place, it is with client permission and is to be documented in the client's chart (B.6.c., B.6.d.). When clients request access to their record the request is honored but may be limited. The degree of access depends upon available evidence to restrict that access. The request is to be documented and rationale included if access is denied or limited (B.6.e.). Counselors provide assistance when records are requested (B.6.f.). If records are disclosed or transferred the counselor seeks written permission (B. 6.g.). Storage and disposal of records after closure or case termination is conducted in accordance to state or federal regulations (B.6.h.).

The purposes of records are many according to Remley and Herlihy (2005). Records should benefit the person receiving services; transfer information to another health provider; provide a history of diagnosis, treatment, and recovery; summarize interaction between the counselor and client; and benefit the counselor in case of emergencies or critical situations. The groups that rely on a counselor's documentation to advocate for the most appropriate and effective care are physicians, mental health professionals, referral sources, employers, other payers, managed care companies, and licensing and accreditation agencies. Medical or mental health records are official and practical means of communication to provide a unified treatment approach consistent with the clinicians work with clients, provide continuity of care from one treatment setting to another, justify need for continued treatment, need for admission, demonstrate appropriateness and cost-effectiveness of care, demonstrate all billable services were provided, and verify the practice's quality of care and approve the clinicians license to operate.

There are three types of records: institutional, private, and practitioner's notes and working notes.

1. Institutional records are governed by institutional policy and statute. The Freedom of Information Act guarantees access to governmental records. Upon a subpoena, records are accessible to court proceedings.
2. Private practitioner's records are not covered by specific legislation for client access but are retrievable through court proceedings.
3. Working notes are considered impressions half-formed hypotheses, or ideas and are temporary documents.

For the most part, records do not belong to the client, although the actual data of the client do belong to the client. The client pays for the service the professional is providing (Keith-Spiegel & Koocher, 1985). Piazza and Baruth (1990) outlined six categories that should be a part of a client's record. These six categories are: intake information, assessment information, treatment plan, case notes, termination summary, and other data. The intake information is to include pertinent self-data such as name, address, age, education, marital status, employment, date of initial contact, admissions, legal documents, and legal status. If the client is a minor additional information is required. Examples would be parent or guardian, siblings, child care, parental occupation, marital status, and reasons for appointment. Assessment is the appropriate data gathering so that a treatment plan can be written. Piazza and Baruth (1990) list six areas for the assessment information: client's motivation for treatment, emotional functioning, intellectual and verbal capacity to benefit from different types of treatment, whether a history of counseling, level of developmental functioning (if a minor), and a diagnosis. The treatment plan is to provide the purposes and anticipated results of the counseling. This plan usually contains a problem statement, target or goals of counseling, and steps to be taken to reach the goals. Case notes are to reflect the progress of the treatment procedures. In addition, these notes are to include the activities that take place during the counseling session. The notes should contain the evaluation of goal attainment. The counselor's impression should also be a part of these notes. A termination summary is to provide the journey of the counseling and contain the important aspects from the presenting problem, goals, activities taken, and assessments. The final category was listed as

other and is to include forms such as release, informed consent, and specific paperwork relevant to the client. Some helpful ideas for case notes are as follows:

1. Date and sign every entry
2. Entries are to be timely and should be proofread
3. Watch abbreviations-use those only that exist in the literature
4. Errors should have a line through the incorrect information, initial and date
5. Don't leave blanks- typically infers information left out
6. Place client name and/or number on each page along with date of entry
7. Use quotes from the client that are clinically significant using descriptive terms
8. Record what was observed during the session
9. Record identified problems from the treatment plan along with goals for treatment
10. May even want to record diagnostic criteria from the DSM-5™

Record retention is not the same in each state. There is no general record retention rule. For the most part, records are retained as long as there is a therapeutic need for them. An individual should consult with the legal retention law, if it exists, for his/her state (Cullari, 2001; Soisson, VandeCreek & Knapp, 1987, 1997). These requirements vary from seven years for IRS retention to states requiring permanent retention. There are a couple of ways to determine proper retention, legal obligations, and client welfare.

A good record will enable a counselor to reconstruct the client's course of therapy and to demonstrate that care was provided in line with the standard of care. It is recommended that summary sheets for diagnosis and treatment and notes about canceled appointments should be retained. Consent or release forms should contain the following: name of person whose records are to be released, which records are being released, purpose or intended use, date signed, expiration date, limitation on data, authorizing signature, person's relationship to client, signature of witness, and a copy should be given to the client (Keith-Spiegel & Koocher, 1985).

## Summary

Ethical standards regulate the manner in which the counselor maintains, stores, or disposes of records. This is required by law, regulations, agency or institutional policies that ensure that entries are accurate, and if errors are made in the records appropriate remediation takes place (ACA, 2014; A.1.b. and B.6.h). Records are considered legal principles and contents of the records are viewed as property of the client (Claim of Gerkin, 1980; People vs. Cohen, 1979). Records are physical recordings of information related to a counselor's practice that include but are not limited to:

1. Clinical case notes
2. Administrative records
3. Audio/video recordings

4. Computerized information systems (test results, etc.)

It is important to place in the file, as a part of charting, that notes and taping releases are included (B. 6.b.). Withholding some or parts of the records when requested, especially in light of the recent HIPAA requirements (B.6.d), is a concern. Documenting requests for access by other parties are to be included in the chart and file (B.6.e). Some general guidelines as to important note entries may be:

1. Reviewing progress goals
2. Knowing when and how important decisions were made
3. What kind of treatments were undertaken-whether efficacy based or none outcome based
4. Helping clients measure change and growth (monitoring efforts)
5. Successes and turning points
6. Continuity of care when referred from one mental clinician to another

Important points to be mindful of concerning client rights.

1. Review notes with some exceptions
2. Subpoena case notes when involved in litigation
3. Legal representative that deceased clients have the same rights
4. Client refusal rights

Some federal laws that could affect counseling records are HIPAA, Family Educational Rights and Privacy Act (FERPA), and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1972 (Remley & Herlihy, 2010).

## Charting/Notes

There are several standard forms to record client treatment and some specific agency preferred methods to meet ethical and legal requirements. A few will be mentioned as examples.

1. DAP –(D)-description of both the content and process of the session, (A) assessment, intervention, working hypotheses, (P)-response or revision, topic covered, next session
2. SOAP-(S)-subjective, patient reports (O)-Objective, (A) assessment and functioning level, (P) Plan
3. BAR-(B) behavior, (A) action, (R) response
4. DAPT-(D) diagnosis, (A) assessment, (P) plan, (T) treatment

Ethical behaviors for records noted in the ACA Code of Ethics are located in Section A (A.1.b. records) and Section B.6. (records and documentation).

## Test Administration

In scheduling a test, clients should have time to prepare physically, emotionally, and mentally. In many states, time must also be allowed for obtaining written consent before administration of intelligence or personality tests. The test administrator should have the necessary training to administer the test and must also have time to familiarize himself/herself with the test manual, test content, standardized procedures, and time factors, and anticipate any deviations which could alter good testing practices (Aiken, 1997). Test publishers as well as professional organizations state within their code of ethics strict adherence to qualifications to purchase, administer, and interpret instrumentation. The ACA guidelines adhere to degree, training, and supervision to utilize certain tests: E.2.a. (competence to use and interpret assessment instruments), E.7. (administration), E.7.a. (administration conditions), E.7.b. (favorable conditions), and E.7.c. (technological administration).

The strictest guidelines would pertain to projective and diagnostic instruments because they often require individual supervision and training. Some examples of this level include, but are not limited to, the Rorschach, Thematic Apperception Test, and the Minnesota Multiphasic Personality Inventory. Other instruments such as interest and most group cognitive (aptitude and achievement) tests would require a test and measurement course and graduate degree. Tests that may require less training are checklists where minimal supervision is required.

The test administrator must also have time to prepare the test materials and the physical setting for the test (Anastasi, 1976). Situation variables such as lighting, noise, ventilation, etc., can affect test results (Aiken, 1997). Studies have shown that even such seemingly minor details as the type of answer sheet, the types of desks used, the manner or behavior of the examiner, etc., can alter test performance (Anastasi, 1988).

The test examiner must also be very responsible in following the directions for administration so that the reliability and validity of the test are not compromised, thus the standardization principles. If the test is administered well (i.e., standardized procedures are followed) the influence of the test-related factors mentioned above should be negligible (Anastasi, 1988).

Although the examiner must be objective, he/she should endeavor to establish a friendly rapport with the client so that he/she will be motivated to cooperate and perform to capacity (Aiken, 1997). Establishing rapport will reduce faking responses and encourage frank reporting on personality tests and can also reduce the negative effects of test anxiety that can adversely affect scores on intelligence and achievement tests. Rapport with the client is also especially important in the case of special populations such as prisoners, juvenile delinquents, emotionally disturbed, etc. (Anastasi, 1988). Finally, rapport is important in order to assist in anxiety reduction. Tryon (1980) defines test anxiety as a general feeling of unease, nervousness, or physical discomfort. Research reveals that those who have had negative or poor performances (low scores) often experience increased anxiety with each additional experience in testing. Training in relaxation techniques, self-control training, and cognitive coping techniques are coping strategies to reduce the anxiety associated with testing conditions.

Following the test, the administrator is responsible for the security of all test materials. Test security is important for two reasons: 1) to prevent test content from being disseminated and thereby

invalidating the test, and 2) to ensure that the test is being properly administered by a qualified examiner (Anastasi, 1988). All too frequently there have been expressed concerns over the Lake Wobegon effect, which is a reflection of inflated test scores. These inflated test scores have resulted as a violation of test security and unethical practices of teaching for the test items, changing scores, altering the timing of the test, and an assortment of non-standardized procedures. This is a violation of norm-referencing (Cannell, 1988, 1989).

In summary, Gregory (1996) cites what he considers four frequency errors for group testing: incorrect timing, lack of clarity in the directions, variations in physical conditions, and failure to explain whether a subject should guess or not, thus a penalty or no penalty. Violations in this type of test administration contribute to variable errors associated with efforts to derive a true score. Therefore, it is advisable to consult the standards for Educational and Psychological Testing, which contains five standards for the recommended procedures for administering tests (American Educational Research Association, American Psychological Association & National Council on Measurement in Education, 1985). The overall duties of the test administrator are to schedule the test, utilize informed consent procedures, become familiar with the test, have a test manual present, achieve the best testing conditions, minimize cheating, follow the directions, maintain and establish rapport, be aware that special problems occur, and collect all testing material after the examination (E.2.; Aiken, 1997).

## Test Scoring

Scoring answer sheets may be done by hand, machine, or computer scanning. Error rates in computer and machine scoring are very small compared to those of hand-scored tests (Aiken, 1997, Gregory, 2000). Scores on individual tests have been dramatically and demonstrably affected by the examiner's biased perception of the client. Gregory (2000) cites that clerical errors are frequently found which should be guarded against with second scorings and checking. Errors in such cases have sometimes resulted in momentous decisions concerning the client that are based on totally unreliable scores (Aiken, 1997).

## Types of Scores

When keys are placed over the answer sheet, the first scoring to take place is a frequency count of correct answers or a sum of scores for a scale. This first counting is usually a raw score. Very few statistical statements can be made regarding raw scores. Two such are the number of correct answers and percentage correct attained by that person. If a person desires to know how his/her score compared to others, then norm-referenced or even criterion-referenced procedures and interpretations are utilized.

1. Raw scores:
   Correct keyed answers vs. incorrect keyed answers. On a test of 100 questions the person had 74 correct answers and 26 incorrect answers. Cognitive tests have right and wrong answers; therefore a percentage correct is appropriate. In the above example the raw scores would equate to 74% correct and 26% incorrect. On non-cognitive tests right and wrong answers are

what the person indicates by his/her choice. Thus, raw scores are derived by the preferred choice of answers as determined by a norm group. In non-cognitive tests the raw scores are converted statistically to a standard score, categories, or rankings.

2. Weighted scores:
   Sometimes a question may have several correct answers but some are considered to be more correct than others. Thus, alternatives may be weighted and one alternative may yield more raw points than other alternatives such as found on intelligence tests. Some answers may be worth two points while others are worth one or zero. Non-cognitive tests also have differing values attached to their answers. If a taxonomy is a part of the teaching or testing objectives, then a direction for weighted points is established. These points are usually awarded for an answer higher on the domain, whether it is a cognitive, affective, or psychomotor domain.
3. Converted scores:
   Raw information (data) is subjected to descriptive statistics (central tendencies and variabilities) to allow for a standard score transformation to percentile ranks, z-scores, T-scores, stanines, stens, etc. These types of scores allow an individual to compare his/her score to scores of others who have taken the same instrument.

## Tools for Interpreting Individual Analysis

All data, whether derived from test or nontest means, are initially in raw form. To understand the information beyond a percentage correct score, the data are organized and translated to a form in which comparisons can be made.

## Test Scores

1. Raw Scores:
   The actual tabulated number that was counted.
   a. A TRUE SCORE is the average of all of the scores for a person upon retesting a large number of times. Ary, Jacobs, and Razavieh (1966) describe the true score as "the score an individual would make under conditions in which a perfect measuring device is used" (p. 277). Ward and Murray Ward (1999) indicate the true score is a hypothetical score that could be attained if the assessment were perfectly reliable.
   b. The OBSERVED or OBTAINED SCORE is the actual score, and the unsystematic error variance accounts for additional variance in the obtained score.
2. Standard Scores:
   Raw data transformed so that standard scores have the same point of reference on the normal curve. What is being compared is the extent of deviation from a common point of reference such as the mean. The mean of a T score is 50 and a standard deviation of 10. A z score has a mean of 0 and a standard deviation of 1.
3. Standard Scores Expressed:
   Each specific standard score has its own standard deviation and mean.

# OBJECTIVE 7B: Norms

Tests can be norm-referenced or criterion-referenced. Norms are the average performance of the standardization sample. They are determined by testing a sample (random, stratified random, or cluster) of the target population for which the test is designed (Aiken, 1997). Norms provide a frame of reference for the interpretation of raw scores. A raw score obtained by testing one individual can thereby be compared to the scores of others in the same norm group (Aiken). Before comparing a client's score to a particular norm group, the counselor should first consider when the norms were obtained and with what population (sample). That is, it is important not to use outdated norms. Secondly, the counselor should consider the characteristics of the norm group and carefully select the set of norms that are most appropriate to use for the specific client. For example, norms can be misused if the norming procedures for a test have only used the majority population. In such cases, it would be invalid, discriminatory, and therefore harmful to use those norms in assessing the performance of a minority or disadvantaged client. Establishing local norms can help prevent prejudice and the misuse of test results (Gladding, 1996). Norms are not absolutes, they are relative (Thorndike, 1997).

Norms are usually found in printed tables in the test manual. These tables give the derived score equivalent for each possible raw score as well as a description of the specified group on which the norms are based. Following is a list of different types of norms commonly used.

## Types of Norms

1. Ordinal-level measures
    a. Developmental norms can be misused because educational and psychological growth is not constant across grades and ages (Aiken, 1997).
        1) Age norms
        2) Grade norms
    b. Percentile norms—Developmental norms are often expressed as percentiles. The disadvantage is that the score units are unequal due to clustering around the median in the normal curve. Percentiles reflect a relative position in the normative sample, not an amount of difference between scores.
2. Norm-referencing: This type of norming allows for a comparison to a large standardization sample. There are two basic categories of norm-referenced scores. The first is using the ordinal (rank) scale of measurement (percentile rank and percentiles). The second is using the interval scales of measurement. These norms tend to use percentile ranks and a variety of standard scores. Some examples of interval level measures are:
    a. Standard score norms—linear transformation of raw scores so that the same shape of the sample is maintained (example -z scores)
    b. Normalized standard scores - expressed in terms of a distribution that has been transformed to fit a normal curve (example—T scores, stens, stanines)

3. Criterion-referencing: An individual's score is compared to a performance standard rather than the "norm" obtained by others on the same test. This norm is based on what the person knows, not how he/she compares to others.
    a. Performance-referencing (mastery testing provides a statement of what the person has done on the test. For instance, on a typing test one might say, "Sandra achieved at a 95% level of accuracy." This statement does not compare her with other people, but it does compare her with an absolute standard (i.e., the possibility of getting 100%).
    b. Expectancy referencing: relates a person's test results to expectancy information based on past experience with test results. For instance, we might want to know how Sandra's typing score related to success in clerical jobs. Her score might be compared with records (expectancy tables) kept on others who have already been working.
    c. Self-referencing: A person's score can be compared with his or her performance at a different time or situation. If a person is tested repeatedly, one can make statements like these: Jim runs twice as fast as he did a year ago; or when Mark types with others, he scores much lower than when he is in his own room by himself; or, Peggy's score on self-esteem have become progressively higher as she maintains attendance at the meetings.

An ipsative measurement is one in which an item is scored for one scale, say will go up, and, at the same time, will lower another scale. It is a type of item format rather than a normative statement. Yet these types of comparisons are only intra-individual and not appropriate for normative comparisons. The response is reflected or measured against the self.

# OBJECTIVE 7C: Statistical Concepts

CACREP objective 7.c. specifies different concepts for understanding and in applying the scales of measurement, central tendency, variability, shapes and types of distributions, and correlations (CACREP, 2009).

Two broad areas of statistics are reviewed in this unit and in the research unit.

1. DESCRIPTIVE – A summarizing of a set of data thus tabulating, depicting and describing a collection of data (Cohen, 2000).
2. INFERENTIAL – Statistics to make inferences about a population from researching a sample (Cohen, 2000).

Describing individual assessment makes use of descriptive statistics. The two descriptive statistical areas for review are central tendency and variability.

## Shapes and Distributions

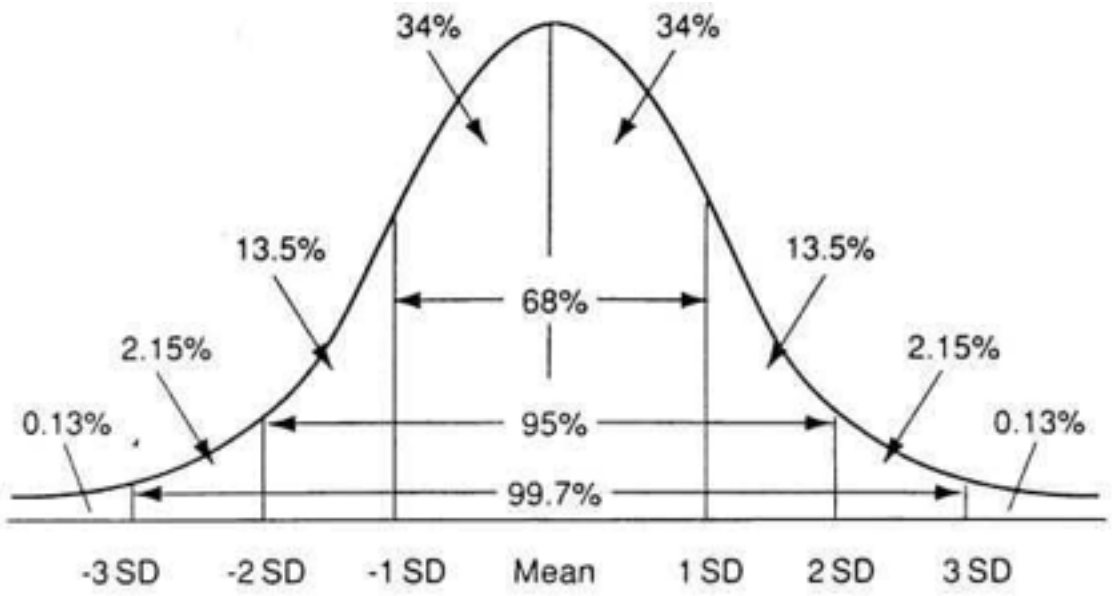
Data or scores can be displayed in a number of ways to reflect frequency distributions. Some of these are by frequency tables, histograms, polygons, symmetrical distributions (normal curve) and

asymmetrical (skewed). Beginning with the normal curve a statistic known as kurtosis reflects peakedness or flatness relative to a normal curve. Thus, the distribution can be mesokurtic (similar in height to normal distribution), leptokurtic (more peaked than normal) or platykurtic (flatter than normal curve).

## Normal Curve

Before presenting the application of descriptive statistics, an understanding of the normal curve is necessary. The normal curve is useful in statistics because many distributions of standardized test scores closely resemble the normal curve (Ary & Jacobs, 1976). Though the normal curve extends in both directions to infinity (± ∞), most scores fall between ± 3 standard deviations from the mean, and almost all scores fall between ± 4 standard deviations from the mean. Percentages within the standard deviations are rounded to the nearest whole number. In the past these rounded numbers have been sufficient for the test questions on the NCE. When the curve is normal (bell-shaped), the following is true (Gay, 1992).

1. 50% of scores fall above the mean, and 50% fall below the mean (z = 0).
2. The mean, median, and mode are the same assuming there are a sufficient number of scores.
3. The farther away from the mean a score falls, the fewer the number of subjects who received that score.
4. The number of scores that fall 1 SD above the mean is the same as the number of scores that fall 1 SD below the mean. The same is true for ± 2 SD, ± 3 SD, and to the extent one moves away from the mean.
5. Thus, the curve is often referred to as a reciprocal curve of distributions.



The curve for a distribution of scores is not always normal. Sometimes the distribution is skewed. In skewed distributions, the mean, the median, and the mode are different; and the mean is pulled in the direction of the extreme scores (curve is distorted). Retrieved from google.com November 12, 2013.

The normal curve is a means or method by which comparisons can be made from different measures. The baseline of the curve is called a linear line and is expressed in z scores with a mean of zero and a standard deviation of one. The bell shaped curve is considered to be a reciprocal curve with + 1.00 standard deviation (s.d.) equal to 34.14% as is a -1.00 standard deviation unit equal to 34.14% of the area of the curve. This means that 34.14% of the area of the curve lies between the mean (0) and a +1.00 s.d. and 34.14% of the area of the curve lies between the mean (0) and -1.00 standard deviation. The same principal holds for each of the remaining standard deviation units, that is, +2 s.d. = 13.59% of the area of the curve, +3 s.d. = 2.14% of the area of the curve and +4 s.d. equals less than 1% of the area of the curve. The percentages are presented as approximations and inserted on the page as 34%, 13.5%, and 2%. The same exact percentages found on the right side of the mean represent the corresponding deviation units to the left of the mean (0), that is 34%, 13.5%, and 2%, thus a reciprocal effect.

Sample data are often small in frequency and therefore do not fulfill the requirements for a perfect distribution of scores. The data can be understood by looking at how they may be skewed. If the information groups itself on the right side of the normal curve, one can infer from the data, if interpreted as test results, the test contained deviant score(s). If the data are grouped on the left side of the curve, they can be inferred that the test contained deviant score(s). This can be interpreted by reviewing the central tendency figures, mean, median, and mode, or a scattergram. If the mean is to the right of the median, it is a positively skewed distribution and if the mean is to the left, a negatively skewed distribution is likely. The mean will lead the skewness. Of the central tendencies the mean is the one most affected by extreme scores, thus is pulled toward the skewness.

A negatively skewed set of scores is evident when extreme score(s) pull the distribution out of shape and toward the left (-1 direction, tail of the curve). This would imply the test may be too easy or that it is a test with a relatively high easiness index. On the other hand, a positively skewed distribution of scores would have a few extreme scores to the right of the majority which would have scores gathered on the left of the curve. It might be assumed this would be too difficult or have an easiness index much lower. Indicating that a test is too easy or too difficult might be an overstatement because it is skewed and might reflect a value judgment at this point of our study. The shape of the curve initially is intended to give the researcher a picture of how the scores fall in relation to each other. To derive meaningful interpretive data researchers employ the use of descriptive statistics.

## Other Distributions

Another way to review individual appraisal is through the use of two sets of data, for example grade point average and a SAT score. A scatterplot or scattergram is a visual representation of the relationship of two sets of data. Each set of data is referred to as a variable. Therefore, two sets when compared can be called a bivariate distribution. Each variable is assigned one of the two lines on the scatterplot. The baseline is called the abscissa and the vertical line is referred to as the ordinate. If the

plotting of the two variables has a left-to-right distribution (orientation), it is referred to as a positive relationship. If the distribution resembles a right to-left orientation, it is a negative relationship. The positive relationship suggests that both variables are going in the same direction, while the negative distribution suggests they are going in opposite directions. The positive (+) and negative (-) before the number refer to direction and not to a value of good or bad, positive or negative.

# OBJECTIVE 7C: Measurement Scales

Ary, Jacobs, and Razavich (1990, 1996) stated that S. S. Stevenson developed a taxonomy of measurement to assign numbers to specific observations.

## Nominal Scale

Categorizes groups as male/female, freshmen/sophomores, etc. Nominal scale is expressed as names or numbers, however does not represent "more or less" of any characteristic. This type of measurement is a qualitative difference. The numbers cannot be used in mathematical computations except for identifying the number of observations (Cohen, 2001). The central tendency most appropriate is mode.

Example: yes and no, two groups.

## Ordinal Scale

Ordinal scaling is the property of order and direction of difference (more than or less than). Ranking of objects, one is bigger, better, or more but no distinction of how much more is determined. Numbers are often assigned to these observations and are a quantitative level of measurement (Cohen, 2001). This scale of measurement yields the statistical calculations of median and variability of the quartile deviation.

Example: job ratings, rank of 50 states in friendliness.

## Interval Scale

Equality of units. The interval scale requires equal distance between points. One variable is so many units (degrees, grades, etc.) more or less than another. The distance and order are meaningful. Tests, which use the interval scale, may use collected data and calculate with central tendencies of mode, median, mean, and variabilities of range, quartile deviations, and standard deviation.

Examples: thermometer, a number line, IQ scores.

## Ratio Scale

A ratio scale has an absolute zero and equal intervals. Physical scales of time, length, and weight are examples. One can be twice, three times as much as another variable.

Example: height in inches.

In summary, each scale contains the prerequisite criteria of the preceding scale(s). The ordinal scale to be ordinal must not only reflect distance and order but also carry the nominal requirement of class or category. Each scale thereafter (interval and ratio) adds another criterion to the qualifications so that ratio, which adds the absolute zero, and ratio quality also include category and distance.

**Question 7-10:**
The mean is an arithmetic average and can be utilized at what beginning level of measurement scale?

a. nominal
b. ordinal
c. interval
d. ratio

Answer: c. interval

**Question 7-11:**
Which measurement scale provides a true zero point as well as equal intervals?

a. nominal
b. ordinal
c. interval
d. ratio

Answer: d. ratio

**Question 7-12:**
Which scale of measurement is the least sophisticated?

a. nominal
b. ordinal
c. interval
d. ration

Answer: a. nominal

**Question 7-13:**
Which measurement scale is typical of classroom tests?

a. nominal

b. ratio

c. interval

d. ordinal

Answer: c. interval

Nominal measurement involves placing people, objects, or things into categories. While an interval scale does provide equal intervals, there is an arbitrary point of origin for each interval; however, there is no true zero point.

Once the measurement scale has been identified and the raw data rated according to weights and summed, the data are then organized. Frequently, the first step to organizing data is to develop a frequency distribution and to illustrate the data in some type of graph form. Examples might be bar graphs, frequency polygons, and, when two variables are introduced, the scattergram.

# OBJECTIVE 7C: Central Tendency

Central tendency describes the middle of a distribution of scores. The three measures used to describe the middle are mean, median, and mode. Each of these measures is utilized depending upon the specifics of the data (measurement scales) or the question to be answered. An example would be when there are extreme scores the median is the preferred measure of central tendency.

The central tendency category describes the middle of the distribution of scores. The three ways to describe the middle are mean, median, and mode. Each of the three types are utilized depending upon the specifics of the data. For example, when there are extreme scores, the median is the preferred central tendency. The mean is the most widely used measure of central tendency and called the arithmetic mean. To derive a mean is to sum the values in a distribution and divide by the number of cases (n) in that distribution. Questions on the NCE are more likely to be with single digits thus fewer opportunities for addition errors. A second question might focus upon when to use which central tendency as opposed to one of the others. The Reading Test Scores for a group of five students are:

9 6 4 2 9

To derive the mean the formula is to sum the five numbers (2 + 4 + 6 + 9 + 9) for a sum of 30. The sum is 30 and is to be divided by the number of test scores (5) that equals a mean score (30 ÷ 5) equal to 6. Thus, a mean of 6.

To illustrate with a second set of numbers (1 + 5 + 4 + 9 + 6) the formula and procedures to calculate the mean add the measures (x) or test scores and divide by the number (n) of test scores.

$$X = \frac{\Sigma x}{n} \qquad \Sigma = \frac{1 + 5+4+9+6}{5} \qquad \Sigma = \frac{25}{5} \qquad \mathbf{X =}\ 5$$

**Median:** The median can be used with ordinal data. The median is the point above which 50% of the measures (scores) fall and below which 50% of the scores fall. The score is referred to percentile rank of 50 (PR50). Determine the median for:

9 6 4 2 9

Step one is to arrange the numbers in ascending or descending order, that is numerical order from high to low or low to high.

2 4 6 9 9

Count up halfway and down halfway and since there are five numbers halfway would be the third number, in which case, three up would be the digit 6 and three down would be the digit 6 or a median score of 6.

The scores must be aligned in numerical order, either low to high or high to low, before the middle number can be located. There are specific guidelines for an odd and even number of measures. Notice that if one had not rearranged the numbers in the example under mean the median would appear to be 4 (incorrect) rather than 6 (correct) when the numbers are ordered.

**Mode:** The mode is the most frequently occurring measure or number. There can be one or more modes. A disadvantage is that the mode is not very reliable. From the above mean set of numbers the digit 9 occurs two times and no other number occurs that many or more times, thus 9 is the mode.

The following example will help in understanding the earlier statement regarding extreme scores and which central tendency is the preferred choice.

Five boys had the following number of professionally signed baseball cards: 11, 11, 14, 16, 38. The central tendency that would best describe or be representative of this group would be the median. If one were to conduct the three central tendencies (mean, median, mode) the mean would be 90÷ 5 or 18, which is a number above 4 of the boys. The median would be equal to 14 and is a score within or nearer to four of the five while the mode would be equal to 11.

Here is another example to determine the mode. 1, 4, 5, 6, 9—For this example, there is no repeating score so no mode or 5 single modes. If we look at 4, 5, 6, 6, 9 the digit of most frequency to represent the mode is 6 that is repeated two times, more than any other digit.

Assuming all criteria were met for a normal distribution of scores (normality) the three central tendencies of mean, median, and mode, if equal, would reflect a perfect distribution of scores.

If the three central tendencies—a mean, median, and mode were all equal to 5 this would meet one of the requirements for a perfectly normal distribution of scores. This would be true if there were a sufficiently large number of scores. In the above example if the mean, median, and mode were to be five; it would be unlikely a perfectly normal distribution would result with only five scores.

**Question 7-14:**
Which measure of central tendency is most appropriate to use with nominal data?

a. mean
b. median
c. mode
d. quartile

Answer: c. mode

**Question 7-15:**
Which central tendency is the most frequently occurring score?

a. mean
b. median
c. mode
d. quartile

Answer: c. mode

**Question 7-16:**
A local newspaper reporter requests for you, as director of counseling, to provide a salary that is representative of the majority of counselors in your local mental-health facility. You have five counselors with the following salaries: $18,000, $19,950, $22,100, $24,400, and $49,000. You have derived the three central tendencies. Which one would you provide to the reporter?

a. mean
b. median
c. mode
d. all three

Answers: b. median. It is best to provide the median with extreme scores. In so doing the $49,000 represents only one salary rather than affecting the overall average, pulling the mean higher because of the difference(s) among all five.

# OBJECTIVE 7C: Variability

Variability refers to how scores spread around the central tendency. Two methods for describing this spread of effect are range and standard deviation.

Range: The range is a statement (or a set of numbers) revealing the low to high score such as 2-9 and represents the lower and upper limits of the set of scores. The range can also be calculated by observing the top (high) and bottom (low) scores. That is, subtract the low number from the high number and add one (+1) (inclusive). Using the previous five numbers of 2, 4, 6, 9, and 9 the low score of 2 is subtracted from the high score of 9, thus 7. Adding 1 to the 7 the range is 8. Adding one is not statistically accurate although it does indicate that the upper and lower limits yield a half unit on

either side of the extremes. If one were to count the digits along that same number line there would be a count of 8. The range is less reliable than the standard deviation. The range is utilized when the data are interval (Ary & Jacobs, 1976). It is not appropriate for nominal or ordinal data.

Semi-Interquartile Range: The semi-interquartile range is based on percentiles and has three points that will divide the distribution into four groups of equal size. The respective spread of scores is referred to as Q3 which is at the 75%, Q1 at the 25%, and Q2 which is referred to as the semi-interquartile range and is the middle 50% between the 25th and 75th percentile. This type of variability is utilized when the median is the preferred central tendency. It is also the choice for extremely skewed distributions.

Standard Deviation: The standard deviation is the square root of the squared deviations from the mean. The standard deviation is used when the mean is reported as the best indicator of the average. This is the most reliable measure of variability for a sample. The application of the standard deviation requires the mean of the distribution. If the mean of a set of scores is 60 and the standard deviation is 5, this means that the normal curve distribution will depart from the mean in equal units of 5 both to the left and to the right of the mean (60 ± 5 or 55-65). Two standard deviations would be two sets of five or 2 x 5 or 10 units to the left and 10 units to the right of the mean (60) therefore 50-70. This means the group as a whole will deviate in equal units of 5 or will disperse themselves from the mean in equal units of 5 above and 5 below the mean. The standard deviation refers to the group data.

**Question 7-17:**
A professor in the psychology department at a local college made out a statistics test for his advanced section of Research Methods. The professor decided to see how the lower level section of the same course would do on this more difficult test. Students in the lower level group did pass the test. However, as expected, there were some extreme low scores. In examining the variation scores, which index of variability should the professor choose in order to minimize the effect of extreme low scores?

a. inter-quartile deviations
b. standard deviation
c. range
d. average deviation

Answer: a. inter-quartile deviations. Inter-quartile deviation is the most appropriate index of variability in this situation.

## Standard Scores

**Standard scores:** Raw scores are converted using the normal curve to form standard scores. They are expressed as the distance a score is from the mean in terms of standard deviations. They are a measure of relative position when the test data are of interval or ratio measurement (Gay, 1996). Standard scores allow scores on different tests to be compared if the raw scores came from the same groups; and once a score is converted to a standard score, mathematical procedures can be performed.

**z Scores:** A z score (portrayed as a small z) is the raw score minus the mean of the group divided by the standard deviation z = x - x s (x is the score, x is the mean and s is the standard deviation). A z score always has a mean of 0 and a standard deviation equal to 1. A z score of 0 is equal to the mean (50%), a z score of .5 is one half of a standard deviation above the mean, and a z score of -2 is two standard deviations below the mean. The z score is the most basic standard score in that the calculations for other standard scores are often derived using z scores. A z linear line is below.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| -4.00z | -3.00z | -2.00z | -1.00z | 0.00 | +1.00z | +2.00z | +3.00z | +4.00z |

**Question 7-18:**
In a standard distribution with a mean of 100 and a standard deviation of 15, what is the z score for a score of 115?

a. +1.00
b. - 1.00
c. 0.00
d. cannot be determined with given data

Answer: a. +1.00. The score (115) minus the mean (100), which is equal to 15, is divided by the standard deviation (15) and therefore this z score is equal to +1.00.

**T Scores:** T scores are the same as z scores although have been multiplied by 10 and a constant 50 is added (T = 10z + 50). The development of the T scores made it easier to interpret scores to individuals because the T-score does not use negative numbers or decimals. It is easier to tell a person he or she has a T score of 40 than it is to explain a z score of - 1.00, though both scores have the same meaning. One difficulty with T scores is that individuals might confuse them with the procedure of school grading which has traditionally been 90-100 (A), 80-90 (B), and 75-70 (C).

**Question 7-19:**
What is the equivalent T score for a score of 34 in a normal distribution where the mean is 20 and the standard deviation is 7?

a. 60
b. 50
c. 70
d. cannot be determined with data given.

Answer: c. 70. Score (34) minus the mean (20), thus 14, which is divided by the standard deviation (7) is therefore equal to a z score of +2.00. This is a z score. Converting the z score of 2 to an equivalent core requires multiplying the z score by 10 (2 x 10) and adding 50 thus 20 + 50 or 70T.

**CEEB Scores:** College Entrance Examination Board (CEEB) scores have the advantage of not using decimals. This score is calculated by multiplying the z score by 100 and adding 500 (CEEB = 100z + 500).

**Question 7-20:**
In a normal distribution, what is the CEEB score for a raw score of 85 when the mean is 100 and the standard deviation is 15?

a. 40
b. 400
c. 4,000
d. cannot be determined with data given

Answer: b. 400. The raw score converted to a z score would be: z = score minus mean (85-100) divided by standard deviation of 15. Thus, -15 ÷ 15 = -1.00. The z of -1.00 is to be entered into the above formula 100(-1.0) + 500 = -100 + 500 = 400.

**Stanines-Standard nines:** The stanine is not a true standard score because the first and last stanine are open-ended. Aiken (1997) cites two advantages of stanines. First they are easy to explain and understand and are useful for grouping. A second advantage is that they represent ranges rather than a distinct point such as a z or T score. A disadvantage is that they are not as exact as other standard scores. Stanines are based on percentile rank. Stanines divide the normal curve into nine parts. Stanines have a mean of five and an approximate standard deviation equal to two. Stanines are only reported to go up to nine although the curve is infinite and conceivably could be extended.

**Stens-Standard Tens:** The stens score is another standard score used to report scores. Like the stanine with nine units, the stens has ten units. Similar to the normal curve of approximately 6 (±3, 34, 14, 2) units consuming the normal curve (99+%) the stens has five reciprocal percentages of scores reflected throughout the normal curve. Five of them are to the left of the mean and five are to the right of the mean. The advantage in using a stanine or stens score is that each will reflect the margin of error in testing and will yield a band or range of scores or percentiles.

# OBJECTIVE 7C: Variability

Variability is defined by how the scores spread themselves around the central measure and is often referred to as the spread of effect. The range, average deviation, and standard deviation can describe this spread of effect.

Range: The simplest of methods is considered to be the difference between the high score and the low score (Cohen, 2000). Subtract the lowest number (score) from the highest number (score) and add one (+1). If a set of test scores were:

4, 5, 6, 8, 9, the range would be calculated as follows: 9 - 4 = 5, 5 + 1 = 6

If one were to count the digits along a number line there would be six digits. This score represents the lower and upper limits of the spread. The range is utilized when the data are interval (Ary & Jacobs, 1976). The process is slightly different if the scores are continuous. It is not appropriate for nominal or ordinal scales. A disadvantage of the range is reliability.

Semi-quartile Range: Where range is the lowest-to-highest set of scores, quartile is the spread through the center of the distribution. There are four equal quartiles (lowest 0-25%, Q1; 25%-50%, Q2; 50%-75%, Q3; 75%-100%, Q4).

The middle 50 percent of the distribution from 25%-75% is called the interquartile range. The semi-interquartile range is the interquartile range divided by two, which yields the average distance from the median to each of the quartiles (Ary & Jacobs, 1976; Cohen, 2000). The quartiles are not affected by extreme scores and therefore become a good measure of variability.

Standard Deviation (s.d.): The standard deviation is the square root of the average of the squared deviations from the mean. The standard deviation is used when the mean is reported as the best indicator of the average. This is the most reliable measure of variability for a sample. It is not likely that one will calculate a standard deviation while taking the NCE. More likely a question would request the examinee to apply a standard deviation or read one. The standard deviation will be provided.

To apply a standard deviation, the mean is required. If the mean of a set of scores is 60 and the standard deviation is 5, then ± 1 s.d. will equal 5 units to the left and 5 units to the right of the mean or a range of 55-65. Two standard deviations would be 2 x 5 or 10 units to the left and right of the mean (60) therefore a range of 50-70. This indicates that the group as a whole will deviate in units of 5 or disperse themselves from the mean in units of 5 standard units above and 5 standard units below the mean. The standard deviation refers to the group data.

# OBJECTIVE 7D: Reliability

Reliability as defined by Anastasi (1988) can be understood from several perspectives. Following are short descriptive excerpts from her work.

1. Consistency of scores is attained by the same individual when:
    a. retested on the same test but at a different time
    b. retested at another time with an equivalent test
    c. different sets of equivalent items are utilized (i.e., one testing)
    d. there are special conditions
2. "Extent to which individual differences in test scores are attributable to 'true' differences in the characteristic under study and the extent to which they are attributable to chance errors" (Anastasi, 1988, p. 109).
3. By estimating what proportion of the total variance of the test score is error variance (p. 109)
4. The relative freedom from unsystematic error of measurement

5. Ratio of true variance to observed variance

Recall the classical measurement theory equation ($X = T \pm e$) where the observed score (X) is equal to the true score (T) plus or minus the error variance (e). Remember the (e) can be positive or negative. Error variance is the remaining factor of the classical measurement equation. Error variance is closely associated with determining reliability. Different types of errors influence the consistency or stability of a test score. The two most common types of errors are systematic and unsystematic. Systematic errors are constant, affecting at all times an either upward or downward error. Unsystematic errors vary and are unpredictable. These types refer to the test itself, administration, and the examinee, all which cause the reliability to be affected. Upon any testing, the subject achieves an OBSERVED SCORE and this score is made up of a TRUE SCORE and the UNSYSTEMATIC ERROR (error measurement which is either positive or negative) (Aiken, 1997; Gregory, 2000). In summary, since no test is considered perfect, nor is any testing situation absolutely perfect, some error of measurement is associated with each observed score. $X = T \pm e$ (Observed score = True score ± Error Variance)

Variance Accounted for is the square of the reliability. The unaccounted amount of variance is the variance accounted for subtracted from 100%. The Coefficient of Determination is another term for variance accounted for (Cohen, 2000).

**Question 7-21:**
Mark took the Canterbury Test for story-telling training. He scored 66 out of 100 questions on this cognitive examination. He retook the examination six weeks later and scored 72. The test mean was 50 with a standard deviation of 8. What was his true score?

a. 66
b. 72
c. 97
d. 99
e. unable to determine

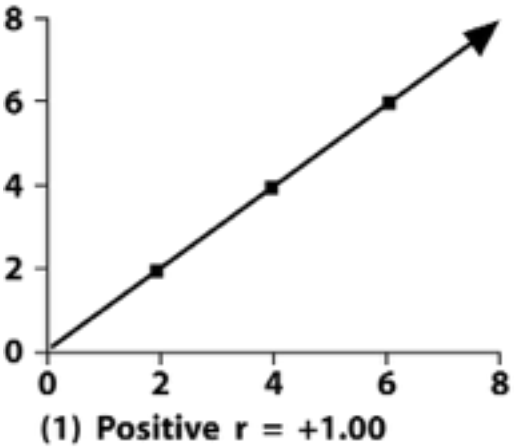
Answer: e. unable to determine. The true score is a hypothetical construct.

## Reliability Correlation

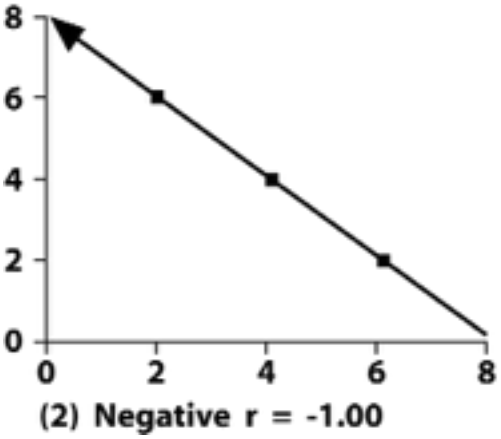
All reliability is expressed in terms of a correlation. The correlation is an expression of the relationship that exists between two independent variables. It is best described on a number line from -1.00 through 0 to +1.00. Both +1.00 and -1.00 are perfect correlations describing the direction of the two variables. A zero correlation is best described as no definable relationship existing between the two variables. A best guess, then, is as good a guess as any regarding the relationship between the two variables. Correlation is viewed on a scattergram by plotting a bivariate distribution. Through the use of a scattergram it is easy to visualize the direction of the relationship, positive or negative, and a lesser or greater degree of association.

## Scatterplot (1), (2), and (3)

Scatterplot 1: A scattergram or scatterplot is a pictorial representation of two variables. Without performing the arithmetic operation of correlation one can view the relationship between two variables, that is, more or less positive or negative.

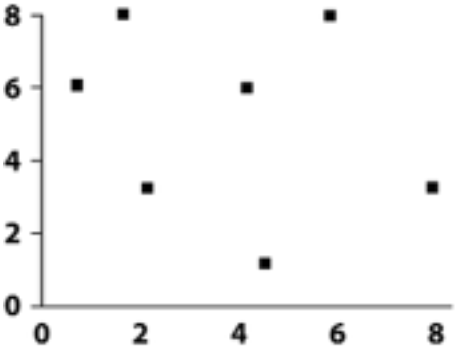



Scatterplot 2: Assuming the vertical line represents one set of test scores and the horizontal line represents a second set of scores. Thus, the student that had a 2 on the first test had a 2 on the second test. Each subsequent student attained the same score and the same position. This is a perfect correlation of +1.00.




Scatterplot 3: Connecting the dots will illustrate the straight-line 45 degree angle for scattergrams one and two. The second one illustrates that the student that had the lowest score on the first test had the highest score on the second and so on. When this scatterplot emerges it is referred to as a perfect negative correlation (-1.00).

The third scattergram reflects an extreme scatter (nearer to 0.00). The left-to-right and right-to-left orientations are visible on this scatterplot.



(3) Negligible = 0.00

A correlation is a mathematically computed term that reveals the relationship of the two variables. This relationship is expressed as a linear relationship on the number line from -1.00 to and through 0 to +1.00 and it is important to note that one variable does not cause the second.

| | |
|---|---|
| (-1) | as one variable increases the other variable decreases |
| (+1) | as one variable increases the other variable increases |
| (0) | no relationship exists between the two variables |

| -1.00 | 0 | +1.00 |
|---|---|---|
| negative (perfect) | | positive (perfect) |

This correlation is expressed by a small (r) and has a range of -1.00 through 0 to +1.00. Depending on the type of data (nominal, ordinal, interval, ratio) specific correlations are required to conduct predictions. Statistical information is presented in the Research & Program Evaluation Unit.

## Standard Error of Measurement

When applying reliability to a single testing for a person, the standard error of measurement is utilized. This term establishes a confidence range or band for which a person's score would fall if the test were taken several times. There are several confidence ranges (bands), although only three will be presented for study. These bands are predictions and stated as a probability.

| | | |
|---|---|---|
| Precise | 68% = | 1.00 x sem |
| Approx | 66 2/3% = | 1.00 x sem |
| Precise | 95% = | 1.96 x sem |

| | | |
|---|---|---|
| Approx | 95% = | 2.00 x sem |
| Precise | 99% = | 2.56 x sem |
| Approx | 99% = | 3.00 x sem |

The top line represents the exact numbers; however, for the NCE study guide it is likely the rounded and approximate numbers on the second line representing ±1, ±2, and ±3 standard deviations for the respective confidence bands will be utilized. The first percentage of 68 is rounded down to 66 2/3 and is equal to and represented by the fraction 2/3. Therefore, upon retesting at ±1 standard error of measurement, or one confidence band, it is said that two out of three times (2/3) the person will score in the range of (assuming the sem is 2) two points to the left of his/her score (obtained score) and 2 points to the right of his/her score. The prediction of 95% would be making the statement: 95 times out of 100 or 19 times out of 20 (19/20) his/her score would fall in the range of ± 4 points of his/her score. The 99% confidence statement is read as 99 times out of 100, and this is represented by ± 3 standard error of measurements (±6).

If an individual scored a raw correct score of 70 on a cognitive examination and wanted to know how he/she would score if he/she took the test again based upon the known unsystematic errors, this can be determined. What is required is the standard error of measurement, which is 3. The degree of confidence requested is for a 95% confidence, that is 2 confidence bands (± 2). This is to indicate that if you took this examination 100 times or 20 times, what would be the observed score range (nearer to the true score) or confidence band (estimate)? The formula is:

2 units (or the 95% prediction) x (3 sem) or

2 x 3 = equals 6

The estimated observed range at 95% or 19 out of 20 times would be ± 6 (2 x 3) from the obtained score of 70 or a range of scores from 64-76. The counselor will be expected to interpret this score prediction to a client. It can be said that if an individual retook an examination there is a 95% confidence that his/her score would fall in the range of 6 points to the right of his/her previous score and 6 points to the left of that same score. In other words not only could he/she score higher but could also score an equal number of points lower.

## Types of Reliability

The following different types of reliability measures are reported and serve different purposes:

Measure of Stability: This requires two administrations and is a test-retest situation using the same test. Very often interest inventories utilize this type of reliability.

Measures of Equivalence: This measure requires two administrations of two different but equal forms of the test. The equivalence of the forms has to do with the content of the items, item difficulty, item discrimination, and that they measure the same objectives. This equivalence is described by a correlation. This is also called the Parallel form measure.

Measure of Internal Consistency: This requires one (1) administration, and comparisons of items are conducted within the test. Some examples of this type are: split-half or first-half items compared to second half items or odd items compared to even items. Frequently odd vs. even comparisons are better than first-half items compared to second-half items because of item easiness/difficulty being closer to one another. Again it depends on the type of instrument (achievement or personality).

The Kuder-Richardson 20/21 are inter-item consistency measures that attempt to make all possible pairings. These consistency measures have become more popular as computers have become more available with speedy computations and returns. Measures of consistency are often utilized in short tests or subtests of larger batteries such as multi-aptitude tests. This reliability is the preferred choice for data that are dichotomous such as right or wrong, yes/no, etc. (Cohen & Swerdlik, 1999). If the items are determined to have the same degree of difficulty the KR-21 is recommended over the KR-20.

Coefficient Alpha is an extension of the Kuder-Richardson method and often the inter-item choice. Coefficient Alpha is utilized with tests that have dichotomous and nondichotomous (attitude/opinion) items. This method utilizes the Spearman-Brown formula as a correction. Keith and Reynolds (1990) indicate that the Coefficient Alpha is the preferred method with the advent of computer technology.

Scorer Reliability: These consistency measures are derived when two independent observers rate or judge some behavior. How closely these two observers conspect, that is observing variables alike, is determined by the stimuli and ratings each provides. Rater reliability is the degree of agreement or consistency (reliability) when two different individuals observe a variable. The Carkhuff rating scale utilizes rater-reliability coefficient measures to train for comparativeness in the core conditions. These reliability measures are often utilized in projective administration and scoring responses. Depending upon the type of test score measurement the Pearson r or Spearman rho is the preferred correlation technique to derive an index of consistency.

## Assessment

Reliability can be understood and assessed in the following ways:

1. Standard Error of Measurement: Range of fluctuations of one's scores as a result of chance error
2. Correlation: Degree of agreement between two sets of scores
3. Scatterplot: Plotting two variables on an ordinate and abscissa

## Influencing Factors

Five specific factors in addition to the test, person, and environment have been identified by Mehrens and Lehmann (1984) as instrumental in affecting the reliability. These are:

1. Test Length: A long test is more reliable than a short test
2. Speed: Faster test more reliable

3. Group Homogeneity: More homogeneous less reliable than heterogeneous test
4. Item Difficulty: Too difficult or too easy are less reliable
5. Objectivity: Single scores more reliable

Interpretation: correlation (r) = .90 A reliability of .90 can be described as 90% of the variance in a test score depending on true variance in the trait measured and 10% depending on error variance. This index of .90 does not say one can repeat your score 90% of the time.

**Question 7-22:**
A classroom teacher conducted a reliability study for a speeded test she gave to an algebra class. Which one of the following reliability measures should not be used?

a. stability
b. parallel
c. split-half
d. equivalent

Answer: c. split-half. Split-half measures are spuriously high because of the odd/even split and will approach 1.00.

# OBJECTIVE 7E: Validity

Validity is a basic concept employed to determine if the test is measuring the purpose or definition of the test. For the most part, validity is measured according to the type of validity (Anastasi, 1988). Validity is the term to which we refer when justifying the use of the test for the purpose so provided. If the test is valid we infer, predict, and make decisions based upon the level or degree of validity.

## Types

Brief descriptions will be provided; however, Anastasi (1988) and Cohen and Swerdlik (1999) are recommended for a thorough review of the following:

Face/Logical: Upon review, does the test appear to measure what it says it does? Determining face validity is through a quick review of the match between testing content and intent to measure. Although face validity may enhance one's confidence about the usefulness of the test it is not an acceptable basis for using face validity to interpret inferences of a test score (Cohen & Swerdlik, 1999). There is no correlation (r).

Content-related: This validity is conducted through inspection of the objectives for testing and the individual items. Taxonomies (cognitive, affective, or psychomotor) are reviewed if the full range of examination is desired. Item analysis is conducted on each item as well as the overall test. There is no correlation (r) to express the level of validity. All cognitive tests are concerned with content validity.

Lawshe (1975) reports a content validity ratio that is determined by a panel of experts who review test items for answers to the question "is the skill or knowledge measured by this item" (p. 675).

Criterion-related: This type of validity utilizes a criterion to measure the performance on a specific test. The two common types are concurrent and predictive. A correlation (r) is the index to describe validity. The preferred correlation is dependent upon the type of data, sample size, and the shape of the distribution.

Concurrent: This type is composed of two measures taken at one time. The objective of the testing is most important. It can be used for a determination now, does the grade point average predict the SAT score?

Examples: SAT and GPA.

Predictive: A longer time interval for prediction and often utilized for selection and classification. Diagnosis is for the future. Example: SAT score will predict success in college, completion of a degree. The criterion measure of prediction is successful completion of college.

Construct-related: This type of validity relates to theoretical constructs such as intelligence, fear, etc. Construct validity is described through the use of a correlation (r) and is most frequently associated with personality theory although it exists for all constructs.

There are other types of validity that will not be reviewed in this manual, such as incremental, differential, discriminant, and convergent. If you are competent with content, construct, and concurrent validities, it is recommended that you review discriminant and convergent validities in the terms section.

## Describing Validity

Correlation: Used for criterion and construct-related validities.

Coefficient of Determination: This is the squared correlation between the test and the criterion. This is the proportion of criterion variance accounted for by the test. If the correlation between the ACT and successful completion of pre-college training is .70, then the coefficient of determination is the correlation of those two measures squared (r =.70) or .49 and interpreted as a percentage. That is 49% of the variation in successful pre-college training can be accounted from knowledge of the ACT.

Standard Error of Estimate: This term is similar to the standard error of measurement, as this term is to set the confidence limits of the true score. This is the margin of error in predicting the criterion score.

Expectancy Tables: Decision theory utilizes cutoff scores for personnel decisions. These tables are easy to read and interpret.

Multiple Regression: A mathematical combining of scores on several tests in order to assign weights. This allows a high score on one test to offset a low score on another test.

## Prediction

Validity is an application of decision theory and it affords one to subject the test scores to a scatterplot and make predictions. Four quadrants are developed on the axes of the ordinate and abscissa with two variables. Thus, one can establish the following predictions.

False rejection: Many incorrect rejections-rejecting when true a false negative in that one incorrectly predicts the person to fail. This is referred to as a Type I or Alpha error.

Valid acceptance:  Accepting when true

Valid rejection: Rejecting when true

False acceptance: Many incorrect acceptances. Accepting when false or a false positive that is incorrectly predicting that one will succeed. If succeed is the variable of study, this is referred to as a Type II or Beta error.

## Validity Application and Interpretation

Validity application is conducted between a test score and a criterion measure.

Standard error of estimate is the margin of error to be expected in an individual's predicted criterion score as a result of the imperfect validity of the test. If r = +.80, then the test will equal +.60. The calculation is .80 squared equaling .64 subtracted from 1.00 equals .36 and the square root of .36 is .60.

$$\sqrt{1 - r^2}$$

Use of such a test enables us to predict the individual's criterion performance with a margin of error that is 40% smaller than it would be if we were to guess. This could be interpreted as the error being 60% as large as it would be by chance. A test may be reliable without being valid, but it cannot be valid without being reliable. It is not likely one would be requested to perform this operation rather than interpret the meaning. That is, how would the Standard Error of Estimate be applied?

Affected: Validity is affected by both systematic and unsystematic errors while reliability is affected by unsystematic error.

Maximum Validity: The maximum validity can be determined by determining the square root of the reliability. If the reliability of a test was .64, the square root would be .80 and the maximum validity.

# OBJECTIVE 7F:  Assessment and Evaluation in Social and Cultural Issues

Section E.8 of the ACA Code of Ethics addresses multicultural issues/diversity in assessment emphasizing caution in the selection and use with assessment techniques and norms other than that

of the client (p.13). This caution is extended to test administration and interpretation. It is critical in assessing clients representing minority populations that the counselor is knowledgeable about the impact of results when using instruments that may not be culturally appropriate (E.9.b., E.12.). The standards for Multicultural Assessment lists 68 standards separated into four tasks; a) selection of assessment instruments, b) norming, reliability, and validity, c) administration and scoring, and d) interpretation and application of results (Prediger, 1994; Whiston, 2009 Appendix E).

An ethical issue in multicultural testing is the civil rights of minorities. The first step in cross-cultural counseling should be to understand the values and worldview of the client before considering the use of testing. Because testing has historically been a dehumanizing experience used to discriminate against minorities, special care should be taken to explore the feelings and attitudes of a minority client concerning the taking of any test. These feelings and attitudes can have a significant impact on test results (Corey, et al., 1988).

A factor that can influence test results is previous test-taking experiences. To combat the lack of test-taking experience of some minority clients, opportunities for practice should be provided, and the client should be retested with an alternate form (Anastasi, 1976). An example of pretest taking experience is evidenced by those taking the NCMHCE. Before the testing begins examinees are provided a sample scenario. Test results can also be affected by the presence of item bias in the form of culturally restricted test content, sexual stereotypes, and unfamiliar or alienating material. Test constructors are becoming increasingly sensitive to such content in instrument design (Anastasi, 1976). Other concerns related to assessing minority clients include the unfairness of testing a client in any other than his/her native language and testing for white, middle-class abilities (Gladding, 1988, 1996). There is even some argument as to whether a test written for one culture can be adequately translated to another language in such a way as to retain its validity (Garcia, 1981). Garcia indicates that "each regional, ethnic, social group should be tested and scaled by the same operation in its own idiom, in its own time, with test elements and incentives drawn from its own domain" (p. 1180). In general, using tests to categorize and label clients in a rigid, discriminatory manner is unethical. Instead, test results should be used for better understanding and planning for optimal development of the client.

In fact, Anastasi (1976) points out the positive side of using tests with minority populations as a way of preventing subjective, discriminatory classification of minorities by teachers, employers, and others who might tend to reward conformity and majority values. Likewise, testing can identify cultural disadvantages and thereby lead to remedial programs to correct social injustices. Likewise, job-placement tests can prevent discriminatory hiring practices.

Finally, as Aiken (1997) maintains, many more minority "mis-placements" would probably occur were it not for objective tests.

According to Constantine and Ladany (2001) multicultural competence has six dimensions: 1) self-awareness, 2) general multicultural knowledge, 3) multicultural counseling self-efficacy, 4) ability to understand unique client variables, 5) effect counseling alliance, and 6) multicultural counseling skills. If a counselor possesses these dimensions of competence it is more likely good decisions will be

evident in assessment procedures. Drummond and Jones (2010) recognize that known biases can exist for the test, content, internal structure, test-taker, and the examiner.

In summary, cultural equivalency occurs when functional, conceptual, linguistic, and psychometric properties have been assessed and met and the assessor practices cultural competence. The term functional refers to when test scores measure psychological characteristics that occur with equal frequency with different cultural groups. Conceptual refers to the extent that different groups are equally familiar with the content of test items and have similar meaning for the content. Linguistic refers to the language used in the test. Do the words have the same meaning for different cultural groups?

# OBJECTIVE 7G: Ethical Issues in Testing

Section E of the ACA Code of Ethics outlines key behaviors surrounding testing. Other principles of the ACA code that are relevant to testing are informed consent, confidentiality, and client welfare.

## Resources

The ACA Code of Ethics (2014) section E.2 a. limits of competence indicates that counselors should use testing and assessment services for which they are trained (p.11). Therefore, counselors are to be knowledgeable about the contents of the standards for Educational and Psychological Testing (AERA), standards for the Qualification of Test Users (ACA, 2005), Code of Fair Testing Practices in Education (Joint Committee on Testing Practices, 2003), Responsibilities of Users of Standardized Tests (RUST), and Responsible Test Use: Case Studies for Assessing Human Behavior (Whiston, 2009). The ACA Code of Ethics in section E.2.b.states that counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments (p.11).

## Qualification for Administration

One ethical consideration in testing involves the qualifications of the test administrator. The counselor is responsible for testing materials and their proper use. It is unethical for a counselor to administer, score, or interpret scores on tests in which she/he lacks adequate training. This training includes a thorough knowledge of the strengths and limitations of the test, the characteristics of the standardization sample, the reliability and validity of the test in comparison to similar instruments, the scoring procedures, norming, and the method of administration (Kaplan & Saccuzzo, 2001). For a counselor to achieve competence in intelligence testing and most personality testing, specific training and supervised practice are required. Vocational tests values/interests inventories require less specialized training, however no test should be administered by an examiner who is not able to properly evaluate the particular test in terms of technical merits, purpose, conditions affecting test performance, and other limitations.

## Client Rights, Responsibilities and Testing Personnel

The Rights and Responsibilities of Test Takers: Guidelines and Expectations (1998) list specifies ten rights that clients can expect during an assessment that are supported by the ACA Code of Ethics (2005). In addition this guideline lists ten responsibilities for a test taker and ten guidelines for testing professionals. Clients have the right to results that are based on results (E.2.c., E.3.b.), confidentiality (B. 1.a-divesity, B.1.b-privacy, B.1.c), and to use least stigmatizing labels. If a diagnosis is a component of an assessment, counselors are to exercise special care, sensitive awareness of cultural and socio-economic experiences (E.5.a.,b.,c.) and refrain from a diagnosis if it would cause harm (E.5.d.).

## Use of Tests

Tests are used as an efficient means of obtaining information for assessment and evaluation purposes (Gladding, 1996). However, examiners must always bear in mind that tests have limitations and scores must be interpreted in light of all available data regarding the individual. Therefore, tests should be chosen carefully with a clear rationale in mind (i.e., a particular test, for a particular client, for a particular purpose) (Anastasi, 1976). The counselor should always keep in mind that the primary use of tests is to provide one source of objective and descriptive data that the client can use to make better-informed decisions. Tests should always be used to serve the client. To use them as a weapon against him/her is unethical (Corey, Corey, & Callanan, 1988). In summary, Gregory (2000) outlines five uses of tests that are: classification, diagnosis and treatment planning, self-knowledge, program evaluation, and research.

## Informed Consent (Section E.3.) and Explanation to Client (E.3.a.)

The client should receive a full explanation of the purpose of the test, the kinds of data sought, how it relates to his/her situation, and how the scores will be used (Corey, et al., 1988). Scores should not be made available for research or institutional purposes without the knowledge and written consent of the client. If used for research purposes, scores must be disguised to protect the privacy of the client (Anastasi, 1976).

Invasion of the client's privacy also becomes an issue in some personality assessment instruments where the client may unknowingly disclose information without full knowledge or consent. This issue has caused much debate and subsequent review of the construction and use of affective instruments (Aiken, 1997).

## Confidentiality

Related to the issue of privacy is the confidentiality of test scores. Whereas the client has a right to his or her test results, caution must be taken to insure that there is no misunderstanding of the meaning of scores. The counselor, therefore, has an ethical responsibility to insure that the test results are communicated in a clear, understandable form (descriptive rather than numerical) and that any

questions or concerns that the client may have are thoroughly answered (Anastasi, 1976). Hood and Johnson (2002) suggest where possible score interpretation should be conducted using probabilities.

Another facet of insuring confidentiality has to do with the storage and retrieval of test scores (assessment security, E.10.). However such records are maintained (i.e., computer storage, etc.), access should be subject to strict controls to insure confidentiality (Anastasi, 1976).

## Client Welfare (E.1.b.)

Client welfare must be a primary concern in effectively transmitting test results. Discussion of test results should be an integral part of the counseling process (Anastasi, 1976). Corey, et al. (1988) emphasize the importance of exploring all issues that surface as a result of the use of test results. An example of an issue that might arise is any discrepancies between perceived abilities, interest, etc., as well as those indicated by the test results.

# OBJECTIVE 7G: Reporting Test Scores

In most states, both the examinee and the parents of the examinee have the right to know the results of a test score (C.6.b., third parties, B.5.b., parents and legal guardians). This is the result of the Buckley Amendment. This federal amendment entitles parents, guardians, and individuals the access rights to information and standardized test results. Two critical components of this amendment are: (1) students over 18 and their parents have access to information and (2) the right to not have information released to unauthorized others (Ward & Murray-Ward, 1999). The New York Truth in Testing legislation also required the disclosure of test items in tests such as the SAT, GRE, LSAT, etc. (Aiken, 1997).This does not mean that the actual score a person receives on a test should be reported. Results must be interpreted in a way that the examinee can understand them. In addition, assessment results of personality should always be supported by behavioral observations and personal interviews (Aiken, 1997).

## Confidentiality

The Buckley-Pell Amendment (Family Educational Rights and Privacy Act of 1974-FERPA) was enacted to protect the privacy and confidentiality of a person's test scores. This act refers mainly to educational records but requires (Aiken, 1997; Whiston, 2000):

1. Informed consent for data collection. This includes an awareness of what the material is, and who is going to see it.
2. Data should be categorized according to sensitivity and treated accordingly. Some information may be privileged.
3. Parents and the student have access to the information. However, the good of society outweighs the individual's right to privacy or privileged information. If a person's life or the life of another is in danger, this information can be released. Also, if a court (judge) requests the

information, it must be given with or without the person's consent. It is always advisable, if in question, to seek counsel before releasing any information.

The ACA Code of Ethics states that "provisions must be made for maintaining confidentiality in the storage and disposal of records and follow an established record retention and disposition policy." Furthermore, "the counseling relationship and information must be kept confidential, consistent with the obligations of the member as a professional person" (Gladding, 1996, p. 576). Arguments against the use of computers for record keeping include confidentiality issues. In a network system, such as in a hospital, care should be taken to protect the record from inappropriate access. A password identifying the user is one simple, yet effective, method for doing this. Also, when information is transferred between computer systems, caution should be used to limit the information transferred. HIPAA requires that entities have encrypted communication.

The use of a computer introduces the need for a judgment weighing the ease of accessibility against the problems of confidentiality. There are no problems with confidentiality that are not apparent with other methods of record keeping. It is no easier to break into a computer system than it is to break into a record room, and with appropriate safeguards, confidentiality is protected.

## Communication of Test Results

Test interpretation is a crucial part of testing. Many people have misperceptions about the meaning of test scores, and many people do not understand score terminology. The lack of information must be shared and explained in an understandable manner. Gladding (1988) lists predecessors to good test interpretation. He indicates that counselors must:

1. Be informed about the instrument (Gladding, 1988).
2. Tyler indicates that test scores should be seen only as "clues" (as cited in Gladding, 1988).
3. Tinsley and Bradley (1986) as well as Miller (1988) suggest one begin with the concrete and move to the abstract, avoiding "off the cuff" remarks.
4. Always have a manual present during interpretations (Gladding, 1988).

In addition, the professional conducting the interpretation should have a good grasp of the material within the manual and have it available when conducting an interpretation.

Results should be presented in terms of descriptive performance rather than isolated numerical scores and should be reported as specific answers to questions by the examinee. The examinee's emotional response to the interpretation should be monitored as well.

Some tests are scored and even provide generated interpretative reports by computers. The APA provides guidelines for using this information in Guidelines for Computer-Based Tests and Interpretations. Computer-assisted psychological assessment (CAPA) is a term that refers to the entire range of computer applications in assessment. Computer-based test interpretations (CBTI) are limited to the interpretation and written report. There are many advantages to this method, such as speed, but there is also concern about the misuse of these interpretations. Aiken (1997) states that

computerized interpretations may be inappropriate for some groups of people like young children, the mentally retarded, severe psychotics, and others. He also points out that some interpretive programs have not been well-validated and that they are based on inadequate norms. Reliability may also be poor. Aiken states that test users must insist that computer-interpreted programs adhere to the standards of validity, reliability, and norms. Another risk is that of unqualified users who secure access to the results. The fact that the results are computerized only adds to the illusion that test results are infallible. The results are more likely to be misused because of this.

Goldberg (1970) cites that examinees seem to like computer-based results, and reports reflect that the computer-based MMPI assessments sometimes outperformed the clinicians in assessing neurotic and psychotic patients. However, according to APA and ACA guidelines, computer interpretations should be used only in conjunction with professional judgment. In summary, Mehren (1986) lists a few advantages and disadvantages of computer-based test interpretations.

**Advantages**

1. allow more tests to be scored in a shorter period of time
2. accuracy in scoring is usually better than hand-scored reports
3. some bias on the part of the counselor to the client may be ruled out

**Disadvantages**

1. a danger of computer interpretations being read by unqualified people which become subject to misguided, incorrect assessments
2. software packages score, interpret, and analyze test results and are readily available often to those untrained
3. computers do not make allowances for emotional or physical states of the examinee
4. software may be updated but the scoring facility may not be

## Interpretation of Scores

Raw scores from a classroom test or observed behaviors are not interpretable except within the person. Percentage is an appropriate statistical description. An example would be a student who answered 72 questions correctly on a 100-item examination. It can be said that he/she answered 72 percent of the questions correctly. If one desires to compare his/her raw score with others then the transformation has to take place for comparison to others. This allows examiners to utilize several different score reports such as percentile rank, percentiles, quartiles, deciles, and many types of standard scores. These terms reflect how a person ranks in comparison to others. However, if there is a desire to know how much better an individual did, then other standard scores are appropriate. Examples of standard scores are z-score, T-score, stanine, sten, CEEB, etc.

Hanna (1988) indicates the percentile rank (PR) is one of the easiest derived scores to interpret and comprehend. A percentile rank of 88 (ordinal scale) indicates that an individual scored better on this

test than 88 out of 100 applicants for college. One caution needs to be made and that is not to confuse percentile rank with percentile or percentage correct. A student who scored at the 64 percentile rank on a cognitive test did not necessarily have 64 correct or 64% of the total number correct. Rather, it means his/her raw score correct (whatever that is) was higher than 64 others who took the same test. It is interpreted as though there were 100 taking the test when in fact there may have been 32. It does mean percentage in that the student had a score higher than 64% of those that took the test. The score is interpreted as ranking at the 64th percentile.

A confidence band reflects the probable range that a person's score would fall into if taking the test many times. The actual computation of the standard error of measurement is essential to establish a confidence band and is presented within the reliability section of a manual. For interpretation purposes if a confidence band is identified as 105-115 this is presented as an interval in which the person's true score will likely fall. The confidence attached to this band has to do with the degree of probability. If the standard error of measurement is applied once to the right and left of the mean then the counselor will make the statement that it is likely that the score will fall in the range of 105-115 two out of three times. This is determined by, ± 1 standard error of measurement from the derived score (110). Plus or minus one standard deviation has an accumulated percentage of the curve 68% (approximation). This is equivalent to approximately the fraction 2/3 or two out of three times. If one desires a greater degree of confidence then the standard error of measurement must be applied again until the confidence degree required is attained. Two Sems equal 95% and three Sems equal 99+%.

Interpreting standard scores is most often conducted by reference to the normal curve. A standard z score is converted to a percentile and then interpreted as scoring better than that number. Interpreting this percentile such as 84% would say that the student scored better than 84% of the students who took the test. The same interpretation is applied to percentile bands or the use of stanine or sten that are bands yet presented in 9 or 10 units. Stanine and sten take into account measurement error.

## Resources in Testing for Individual and Group Assessment

Oscar K. Buros' Mental Measurement Yearbook (Plake, Conoley, Kramer, & Murphy, 1991; MMY) is now published by the Buros Mental Measurements. It reviews nearly all available psychological, educational, and vocational tests commercially available (Anastasi, 1988). This reference manual provides a critical review of tests.

Tests in Print (Murphy, Conoley, & Impara, 1994) is another source of information about tests. The Buros Institute also publishes it. It provides cumulative coverage of all known commercially published tests. Each successive edition of Tests in Print can also be utilized as an index to all the MMYs preceding it (Anastasi, 1988).

Standards for Educational and Psychological Testing (AERA, APA, & NCME, 1985) is a comprehensive guide for the evaluation of psychological tests. The APA along with the ERA and NCM prepares this source. The latest edition was published in 1985. Each revision gives increasing attention to proper test development and use as well as correct interpretations of scores (Anastasi, 1988).

## Review Questions

Questions 7-23 to 7-29 are a sample of questions for appraisal. The material for the content of these questions can be found in this unit of study. Questions 7-30 to 7-42 are more time consuming than will be found on the NCE.

**Question 7-23:**
Which one of the following is an example of a measure of variability?

a. range
b. median
c. factor analysis
d. correlation

Answer: a. range. Range and standard deviation are two variability measures.

**Question 7-24:**
Which one of the following is not an example of a normalized standard score that has been transformed to fit a normal curve?

a. T-score
b. z score
c. ratio IQ
d. percentile

Answer: c. ratio IQ

**Question 7-25:**
It is possible to derive a ratio scale on which one of the following types of measures?

a. personality
b. attitude
c. judgment
d. achievement

Answer: d. achievement

**Question 7-26:**
Likert scales, which are typically used to measure attitudes, yield which type of measurement?

a. nominal
b. ordinal
c. interval
d. ratio

Answer: b. ordinal

**Question 7-27:**
The term that someone's overall attitude toward another person influences ratings on a specific trait is:

a. leniency error
b. halo effect
c. Hawthorne effect
d. error of central tendency

Answer: b. halo effect

**Question 7-28:**
Bruce has recently transferred to a new school and the counselor evaluates his reading scores on the Gates-MacGinity Reading Test from his previous school. Bruce's score on reading was 8.9. Upon entrance at the new school he took the Standard Reading Test and scored 9.2. What can the counselor say about these scores?

a. The scores are comparable, and the student is reading above average.
b. The scores are not comparable unless the tests are equated.
c. The standard error is one year, therefore the student falls within that range and the scores are comparable.
d. The tests measure different traits and are not comparable.

Answer: b. The scores are not comparable unless the tests are equated.

**Question 7-29:**
You are deriving the 95% confidence band based on observed scores for a derived true score of 57. The mean of the test is 50, the standard deviation is 7, and standard error of measurement is 3. The confidence band is:

a. 50-64
b. 54-60
c. 43-71
d. 51-63

Answer: d. 51-63

**Question 7-30 to 7-33:**
The guidance counselor was evaluating specific abilities for four students in the senior class. Since the tests were in four subject areas and were from different sources, the counselor could not merely average the results. From the data to follow:

| | English | Social Studies | Mathematics | Science |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| $\bar{x}$ | 82 | 85 | 79 | 89 |
| s.d. | 8 | 6 | 9 | 10 |
| Student | English | Social Studies | Mathematics | Science |
| Linda | 98 | 94 | 91 | 93 |
| Tom | 94 | 90 | 79 | 90 |
| Bob | 92 | 85 | 70 | 92 |
| Sue | 96 | 92 | 89 | 96 |

**Question 7-30.** Which of these students scored better in English and Social Studies?

**Question 7-31.** Which of these students scored lowest in math?

**Question 7-32.** Which students scored below the class mean(s) in each subject area?

**Question 7-33.** In all four subjects, which student had the highest score in comparison to the rest of the class scores?

Answers:

7-30. a. Linda = English +2.0, +1.5 Social Studies

7-31. Bob (70) = -1.00

7-32. Bob in Math

7-33. Linda exceeded all students with the highest score attained in each subject with the exception of Sue in Science

**Questions 7-34 to 7-38:**

These questions refer to a set of group score results from one administration of the NCE.

| | | Mean | S.D. | Mark's Score |
|---|---|---|---|---|
| Section #1 | Human Growth | 13 | 2.00 | 17 |
| Section #2 | Social Foundation | 14 | 2.00 | 17 |
| Section #3 | Helping Relation | 15 | 3.00 | 14 |
| Section #4 | Group Dynamics | 14 | 1.00 | 14 |
| Section #5 | Career Development | 12 | 2.00 | 17 |
| Section #6 | Individual Appraisal | 11 | 2.00 | 10 |
| Section #7 | Research & Program Evaluation | 11 | 4.00 | 15 |

| | | | | |
|---|---|---|---|---|
| Section #8 | Professional Orientation | 14 | 2.00 | 14 |
| TOTAL: | | Mean of test = 104 | S.D. = 14.00 | Mark's score = 118 |

**Question 7-34.** On which section were the scores more homogenous?

a. #3 b. #4 c. #6 d. # 7

**Question 7-35.** Which section of the test had the greatest spread of effect?

a. #3 b. #4 c. #6 d. # 7

**Question 7-36.** When compared to the mean of the group, on which subtest did Mark score better?

a. #1 b. #5 c. #6 d. #7

**Question 7-37.** On which subtest in comparison to the norm group did he score highest?

a. #1 b. #2 c. #5 d. #4

**Question 7-38.** Overall, Mark's percentile when compared to the group was?

a. 50% b. 53% c. 68% d. 84%

Answers: 7-34. b. #4, 7-35. d. #7, 7-36. b. #5 (2.5 s.d.), 7-37. c. #5 (2.5 s. d.), 7-38. d. 84%

# Unit 7 – Terms

ACHIEVEMENT:
The degree to which one has achieved on a standardized test. Used primarily in studies of education. An achievement test is any test designed to evaluate a person's current state of knowledge or skill, contrasted to an aptitude test which is designed to evaluate potentialities for achievement independent of current knowledge (Reber, 1985).

APTITUDE:
The capability to learn a task or skill. Frequently the potential for achievement. Aptitude tests are often used to predict success in an occupation and measure a homogenous segment of ability.

COEFFICIENT ALPHA:
Coefficient alpha is a reliability index that is an extension of the KR-20 or 21. All of the possible mean split-half coefficients are corrected by the Spearman-Brown formula (Gregory, 2000).

CONFIDENTIALITY:
The term is most commonly used with respect to an ethical issue regarding the sharing of personal information. This principle protects as in a contract the information shared or communicated in a counseling session. This refers to testing and test scores as well (Reber, 1985).

CONSTANT ERROR:
A constant error is a systematic error that causes a measurement to deviate consistently from a true value. A random error deviates in varying amounts, that is, higher or lower than the true value. A constant error goes in one direction, only. If a gasoline pump always provides slightly less than a gallon of gas and if it always does this a constant error exists. If it was under sometimes and over sometimes it would reflect a random error.

CONVERGENT VALIDITY:
Convergent validity is utilized to show construct validity and in order to do this one test is correlated against another that measures the same variables of the first test and therefore one method to establish validity (Domino, 2000).

CRITERION-REFERENCED:
A specified content domain where an examinee's test performance can be reported in terms of specific kinds of operations he/she has mastered, difficulty level, or amount of learning. An individual's score is compared to an established criterion (Whiston, 2000).

CRYSTALLIZED INTELLIGENCE:
Mostly an acculturation learning. This type of learning is organized by the culture in order to make it useful for that culture. Crystallized intelligence is used when performing tasks that require a learned or habit response. Skills and knowledge are acquired and influenced by cultural, social, and educational experiences (Whiston, 2000).

CULTURAL EQUIVALENCE:
Cultural equivalence in test development and use is through a systematic effort to achieve functional, conceptual, linguistic, and psychometric properties in the test construction and interpretation.

DISCRIMINANT VALIDITY:
Somewhat the opposite of convergent validity, discriminant validity is to show that the test or test variables do not correlate with variables they should not correlate such as aggression and friendly (Domino, 2000).

EXPECTANCY TABLE:
Gives probability of different criterion outcomes for a person who obtained a certain score. Expectancy tables can be used in evaluating criterion-related validity of a test (Cohen & Swerdlik, 1999). Frequently tables show an interval range of scores in which individual scores are placed in categories, like insurance, longevity rates, PSAT, etc.

FACTOR ANALYSIS:
Attributed to Charles Spearman. A class of mathematical procedures designed to identify factors that are presumed to influence or explain test performance.

FLUID INTELLLIGENCE:
One of two types of intelligence factors within Cattell's theory. Fluid intelligence is a nonverbal form of mentality and reflects causal learning. Cattell considered this an inherent capacity to learn and solve

problems when adapting to a new situation. It is also culturally free and assessed in memory span and spatial thinking (Whiston, 2000).

FLYNN EFFECT:
James Flynn referred to this effect as the steady rise in intelligence scores in the last fifty years. It was his contention that intelligence scores on intelligence instruments rose on the average three points per decade (Whiston, 2000).

FORCED-CHOICE:
An item format in which a subject is to pick between two alternatives such as true or false, yes or no. A forced-choice format will reduce the effects of social desirability.

FORMATIVE EVALUATION:
A formative evaluation is immediate feedback (Neukrug, 1999). Immediate feedback can be oral, written, or as in a rating form. A formative evaluation is a series of evaluations to chart progress for a course or project. An example would be to have three or four examinations throughout a quarter, thus the student has a bearing as to where he/she stands in relation to a final grade.

GUTTMAN SCALE:
A scaling to understand separate answers to attitude questions. This scale is unidimensional. If the test taker answers with the most extreme response, she or he agrees with the milder responses.

HALO EFFECT:
A tendency to allow an overall impression of a person or one particular characteristic or trait to influence the total rating of that person. It often emerges as a bias on personal-rating scales (Reber, 1985).

ITEM ANALYSIS:
The process of evaluating single test items for easiness and/or difficulty levels and whether or not the item discriminates the learners from the non-learners. Overall values are attained for the entire test.

LIKERT SCALE:
A scaling method used primarily in measurement of attitudes. The respondent is given a series of attitude statements and is requested to rate them according to his/her degree of agreement or disagreement along a continuum, usually five points (Reber, 1985).

MAINSTREAMING:
The practice of integrating students who were identified as developmentally disabled into the regular classes. Mainstreaming came about with the passage of the Education for All Handicapped Children Act in 1975 (PL 94-142). Mainstreaming is considered the least restrictive environment.

OMNIBUS:
A test that measures a variety of mental operations. Operations are all combined into a single sequence rather than type by type.

POWER TEST:
A test intended to measure level of performance rather than speed of response.

PUBLIC LAW 94-142: 1975 EDUCATION FOR ALL HANDICAPPED CHILDREN ACT:
The right to receive education for all children including handicapped children. Educational planning is the heart of the act and includes an early identification (evaluation and placement), children to be placed in a least-restrictive environment for learning, and an individually developed contract (IPS), parental access to records and confidentiality (Sattler, 1990).

Q-SORT:
A method of personality assessment where the examinee sorts a group of cards with certain statements printed on them into a rank order from least descriptive to most descriptive. Carl Rogers utilized the Q-sort to assess if the real and ideal self were congruent.

REGRESSION:
The tendency for a predicted value to be closer to its mean than a predictor is to its own mean. Extreme scores tend to be unreliable. A score on one variable is used to predict the score on another variable (Kaplan & Saccuzzo, 2001).

RELIABILITY:
The extent to which a test is consistent in measuring what it is supposed to measure: how dependable, stable, and consistent in measurement.

SEMANTIC DIFFERENTIAL:
Semantic differential was developed by Osgood, Suci, and Tannenbaum as an alternative method to measure attitudes. These authors believed there were two meanings to every object, denotative and connotative (as cited in Ary, et al., 1966).

SOCIOMETRY:
A sociometric is a retrospective measurement by others of traits/attributes of the interpersonal relationships prevailing among the members of a group (Ward & Murray Ward, 1999). Sociometric measurement is usually with affective instruments and traits. Likes and dislikes can be graphically displayed through sociometry.

SOMPA:
Social Intelligence is authored by Jane Mercer. The System Of Multicultural Pluralistic Assessment for ages 5 to 11 is a test that provides for an adjusted intelligence score based upon cultural factors.

STANDARD ERROR OF MEASUREMENT:
An estimate of the magnitude of the "error of measurement" in a score. This is an amount by which an obtained score differs from a hypothetical true score.

STANDARDIZATION:
Uniformity of procedures in administering, scoring, and interpreting tests.

STEM AND LEAF:
That part of an objective test item that poses the question or sets the task along with options.

SUMMATIVE EVALUATION:
An examination that reflects accountability (Neukrug, 1999). One purpose of this form of evaluation is

to determine if a program should continue and if so what adjustments can be learned from this evaluation. It can also look like a terminal evaluation such as an end of a course (cumulative).

TRUTH IN TESTING:
New York and California have truth and testing laws guaranteeing certain rights to the consumer. For tests for post-secondary or professional school admission, the actual questions and answers must be available for public scrutiny within 30 days of the test administration.

VALIDITY:
The extent to which a test measures what it is supposed to measure.

VARIABILITY:
The extent to which scores are spread out and away from the mean.

# Unit 7 - References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# UNIT 8 -Research & Program Evaluation

## Introduction

Research and evaluation questions tap knowledge in techniques and methodology of measuring, describing, and evaluating data. The number of questions for this study area for the NCE has been reduced from 25 to 21, and only 16 of those are a part of your score. It is important to have a working knowledge of research methods and statistical techniques for descriptive and inferential statistics. It will be important to identify basic types of research, research design, research vocabulary, and appropriate statistics. Study material will emphasize recognizing and working with averages, variables, measurement scales, relationships, inferences, and interpretation statements.

Recent changes in the NCE are reflected in the name change for this chapter, program evaluation. Emphasis in program evaluation will highlight material in analyzing organizational and therapy effectiveness.

Be familiar with Sections G of the 2014 Code of Ethics of the American Counseling Association (ACA, 2014, p. 15). Recent test questions have included research ethics and computer-assisted evaluation. Ethically, it is important to remember that subjects must not be harmed in any way. If a risk is involved, the subjects must be informed of the nature of the risk, and informed that participation is voluntary, and a signed release is secured before the study. If subjects are not aware of the nature of their participation in a study for control purposes, then the subjects should be debriefed at the conclusion of the study. It is not ethical to observe a subject without permission. The welfare of the subject is the

responsibility of the researcher. Also, all data obtained from an individual should remain confidential. Scores or observations should be reported in group form (collapsed) rather than as individual scores.

The National Research Act of 1974 and, more specifically, Public Law 93-348 stipulate that research studies involving human subjects be approved by a panel of authorities. These panels are often referred to as an institutional review board (IRB) of an institution (such as a college or governmental agency) or an ethics guidance program. The research proposal and actual research are to be submitted to a review board before any aspect of the research is enacted, in order to protect subjects from possible harm and to ensure that they voluntarily participate through informed consent. It is the researcher's responsibility to identify potential sources of risk and to eliminate or reduce them.

# CACREP Objectives

Research objectives are outlined in the CACREP 2009 standards (www.cacrep.org) . Each curriculum objective is abbreviated and full statements are to be found on-line.

These objectives are outlined in the CACREP 2009 standards for Research and Program Evaluation.

A. importance of research in advancing the profession
B. research methods-quantitative, qualitative, single-case designs, action and outcome based research
C. statistical methods in research and program evaluation
D. principles, models, and applications in needs assessment and program evaluation
E. use of research to inform evidence-based practice
F. ethical and culturally relevant strategies for interpreting and reporting

Example research questions for the listed objectives:

**Question 8-1: (Objective A.)**
A specific difficulty in conducting a true experimental design is:

a. defining measurable variables.
b. locating appropriate dependent variables.
c. securing permission.
d. managing the controls.

Answer: d. managing the controls. Controls are not to be managed; therefore, whatever happens to them can influence results.

**Question 8-2: (Objective B.)**
A research study designed to determine public attitude toward depression would be most similar which research method?

a. Historical

b. Descriptive

c. Causal-comparative

d. Experimental

Answer: b. Descriptive. Descriptive-review section on methods.

**Question 8-3: (Objective B.)**

When writing a manuscript for publication all of the following are to be included in the methods section except:

a. population for intervention

b. protocol, techniques, goals for intervention

c. IRB acceptance document

d. materials needed and relevant terminology

Answer: c. IRB acceptance document. Guidelines for the methods section include all of the above except the IRB approval. Falco and McCarthy (2013)

**Question 8-4: (Objective C.)**

When using a table from a research text and completing the appropriate statistical analysis, the researcher would enter what type of table to read for significance level?

a. F-ratio table

b. S-significance table

c. I-interval table

d. H-hypotheses table

Answer: a. F-ratio table. F and T-ratio tables are found in most research textbooks. Using technology significance findings are tabulated using SPSS.

**Question 8-5: (Objective D.)**

When small amounts of data are available for research relevance, it has been common for researchers to combine small data research. This is a series of studies called:

a. meta-analysis.

b. formative analysis.

c. qualitative.

d. quantitative.

Answer: a. meta-analysis. A meta-analysis combines small data sets and look for findings.

**Question 8-6: (Objective E.)**

An elementary school counselor is attempting to conduct an effectiveness study in the work she does with a 3rd grade student. The more appropriate type of research might be:

a. non-parametric.
b. action.
c. parametric.
d. school-age.

Answer: b. action. Action research is the choice even though single subject may be the choice. Action research does not have to be one subject. It could be a single variable.

**Question 8-7: (Objective F.)**
Which segment of a research article is to include the relevance of an intervention in terms of diversity and multicultural competence?

a. introduction
b. methods
c. results
d. discussion

Answer: d. discussion. The discussion is to include relevance to existing theories, interventions and the work of others. This discussion should discuss the impact of this intervention regarding human diversity factors and multicultural considerations (Falco & McCarthy, 2013).

# Terms

Terms are defined at the end of this chapter.

Action Research
Analogue
Applied Research
Attrition
Attribute Variables
Cohort Design
Confidence Intervals
Control Group
Covariance
Degrees of Freedom
Dependent Variable
Double Blind Procedure
Ex Post Facto Design
External Validity
F-ratio chart
History
Inferential Statistics
Maturation
Meta Analysis
Non-parametric statistic
Observer Effect
Observational effect
Parameter
Pilot Study
Placebo effect
Population
Power
Quasi-experimental

| | |
|---|---|
| Randomized-post-test | Type I (Alpha) |
| Regression | Type II (Beta) |
| Research Blinding | Snowball Sampling |
| Stratified random | Social Validity |
| True Score | Willowbrook study |

# OBJECTIVE 8A: Importance and Purpose of Research

CACREP (2009) core curriculum objective 8.1 emphasizes the importance of research in advancing the profession. The 2014 ACA Code of Ethics Section G titled Research and Publication (G.1.- G.5.h.) includes the ethical understandings and implications concerning precautions, responsibility, multicultural/diversity, rights of participants, informed consent procedures, deception, supervisor and client participation, confidentiality, commitments, disposal of research documents, relationships, beneficial interactions, reporting results, accuracy, unfavorable results, identifying participants, replications, publications, plagiarism, contributors, duplicate submission, and professional review. The introduction to the ACA Code of Ethics (2014) is to unite and enhance the professional identity of counselors. In this vein Whiston (1996) states that the professional identity of counselors can be enhanced through action research demonstrating effectiveness of services.

Gay (1996) defines research as the "formal, systematic application of the scientific method to the study of problem" (p. 6). Barkley (1982) states that systematically collecting, organizing, and interpreting data so that questions can be answered as unambiguously as possible are the steps in research. The goal of research is the same as that of the scientific method, to explain, predict, or control phenomena. In summary, Heppner, Kivlighan, and Wampold (1992) indicate that the purpose of research is to answer questions, solve problems, or develop theories of interest to a specific area, and to add to the existing knowledge.

## Sources of Knowledge

Ary, Jacobs, and Razavieh (1996) list five methods in which answers are derived for different research questions. They categorize these sources of knowledge as experience, authority, deductive reasoning, inductive reasoning, and the scientific approach.

1. Experience: The ability for human beings to learn from their experience is a prime characteristic of human intelligence. However, while researchers can profit from personal experiences as well as the experiences of others, experience has limitations as a source of truth.
2. Authority: Researchers often seek answers to questions from those who have had experience or are considered a reliable source of expertise with a similar problem.
3. Deductive reasoning: If the premise is true, the conclusion is considered to be true. Deductive reasoning enables researchers to organize premises into patterns that provide conclusive evidence for the validity of a conclusion. However, scientific inquiry cannot be conducted

through deductive reasoning alone because of the difficulty involved in establishing a universal truth for many statements dealing with scientific phenomena.

4. Inductive reasoning: A conclusion is reached by observing examples and generalizing from those examples to the group being studied. These inductive conclusions are generally imperfect, because all examples would have to be observed to derive a perfectly true induction. In scientific research one observes a sample of a group and infers from the sample what is characteristic of the entire group. When this is done, the researcher is relying on imperfect induction based upon incomplete observation.
5. Scientific approach: The scientific approach integrates the most important aspects of inductive and deductive methodology. Charles Darwin is usually referred to as the first person to use the scientific approach. He utilized this method while developing his theory of evolution.

## Scientific Method

The scientific method is the most efficient and reliable source of knowledge (Gay, 1992, 1996). Leedy (1993) defines the scientific method as a way to seek insight into an undiscovered truth by:

1. identifying the problem
2. gathering data
3. proposing a tentative hypothesis
4. empirically testing the hypothesis

With the scientific method, only the facts should be considered, and conclusions should be drawn from them alone. According to Leedy, inductive logic is primarily used.

Inductive logic begins not with a major premise, but with an observation. This type of logic is a generalization based on specific observations. Example: Katie can read. Katie is five years old. Therefore, all five-year old children can read.

Deductive logic begins with a major premise or what seems to be true (Leedy, 1993). It involves reaching specific conclusions based on generalizations. Example: Children in kindergarten can read. Katie is in kindergarten. Therefore Katie can read.

Both types of logic have flaws, but as Gay (1992) points out, both are necessary. Gay writes that the scientific process calls for the induction of hypotheses based on observations, the deduction of implications of the hypotheses, testing the implications, and accepting or not accepting the hypotheses.

## Classification of Research

Research can be classified by the method or purpose (Gay, 1996). Though there are procedures common to all research, such as data collection and analysis, specific procedures used in a study are

determined by the method of research. There are many methods of research; however the following five methods of research will be explored because of their unique applications and frequency of use.

Classifying research by purpose entails determining to what degree the findings can be applied or generalized to other situations (Gay, 1992, 1996).

Basic: Concerned with the development of a theory. Basic research is similar to scientific laboratory research (Gay, 1996).

Example: Piaget's theory of development.

Applied: Concerned with the application of a theory. It evaluates theory and its usefulness by using existing theories and knowledge (Gay, 1996).

Example: Testing principles of conditioning to determine if they can be used to improve discipline (behavior modification).

## Evaluation

Determines the effectiveness of an existing program. It requires the collection, analysis, and interpretation of data to determine not if something is good or bad, but rather to determine which alternative is better (Gay, 1996).

Example: Whether to adopt a new philosophy or not.

Research and Development (R & D): The purpose of R & D is to develop products, not to develop or test theory (Gay, 1996). Field testing a product.

Example: Field-testing of a set of behavioral objectives in a mental hospital.

## Methods of Research

### Historical Method

This method involves studying and explaining past events. The purpose is to arrive at a conclusion concerning cause, effect, or trends of past events that help explain current or predict future events (Gay, 1992, 1996). A new treatment cannot be administered using the historical method.

Primary data source: Firsthand knowledge, eyewitness reports.

Secondary source: Secondhand information is when the person is providing information; however, was not present when the behavior or event occurred.

External criticism: Assesses the authenticity of data.

Internal criticism: Valuates the worth or accuracy of data.

Example: A study of the effects of the decisions of the U.S. Supreme Court on mental health care.

## Descriptive Method

Descriptive research involves collecting data in order to answer questions about the current status of a subject (Gay, 1996, 1992). It determines and reports the way things are now.

Self-report: Method of collecting data that often involves a questionnaire, a survey, or an interview.

Observation: Method of collecting data by direct participatory or non-participatory observation. Individuals are not asked for information.

Ethnography: Collects intense data for extended periods of time in a natural setting.

Example: A study to determine public attitude towards people with depression.

## Correlational Method

Correlational research relates two or more variables to determine whether and to what degree a relationship exists between them, but it does not establish a cause-and-effect relationship, nor does it involve a treatment. This type of research involves one group of people who have two or more variables measured, and it must have a formal hypothesis. The degree of a relationship is expressed as a correlation coefficient (range is -1.00 to +1.00).

Directional Hypothesis: X and y are positively or negatively related.

Nondirectional Hypothesis: X and y are related or unrelated.

Null hypothesis: X and y are unrelated.

The Correlational Method does not establish cause and effect.

Example: A study to determine if there is a correlation between shoe size and intelligence (IQ).

## Causal Comparative Method

Causal comparative research is sometimes called ex post facto research because both the effect and the cause of the effect have already occurred. It involves group comparisons but involves no planned treatment. It can establish a cause-and-effect relationship; however, these are tentative and need to be followed up by an experimental research study. There is no treatment applied during the actual study. The function of a causal comparative research is to determine the reasons for the present status of things (Wiseman, 1999).

Example: A study of the effect of gender on depression.

## Experimental Method

Experimental research method is the same as causal-comparative except that a treatment must be administered to the experimental group and not to the control group. This method is the only one that can establish a true cause-and-effect relationship. With the experimental method, the researcher will manipulate one or more independent variables in a controlled setting in order to determine the effect on the dependent variable (Ary, Jacobs, & Razavieh, 1996).

Independent variable: An independent variable is (experimental variable) the treatment, or the characteristic that is believed to make a difference. The experimenter manipulates the independent variable. It is the "cause."

Dependent variable: Is (criterion variable) the characteristic that is measured. The experimenter has no control over this variable. It is dependent upon the independent variable. It is the "effect." The dependent variable is the test score or observation.

Internal validity: Determines if the differences in the dependent variable are the direct result of the independent variable. This is the confidence one has in inferring a causal relationship among the variables while eliminating other hypotheses.

External validity: Determines if the results are generalizable to groups outside the experimental setting.

Example: A study to determine the effect of career counseling on job satisfaction. Assuming random sampling and sufficient participants, counseling would be the independent variable, and the amount of satisfaction as measured by observations or instruments would be the dependent variable.

**Question 8-8:**
From a group of flight attendants at Jet Airlines, a researcher randomly selected 60 employees. The flight attendants were divided into two groups by random assignment of 30 to group A, a traditional in-service program on customer attitudes, and 30 to group B, a new program designed to help flight attendants cope with customer attitudes while on the airplane. The two programs were compared at the end of a six-month period by change scores on a scale designed to measure attitudes toward customers. The independent variable is:

a. the type of in-service curriculum.
b. the score on the customer attitude scale.
c. randomly selected 60 flight attendants.
d. the change in the attitude scores toward customers.

Answer: a. the type of in-service curriculum. The independent variable is what is being manipulated such as a program of treatment.

**Question 8-9:**
The operational definition of the dependent variable is:

a. a new program designed to deal with the history of customer service complaints.

b. the scores from a scale designed to measure attitudes toward customers.

c. the gender and size of each group.

d. an unknown variable which is not described.

Answer: b. the scores from a scale designed to measure attitudes toward customers. An operational definition means specifying the activities or operations which are necessary to measure the construct. In the above example, attitudes toward customers are to be measured.

## Ethical Obligations

Ethical research responsibilities are covered in the ACA Code of Ethics (2014) involving conducting research (G.1.a.), confidentiality (G.1.b.), independent researchers (G.1.c.), deviation from standard practice (G.1.d.), avoiding injury (G.1.e.), principal researcher (G.1.f.), participant rights (G.2a.), student/ supervise participation (G.2.b.), client participation (G.2.c.), confidentiality (G.2.d.), not capable of informed consent (G.2.e.), commitment to participants (G.2.f.), after data collection explanation (G. 2.g.), informing sponsors (G.2.h.), record custodian (G.2.i.), maintaining boundaries (G.3.a.), extending researcher-participant boundaries (G.3.a.), relationship with participant (G.3.b.), harassment of participant (G.3.c.), reporting accurate results (G.3.a.), report unfavorable results (G.4.b.), reporting errors (G.4.c.), identity of participants (G.4.d.), replication (G.4.e.), case example (G.5a.), plagiarism (G. 5.b.), previous work (G.5.c.), contributors (G.5.d.), agreements (G.5.e.), student research (G.5.f. ) duplicate submission (G.5.g. ), and professional review (G.5 h.).

# OBJECTIVE 8A: Advancing the Profession

Advancing the profession through research comes about in a multitude of ways. Two validity considerations are important for responsible research that will meet legal and professional regulations in conducting and publishing research. That is research that is conducted through a rigorous procedure and in an ethical manner that enhances the over-all commitment to promoting knowledge, skills and application of research outcomes. Wester (2011) emphasizes the importance of conclusion and social validity whereby professionals assume personal responsibility when conducting research. Conclusion validity is the degree to which the findings and conclusions are accurate and correct. Social validity from the standpoint of the researcher is to take into consideration the impact the study will have on the profession and society. Therefore according to Emanuel, Wendler, and Grady (2000) to further the medical, psychological, and sociological professions through research it is crucial that researchers adhere and practice seven requirements. These requirements are to:

1. value that the enhancement of health or knowledge is through research
2. that scientific validity methodologically is rigorous
3. honor fair subject selection,
4. discuss favorable risk-benefit ratio
5. utilize an independent review

6. practice informed consent
7. demonstrate respect for Subjects (abstract)

## Institutional Review Boards (IRB)

Section G.1.c. stipulates that independent researchers are to consult with researchers who are familiar with IRB procedures for appropriate safeguards (ACA, 2014). In 1979 the federal government developed regulations and ethical principles in conducting research for the protection of human subjects. The institutional review board reviews research proposals in state and federal agencies that receive federal funding. The purpose of this board and the research committee is to protect the rights and welfare of individual research subject or group of subjects. Requirements for regulatory research are evaluated during the review by an IRB committee include:

1. Risk to subjects are minimized (G.1.e., G.2.a.3.)
2. Risk to subjects are reasonable in relation to anticipated benefits
3. Selection of subjects is equitable, i.e., fair
4. Informed consent is sought from each subject or his/her legally authorized representatives (G. 2.a.)
5. Informed consent is appropriately documented
6. When appropriate, the research plan makes provisions for monitoring data collection
7. Privacy and confidentiality of research subjects are appropriately protected, and
8. When some or all of the subjects are likely to be vulnerable to coercion or undue influence, additional safeguards have been included

In summary, the IRB criteria reviews are conducted for the prospective subject population, methods of recruitment, research methods and procedures, potential risks, potential benefits, risk/benefit analysis, subject compensation, confidentiality, informed consent, investigator qualifications, and monitoring requirements.

There have been a number of unethical practices with human subjects, many resulting in physical and psychological harm. The types of risks may be physical, psychological, social, legal, and economic. Some unethical studies emanate from the medical research environments such as the Nuremberg codes, Tuskegee syphilis study, Willowbrook hepatitis study, plutonium study, Jewish chronic disease study, Cincinnati project, and the Washington state prison and lead paint study at John Hopkins. Some unethical practices have been reported in psychological research such as the Milgram study. Whether medical or psychological the over-riding protocol, or lack of one, where clients were not informed of the risks or were not provided releases to participate in the study were omitted.

Dubois (2006) outlined several vulnerabilities for research participants. Vulnerabilities are considered to be characteristics that might interfere with the participant's ability to protect themselves. These vulnerabilities are:

1. cognitive or communicative.
2. institutional.
3. deferential.
4. medical.
5. economic.
6. social.

# OBJECTIVE 8B: Research Methods and Outcome-Based Research

Objective 8b isolates the importance of acquiring knowledge concerning research methods (qualitative, quantitative, single-case designs, action research, and outcome based research).

## Method of Research

### Qualitative Method

Ary, Jacobs, and Razavieh (1990, 1996) state that qualitative inquiry is a generic term for a variety of approaches to research and evaluation. Qualitative research is often referred to as ethnographic research (Wiseman, 1999). Naturalistic inquiry, case studies, field work, field studies, and participant observation are all examples of qualitative inquiry. The qualitative method involves the researcher observing people or events in their natural setting. The major purpose of qualitative research is to understand the effect of the context on the events. Qualitative researchers frequently use narrative to describe findings. Qualitative inquiry differs from quantitative inquiry in the study of social particular and behavioral phenomena in their basic aim and methods (Ary, et al., 1996). Qualitative methods are inductive rather than deductive.

Descriptors for qualitative research includes artifacts, context sensitivity, emersion (unobtrusive involvement), extended presence, field notes, naturalistic settings, nonrandom sampling participant-observers, photographs, process examination, tentative hypotheses, and triangulation (Wiseman, 1999).

### Quantitative Method

Suter (2006) defines quantitative methods as research that will test hypotheses with numerical values rather than explaining the conclusion or complex question through a written or verbal description (numbers versus words). The data is analyzed statistically and has tables or charts to reflect the findings.

What is being researched using a quantitative method requires identifying and describing the target population. Quantitative methods are utilized when the question or need is more objective, little is

known about the topic or population, to support or disconfirm theoretical formulations (Trusty, 2011), are more deductive and the research design is set before the data are collected (Creswell, 2007).

Wiseman (1999) lists descriptors as control groups, correlation, data sets, dependent variables, experimentation, independent variables, and intervening variables, level of confidence, moderator variables, questionnaires, statistical analysis, and testing.

Single-case designs or single-subject designs are utilized when a treatment is administered to a single subject. There is to be at least one posttest. The purpose of a single-case is to monitor behavior rather than to generalize results. Baseline data is acquired and later data observed to note change. This can be done a number of times, baseline followed by treatment followed by baseline followed by treatment and a posttest.

## Action research

Lewin coined action research for the use of the scientific method to solve research questions that have social value (as cited in Johnson & Johnson, 1997). The purpose is "to solve practical problems through the use of the scientific methods" (Gay, 1996, p. 10). The goal is a solution to a specific problem. There is no concern as to whether or not the solution is generalizable. Herr and Anderson (2005) define action research is concerned with 'rather' than with subjects or participants in the study. The problems are generated by the subjects rather than by someone else and the results are to empower or improve the condition. The power of this research is its' ability to be pragmatic, that is use qualitative, quantitative or a mixed approach. The outcome of action research is not to seek knowledge for generalizability rather to seek knowledge for a specific situation (Guiffrida, Douthit, Lunch & Mackie, 2011).

Example: Research to find a solution for nonattentiveness among clients at the Day Treatment program in City X.

After a problem has been identified and stated, the researcher conducts a review of the literature that is related to the problem. After the review is completed, a hypothesis, which is necessary for all types of research except descriptive, is formulated.

## Meta-Analysis

Meta-analysis is a method to synthesize data. According to Erford, Savin-Murphy and Butler (2010) the purpose of meta-analysis is to quantitatively analyze the results of a number of empirically researched topics. Conducting meta-analysis is another way to advance the profession. It is useful to gather conducted research from a variety of fields (i.e., social work, psychology, counseling, education) where the same topic or intervention has been studied for statistical analysis and outcome results from individual studies for future use and/or modifications. Often these individual studies are not published in the journals but found in dissertations but do offer contributions to the profession. Like quantitative studies meta-analysis research does have dependent and independent variables. In addition, effect size is to be conducted. Effect size is to translate the data from each individual study to standard score form much like the simple t-test. Another definition for effect size is an index expressed

as a standardized difference between two means, a percentile shift from a baseline (Suter, 2006, p. 201). The effect size index is useful when considering sample size. For publication sample size is to be reported for a meta-analysis.

Whiston and Li (2011) provided a 6 step-outline for planning a meta-analysis study. The procedural steps are to; (1) formulate a research question, (2) determine meta-analytic approach that best fits, (3) search the literature and identify possible studies, (4) determine inclusion criteria and develop the coding manual, (5) extract and code study information, and (6) perform data analysis. A process and needed observations in the results has to do with adjustment for biases. Types of biases may be sample sizes, quality of studies, and studies included because they vary in qualities (designs, reliability, and validity of measurements).

## Outcome-based Research (OBR)

Standard 2014 Code of Ethics C.7.a. (Scientific Bases for Treatment Modalities)

Section C.7.a. refers to the inherent value of research to provide the foundational information in developing and promoting a scientific basis for clinical knowledge and application (ACA, 2014). The ethical obligation of nonmaleficence is critical when using clinical interventions (Eaves & Erford, 2010). The spirit of this research is in the best interest of the client, counselor and profession. Accountability rests with the counselor to become aware of information in the published literature, seek training accordingly and apply those treatments that are grounded in theory, and/or have empirical or scientific foundations. When counselors use techniques or treatments that do not meet that criteria they are to inform the client that the procedures are "unfounded" or "undeveloped" and advise them of the potential risk or harm (C.7a., C.7b.). The counselor will take steps to see the client is not harmed A. 4.a. (avoid harm, E.5.c., ; ACA, 2014). Information evidenced, or lack of evidenced, gleaned from outcome research and efficacy studies guide the counselor's choices for client treatment. Outcome research is the study of end results that are captured in services to the client's experiences, preferences, and values (Clancy & Eisenberg, 1998).

Lambert and Cattani-Thompson (1996) report that positive outcomes evolved from the client are common factors and specific interventions. Lambert and Anderson (1996) found that the most important factors for outcomes resided in the severity of the disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and ability to identify a focal problem.

Outcome-based research is to provide scientific evidence regarding the decisions as to the procedures, treatments, and techniques during a therapy study (Krumbolz, 2009). The decision to use a certain theoretical treatment is to be founded on literature research so that the treatment can be tested for observed effectiveness in client change. Critical in the selection of an approach is the care taken in making a decision that fits all populations or not utilized by practitioners when a fit does not exist. In essence the counselor is accountable for combining theory, intuition, and science (Sexton, Schofield & Whiston, 1997). A positive component of outcome research is the feedback loop that exists as there is constant reassessing for effectiveness. Adjustments and modifications can be made with previously considered practices and results.

According to Uppgaard (2013) and Uppgaard, Eaves and Erford (2010) the main difference between efficacy-based and evidenced-based research is the lack of a control group. Krumholtz elaborates on this definition to emphasize the purpose of outcome research which is to observe how the client treatment impacted, that is, the consequence of the alternative treatment. In addition to the client's observation others who pay attention to the outcome are the providers, health care payers (insurance, managed care), and the public. Outcome research focuses on the client and public perspectives. Treatment has been implemented and outcome data and record keeping is essential which guides future use and at the same time gathers knowledge as to what improves the lives of clients (American Heart Association). In a simplistic description the clinician, perhaps in collaboration with the client, determines what treatment will work best and then work backward from there. The dependent variable is the outcome variable.

Best practice counseling has come to mean an evidence-based, evidence-informed approach or outcome-based research that is derived from clinical research. The Journal of Counseling and Development has added to the table of contents a section titled Best Practices.

A differentiation between efficacy and effectiveness is best understood by reviewing the procedures and requirements. Efficacy studies are highly controlled and are methodological. Effectiveness studies look at how much benefit the client gains from the therapy or an intervention. Clients have already begun the therapy in effectiveness studies. In this type of research the researcher has no say in how therapy is conducted and does not select the clients who undergo which type of therapy. A control group is not created to form a baseline and no placebos are administered. There are pros and cons to efficacy and effectiveness studies (Seligman, 1995).

Several terms for outcome based research such as effectiveness, efficacy, and comparative effectiveness appear to be interchangeable in the literature although this is not the case. Advancing the profession through outcome-based research is noteworthy as the findings can be used to improve practice (Grela, Hser, Teruya, & Evans, 2005).

In conducting outcome-based research it is imperative that the researcher takes into account conceptualization, methodological issues, effect size, and issues inherent in agency settings (Hill & Beamish, 2007). The pivotal outcome in this research is change. It is critical to define outcome for client change to be mindful to compare treatment with diversity, disorder, age, research methodology (type of design), and length of treatment, stages of change and other variables. Common factors across therapies are associated with positive outcomes. These common goals are included in three groups of factors, support, learning, and action (Lambert & Cattani-Thompson, 1996).

The American Psychological Association Division of Psychotherapy Task Force (Division 29) identified elements of effective therapy relationships and effective methods of therapy regarding individual client issues (Norcross, 2003). These patient characteristics are considered reliable markers for matching the therapy relationship to effective outcomes. Markers were resistance, functional impairment, and coping style. The same task force in 2006 defined evidence-based practice as the "integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 273). Warwar and Greenberg (2000) singled out therapeutic alliance as the most important common factor in effectiveness. Sexton (1999) suggested

that effective outcome in therapy has more to do with the level of skillfulness (competence), cognitive complexity (think diversely and complexly) and ability to relate with the client.

Criticism exists in terms of a full commitment to supporting evidenced-based treatments (EBT). Field (2014) provides some of this criticism of the left hemisphere intervention as the research focus regarding efficacy. The left hemisphere is responsible for rational, logical, and abstract cognition and conscious knowledge and research has mostly ignored the function or impact of the right hemisphere. The right hemisphere is composed of the unconscious social and emotional learning, and includes intuition, empathy, creativity, and flexibility and has been ignored in the research regarding effectiveness. There is ample support for the importance of the relationship for outcome based interventions for client improvement. Combining the left and right brain functions are supported by neuroscience integration.

In summary, a goal of outcome-based research is to determine what works in a practical sense regarding an intervention and techniques across a population of clinical issues (James & Mennen, 2001). To move the profession forward using this mode of research requires data collection, review of the information, open to different population and client reactions to the intervention and adding to the literature.

**Question 8-10:**
Common factors in effectiveness studies has to do with all of the following except:

a. competence
b. thinking diversely and complexly
c. relating to the client
d. theoretical orientation

Answer: d. theoretical orientation. Sexton (1999) and Sexton, Schofeld and Whiston (1997) are in agreement regarding the common factors are a. (competence-skillfulness), b. (cognitive complexity), and c. relating to the client (relational qualities of client-counselor).

## Research Designs

Ethical practice in conducting research is for counselors to plan, design, conduct, and report research that is consistent to ethical principles, federal, state laws, host institutional regulations and scientific standards that govern research (G.1.a, ACA, 2014).

TRUE EXPERIMENTAL DESIGNS are the most highly recommended designs for experimental research because of the control that they provide (Suter, 2006; Ary, Jacobs, & Razavieh, 1990, 1996; Campbell & Stanley, 1963; Gay, 1996). There are several advantages for researchers using true experimental designs compared to researchers whose work involves studying events without control. Some of these advantages are that the experimental researchers can:

1. manipulate or vary the conditions systematically and note the variation

2. make the event occur at a time when they are ready to make accurate observations and note accurate measurements
3. repeat observations under the same conditions to verify, describe, or replicate results

Manipulation of the independent variable and random assignment are the two distinguishing features that separate a true experimental design from a quasi-experimental design.

Some designs which reflect an experimental design are pre-post-test control, post-test only, and Solomon Four group.

The type of statistic selected (parametric or non-parametric) is dependent upon the type of measurement scale (nominal, ordinal, interval, ratio) and independent-dependent variable. If the independent variable is considered nominal and the dependent variable is ratio data a parametric statistic may be the statistic of choice. If neither the dependent nor independent variable is ratio nor interval scales a non-parametric statistic may be the more likely choice. This does not suggest that if one of the variables is nominal that a parametric statistic would not be appropriate.

Pretest-Posttest Control Group Design: Controls for all sources of internal validity. External validity problems occur because of the pretest which may make the results generalizable only to others who have had the pretest.

Posttest Only Control Group Design: Controls for all sources of internal validity except mortality. Controls for all external validity.

Solomon Four Group Design: Controls for all sources of internal and external validity, but it requires twice as many subjects so is not used as often as others.

## Quasi-Experimental Designs

A quasi-experimental design is used when subjects are not randomly assigned and are usually ready-made or available groups (Campbell & Stanley, 1963). Quasi-experimental designs are useful in studying the effect of treatment on a single subject and are often useful in behavioral research (Ary, Jacobs, & Razavieh, 1996). Some examples are:

Nonequivalent Control Group Design: Sources of invalidity are possible regression and selection interaction that involves maturation, history, and testing. The problem of external validity exists due to the pretest.

Time Series Design: History and instrumentation are sources of internal invalidity (threat) for this design. The problem of external validity exists due to the pretest.

Counterbalanced Designs: Selection interactions are a problem for internal validity. External validity could be poor because of the pretest administration and because of the multiple treatments received by subjects.

In summary, using a quasi-experimental design without randomization but with manipulation weakens the ability to search out cause-and-effect relationships.

**Question 8-11:**
Identify which of the following research hypotheses suggests a true experimental research design:

a. a sample of all preschool-age children in the U.S. who are read a story by their fathers will not retain the material as long as those who are read the same story by their mothers.
b. a sample of teenagers with learning disabilities are more likely to have behavior problems documented in school records than are teenagers without learning disabilities.
c. all children in a particular county whose parents are divorced have lower self-esteem than do children from intact families.
d. all of the above research hypotheses call for experimental research designs.

Answer: a. preschool-age children who are read a story by their fathers will not retain the material as long as those who are read the same story by their mothers. This research hypothesis calls for an experimental design because an independent variable is being manipulated.

## Causal Comparative (ex-post facto)

Causal comparative research or design is used to discover relationships for causes or effects. This is accomplished by comparing groups of people who differ on an attribute, not an independent variable. The search may be for preexisting conditions or behaviors. Thus the cause and effect have already occurred. An example might be to research, after ten weeks, the effects of an already administered antidepressant with two different racial groups diagnosed with depression. The attribute variable, not independent variable, already exists and the difference is discovered in recovery, could be time, side-effects, or on some scale of rating for improvement. In causal comparative research there is no manipulation, randomization and intervention. Caution is exercised in making conclusive statements.

## Factorial Design

A factorial design "is one in which two or more independent variables are manipulated simultaneously in order to study the independent effect of each variable on the dependent variable, as well as the effects due to interactions among several variables." (Ary, Jacobs, & Razavieh, 1990, p. 331). The 2 x 2 factorial design is the most common. Considered a strength, a factorial design allows the testing of more than one hypothesis and how the factors interact (Glass & Stanley, 1970). It is the simplest factorial design, with each factor having two levels. In a factorial design, independent variables are called factors. A factor may have two or more levels. In a 2 x 3 factorial design the first factor has two levels (male and female for example—2 in the first position) and the second factor has three levels (high IQ, medium IQ, and low IQ—3 in the second position). Factorial designs can have more than two factors. For example a 3 x 3 x 2 design has three factors, two of which have three levels and one of which has two levels.

**Question 8-12:**
A group of researchers is interested in evaluating the effectiveness of three different therapy approaches and a control group for clients who exhibit symptoms of depression due to unresolved grief issues. The researchers are also interested in whether males or females resolve grief issues

differently. After six therapy sessions, the mean scores on the Beck Depression Inventory are compared among and between the four groups. From the available data which type of research design would these researchers utilize in analyzing the data?

a. quasi-experimental
b. historical
c. experimental
d. factorial

Answer: d. factorial. Without more specifics a 3 x 2 factorial design would be recommended. The first independent variable (therapy) has three approaches while the second independent variable (gender) has two, male and female. Letter a. quasi-experimental design could be a choice as there is no information about the manipulation of the treatment and randomization. On the NCE one of the options would not be available (a. or d.).

## Threats to Experimental Validity

Misinterpretation takes place during research and as a result there may be different interpretations to the results. Two common interpretations found in the literature occur due to subtle cues that provide a false reading, Pygmalion and Hawthorne. The Pygmalion misinterpretation is due to expectations while the Hawthorne to attention or novelty effect (Suter, 2006). Effects such as expectations and attention are variables to be controlled through design and research blinding (keeping data collectors unaware of conditions) to reduce threats to internal and external validity.

Valid experimental results are due only to manipulation by the independent variable and the results are generalizable to other situations. If extraneous variables affected the results, then the experiment is not as internally valid. If the results are not generalizable to situations outside the experimental setting, then the experiment is not externally valid.

## Threats to Internal Validity

"Internal validity refers to the ability of an investigation to produce findings that are valid to the group under study" (Wiseman, 1999, p. 50). Bledsoe (1963) outlined eight major threats to internal validity.

History: Affects performance on the independent variable during the time of the treatment but is not the independent variable. Events in one's environment surface during the research. Example: Between the pre-test and the post-test, a loud thunderstorm began. Control: Best method is to use two groups so the event affects both groups equally.

Maturation: The physical or mental changes that occur within subjects over time. Example: Results of a pre-test given at the beginning of the school year and a post-test given at the end of the school year may be due in part to age increase of subjects (more knowledgeable, better coordinated, etc.). Control: random assigning preferred.

Testing: Improved results on the post-test as a result of the subjects having taken a pre-test. Example: Subjects find out how to answer questions they missed after taking the pre-test and therefore increase their performance on the post-test. Control: testing only once.

Instrumentation: Results from a problem with the instruments used for assessment: changes in the measuring device or procedure over the course of a study. Example: Poor reliability or validity because some instruments may be affected by the climate or observers may not always be attentive.

Statistical Regression: The tendency for scores to regress toward the mean. Example: Students who score exceptionally high are probably scoring in the top of their range of the standard error of measurement and will be more likely to score lower next time the test is taken. Students who score low are more likely to score higher: when one of two groups scores rather high or low prior to the study. Control: random assignment and therefore regression is about the same for both groups.

Biases or Differential Selection (existing groups): When groups are different before the study begins due to the use of already-formed groups. Example: If a researcher uses all of the clients in an already-formed morning group for group A and the clients in the already formed evening group for group B-if members are selected that do not represent the population (Wiseman, 1999).

Mortality (attrition): Occurs when subjects drop out of the study. Example: All the unmotivated people drop out of the study.

Selection: When already-formed groups are used, one may profit more from the treatment than the other. This occurs because of history, maturation, or testing factors.

## Threats to External Validity

"External validity refers to extent to which the findings of that study can be generalized to other populations" (Wiseman, 1999, p. 50). Gay (1992, 1996) incorporates Bracht and Glass's (1968) threats to external validity into Campbell and Stanley's conceptualizations. External validity refers to the generalizability of the results of a study.

Pretest Treatment Interaction: When subjects respond differently to treatment because they have been pre-tested, so the results are only generalizable to other pre-tested subjects. Example: If a subject was pre-tested on attitudes about homosexuals, then read a story with a subplot about a homosexual relationship, the subject might focus on the subplot because he or she realizes that is the point of the study whereas subjects who had not been pre-tested would not.

Multiple Treatment Interference: When more than one treatment is administered in an experiment, the earlier treatments may affect the later treatments. This could include subjects who had previous treatment in another study. Example: If a study were conducted on individuals with multiple phobias who had responded well to systematic desensitization with one phobia and were later treated with a new therapy for their other phobias, then some of the apparent success of the new therapy may be due to the previous learning of systematic desensitization techniques.

Selection-Treatment Interaction: Occurs when subjects are not randomly selected from the population. If the sample is not representative of the population, the results cannot be generalized to the population.

Specificity of Variables: While the population and the sampling method must be described in detail, care should be taken that the experimental situation is still generalizable. Example: Attempting to generalize to all high school students the effects of a specific career counseling procedure when the subjects were all rural eleventh graders.

Experimenter Effects: When the researcher causes the results to be different from what they would have been because of the experimenter bias effect when the researcher's expectations affect the researcher's behavior and it then will affect the outcomes (Gay, 1992). A second type is the experimenter personal-attributes effect, that is, when the researcher's personal attributes such as temper, sex, age, etc., affect the outcomes (Gay, 1992, 1996).

Reactive Arrangements: Caused by any factor that affects the way the study is conducted or the way the subjects respond. An example would be the subjects' knowledge that they are participating in a study (Hawthorne Effect) or when subjects feel threatened and therefore outperform their previous performances (John Henry Effect), or simply increased interest and motivation in the subjects because they know they are getting special attention (Novelty Effect). Also the highly experimental situation the researcher creates to increase internal validity may decrease external validity.

**Question 8-13:**
In planning a research design with the focus on influencing variables that might affect the outcome the researcher would attempt to control for:

a. internal and external validity
b. internal and external reliability
c. internal validity
d. external validity

Answer: a. internal and external validity

**Question 8-14:**
A school system initiated a new curriculum for reading. Students in the seventh grade were measured on several cognitive variables at the beginning of the school year and again at the end of the year. The data indicate that students who were exposed to the new curriculum were more proficient at the end of the year and were viewed as supporting the effectiveness of the new curriculum. Identify the threat or threats to internal validity regarding the results.

a. history
b. maturation
c. instrumentation
d. regression

Answer: b. maturation

**Question 8-15:**
Identify which of the following is a threat to internal validity, that is, an event that is not the independent variable that affects performance on the independent variable.

a. instrumentation
b. testing
c. history
d. maturation

Answer: c. history

## Hypothesis

Suter (2006) identifies four types of variables and three types of hypotheses. Variables are considered to be independent, dependent, attribute and extraneous. Hypotheses are research, alternative, and null. A research hypothesis is a best predicted outcome or reasonable outcome. An alternative hypothesis may be a competing hypothesis based on some type of influence and usually eliminated. A null hypothesis states there is no difference or connection among the variables.

In summary, a hypothesis is a:

1. "logical supposition, a reasonable guess, an educated conjecture which may give direction to your thinking with respect to the problem and thus aid in solving it" (Leedy, 1985, p. 64 ).
2. "tentative explanation for certain behaviors, phenomena, or events that have occurred or will occur... states the researcher's expectations concerning the relationship between the variables in the research problem" (Gay, 1992, p. 66-67).

A researcher does not attempt to prove or disprove the hypothesis. Instead, a researcher attempts to collect data that supports or does not support the hypothesis. A good hypothesis (Gay, 1992, 1996):

1. provides a reasonable explanation.
2. states the expected relationship between two variables as clearly as possible and defines the variables in measurable terms.
3. must be testable.

A research hypothesis is either directional or nondirectional. A statistical hypothesis is stated in a null for:

1. Directional hypothesis (rarely used terminology): Couples with marital problems who go through one year of therapy will demonstrate a significant improvement in ability to communicate with each other. The direction is improvement (better).

OR

2. Couples with marital problems who go through one year of therapy will demonstrate a significant reduction in ability to communicate with each other. The direction is less or reduction.

Nondirectional hypothesis: Couples with marital problems who go through one year of therapy will demonstrate a significant difference in their ability to communicate with each other. Difference does not indicate better or worse (up or down).

Null hypothesis: There is no difference (mean scores) in ability to communicate with each other between couples with marital problems who have gone through one year of marital therapy and couples who have had no therapy.

## Subjects

In order to generalize the results of a study to the population, a sample that is representative of the population is required to conduct the research. Through the process of sampling, a smaller number of subjects that are a good representation of the entire population is selected. Inferences about the population are drawn based on the behavior of the sample.

## Population

A population is the group to which the researcher wants the results of the research to be generalized (Gay, 1992, 1996). This target population is the group that the researcher would like ideally to generalize the information.

Example: the entire freshman college population in the United States. The assessable population is the group that the researcher can realistically locate to make the selection. This group must be defined in detail so that others can determine if the results can be generalized to their situations, that is replicate the study (Gay, 1992). Example: college students in a particular state.

## Sample

A sample is the smaller group or subset that is selected from the assessable population that is used in the research to represent the larger population (Cohen, 2001). The degree to which the sample accurately represents the population determines how comparable the results are. The techniques used to select the sample are therefore very important.

## Sampling Techniques

No sampling technique guarantees a sample that is representative of the population, but there are techniques that increase the chances of a representative sample being selected. Random sampling is considered to be the best technique, and is required for inferential statistics. Snowball sampling is the easiest to develop as it starts with a small number of participants and builds up.

## Random Sampling

Random sampling is a process of selecting individuals from the population so that each individual has an equal and independent chance of being selected for the sample (Gay, 1992, 1996). Cohen (2001) points out that true random sampling is almost impossible to acquire, therefore samples of convenience are the more likely. One specific requirement for random sampling is that each individual has the same probability of being selected. The table of random numbers is frequently applied to ensure this requirement is met. A second requirement noted by Cohen is that each selection is to be independent (replacement) of another.

Example: drawing names from a hat.

## Stratified Random Sampling

A stratified random sampling is a process of selecting individuals from a population in such a way that the "subgroups in the population are represented in the sample in the same proportion that they exist in the population" (Cohen, 2001, Gay, 1996, p. 116-117), or to select an equal number from each subgroup if needed as in the example below.

Example: classifying students from the population of students at City X High School into categories by grade point average, then randomly selecting the same number of students from each category for the sample.

Many standardized achievement batteries utilize this type of sampling in developing a representative norm group. They systematically select seventh-grade students across the United States and stratify for geographical, economic, and race proportions known to exist. This form of sampling requires resources usually beyond the individual researcher.

## Cluster Sampling

A cluster sampling is a process in which groups rather than individuals are randomly selected. Example: randomly selecting several hospitals to represent all the mental hospitals in the United States, state, region, or city.

## Systematic Sampling

Gay (1996) defines systematic sampling as "sampling in which individuals are selected from a list by taking every Kth name" (p. 122). A number is assigned for K. For example, every Kth name could be every second name or every eleventh name. All individuals do not have an independent chance of being selected in this type of sampling because after the first person is selected from the list, the rest of the subjects have already been determined.

Example: Taking every fourth name from the telephone directory.

**Question 8-16:**
A group of professors in the counseling department at a local university planned to investigate within their state the effectiveness of middle-school counselors. These researchers randomly selected 20 middle schools in that state. In the selected schools, the team administered a packet of Likert type instruments to all teachers and students in the seventh grade. The process of sampling used by the investigators in this study is known as:

a. systematic.
b. random.
c. stratified random.
d. cluster.

Answer: d. cluster. Because the schools were selected randomly this example would be a randomized cluster. Cluster sampling is the process in which groups rather than individuals are randomly selected. The professors from the local university randomly selected schools to represent all schools statewide.

## Sample Size

Leedy (1985, 1993) identified three factors to be considered when determining what size a sample needs to be.

1. the degree of precision required between the sample and the population
2. the variability (standard deviation) of the population
3. the technique of sampling that is to be employed

The larger the sample size, the more representative it is of the population. The needed sample size is determined by the type of research being conducted (Gay, 1992, 1996). Keep in mind numbers alone do not determine a proper sample size. Sample size will be important in the selection of a parametric or non-parametric test. Sample size is also determined by the confidence level or interval and Cohen (2001) suggests that the 95% level is the most common. The larger the sample size the smaller the confidence level or interval. The following suggestions are not the only determinations but are provided for purposes of differences or similarities.

1. Descriptive research: 10% for large populations and 20% for small populations.
2. Correlational: minimum of 30 subjects
3. Causal comparative: minimum of 30 subjects
4. Experimental: minimum of 30 subjects, (unless tightly controlled, then less may be appropriate)

## Sample Error and Sample Bias

Sample error is not the fault of the researcher. A sample error occurs when the sample differs significantly from the population because of random chance differences.

Sample bias is the fault of the researcher. Sample bias occurs when the sample differs significantly from the population because of something the researcher did wrong or did not take into account. Sample bias can occur because of the use of nonprobability sampling techniques (Gay, 1992). These sampling techniques include:

Convenience sampling: Samples of convenience are the most common in research such as the use of volunteers or already-existing groups such as Psychology 101.

Judgment sampling: When the researcher uses his or her judgment to create a sample that is believed to be representative of the population.

Quota sampling (most often used in research involving interviews): Where a certain number of people are provided by request for an interview. This group does not represent the people more difficult to access.

## Selection of an Instrument

More than one instrument can be used in a research study. The important factors in selecting an instrument include the consideration of the reliability and the validity. The operational definition of whatever is being measured (independent variable) is determined by the instrument measuring it. For example, extroversion could be defined as scores on the Myers-Briggs Type Inventory. A rationale as well as a description of an instrument should be a part of the write-up for the study (Gay, 1992, 1996).

# OBJECTIVE 8C: Statistical Methods

Descriptive statistics involves the summarizing of collected data. The researcher organizes, summarizes, interprets, and communicates quantitative information obtained from those observations. Inferential statistics allow the researcher to take these data and make inferences, or tentative statements, about a population based on the observation of the sample (Ary & Jacobs, 1976; Cohen, 2001; Gay, 1996). The inferences can be parametric or nonparametric.

Research questions can be grouped as descriptive, differences, and as a relationship (Drew & Hardman, 1985). Descriptive questions ask what an event is like and are answered through surveys, inventories, and interviews. Difference questions make a comparison between groups of people and are analyzed through between-group and within-group designs. Relationship questions analyze the degree to which two events (constructs) are related. Correlations and regression equations are appropriate statistical tools for this measurement.

# Descriptive Statistics

Important types of descriptive statistics include the following (Gay, 1992, 1996):

1. Measures of central tendency—used to describe the average score of a group of scores. Examples: mode, mean, median.
2. Measures of variability—describe how spread out a group of scores are or how they spread themselves away from the central tendency (mean). Examples: The range and standard deviation are more commonly utilized.

## Correlation

For correlational research, the degree of relationship between two variables is sought. This relationship is expressed as a number between -1.00 and +1.00. If the two variables are highly related, the correlation coefficient will be close to -1.00 or close to +1.00. If the two variables are unrelated, the correlation coefficient will be near 0.00. Though a decimal point is used, a correlation coefficient is not a percentage. A correlation of .70 does not indicate that the variables are 70% related. Also a correlation of .20 is not twice as strong as a correlation of .10. It is important to remember that no cause and effect relationship is claimed to exist with these calculations or expressions. The strength of a correlation is often referred to as strong, modest, and low.

The common variance is the "variation in one variable that is attributable to its tendency to vary with the other" (Gay, 1996, p. 298). The stronger the relationship between two variables, the more the variation of one variable has to do with the variation of the other variable. Variance accounted for is calculated by squaring the correlation coefficient. Example: If the correlation coefficient is .90, then the common variance would equal 81%.

## Correlational Tests

First recall that a correlation is a bivariate. A bivariate means there are two (bi) variables (variate) being compared. The second step is to determine for each variable the measurement scale and/or if the data are continuous, discrete, or dichotomous.

When determining which correlation to select for a statistical design it is necessary to understand different types of measurement. In addition, it is important to recognize the distinction between the numbers and what it is these numbers represent. For the correlations noted below: continuous, discrete, and dichotomous variables will be reviewed.

Continuous variables are measured on a scale that changes gradually as though there are divisions between the steps. Tabachnick and Fidell (1989) suggest age, temperature, distance, and scores on the Graduate Record Examination as examples. If one were to compare two individuals in height even if they are very, very close it is always possible to find someone whose height is between the two (Cohen, 2001).

Discrete variables are of a finite value and can assume only certain values. Some examples would include categories of political affiliations, social classes, etc. The number of puppies in a litter represents a discrete variable for that litter.

Dichotomous variables are two levels such that it is either yes-no, in-out, religious-areligious, etc.

1. Spearman Rho: If the data in the correlational study are expressed as ranks, the Spearman rho is used to calculate a correlation coefficient (Gay, 1996). A researcher who wanted to know the relationship between typing speed and typing accuracy would rank the subjects on each variable, and then apply the Spearman rho, which is easier to compute than the Pearson r. Both variables are ordinal variables, that is, ranked (Gay, 1996).
2. Pearson r: When data are represented as interval or ratio scales, the Pearson r is the appropriate measure of correlation. The Pearson r is the most stable measure of correlation, because it takes every score on both distributions into account. This formula is the most commonly used and it assumes that the relationship among the variables is a linear one. Both are interval or both ratio (Gay, 1996). Examples: Variables such as height, weight, achievement and personality measures. The Pearson r is frequently utilized to determine the reliability and validity of certain traits such as personality.
3. Phi: When both variables are genuine or true dichotomies, this test is used (Drew & Hardman, 1985). Example is when a person is present or absent.
4. Point Biserial: When the data on one variable are continuous and on a ratio or interval scale while the other variable is a true dichotomous, a point biserial is the correlation of choice (Drew & Hardman, 1985). Remember, dichotomous variables are usually described as whole numbers while continuous variables have divisions between the whole numbers.
5. Biserial: When the data on one variable are continuous (interval or ratio) and the data on the other variable are artificially dichotomous (nominal), this test is used (Drew & Hardman, 1985). Artificially dichotomous means that the data are continuous, but a cutoff point has been assigned at which scores below are assigned a 0 and scores above are assigned a 1 and therefore appear to be dichotomous.
6. Tetrachoric: When both variables have been artificially dichotomized variables this test is used (Drew & Hardman, 1985). For example, if a researcher wants to study the relationship between students who are dichotomized as being superior athletes or poor athletes and their ability to speak in public, which is also dichotomized as superior or poor, then the researcher's only scores are 0 (superior) or 1 (poor).

**Question 8-17:**

A correlation coefficient of .89 can be described as:

a. strong positive.
b. strong negative.
c. mild positive.

d. mild negative.

Answer: a. strong positive. 89 is sufficiently high and near 1.00 to indicate a strong positive correlation.

**Question 8-18:**
Two evaluators ranked five dogs for running form for each of two days. The evaluators assigned ranks for each dog for each day. Which correlation would be the most appropriate to analyze the data?

a. Spearman r
b. Tetrachoric
c. Point Biserial
d. Phi

Answer: a. Spearman r. The intention is to correlate rankings on day 1 with rankings on day 2. The correlation is one set of ranks with another set of ranks of the same dog.

# Inferential Statistics

Inferential statistics, parametric and non-parametric, help determine how likely scores obtained for a sample (statistics) are the same as the scores that would be obtained for the population (parameters). This determination is obtained by using a test of significance. These tests allow us to decide if we are going to accept or reject the null hypothesis.

# Power

Power is a probability. The purpose of power analysis is to be able to reject the null hypothesis when the hypothesis is false. When consideration is given to designing a study the desired effect size, significance level, and sample size are important in a quantitative research (Balkin & Sheperis, 2011). If a low power index exists a type II error is more likely to occur.

The power of a test is an index between 0 and 1 and referred to as a probability of finding a difference (Suter, 2006). The purpose of determining power is to uncover relationships in order to reject the null hypothesis (difference does exist). Researchers prefer to establish power to be .90 or higher. To establish power the researcher is concerned about the size of the sample and the strength of effect. In planning the research the question is posed as to what might be the minimum number in the sample because as the sample size increases so does the power. Power is calculated as 1-beta or type II error. Finally, beta decreases as sample size increases. APA requires power to be reported in a manuscript for publication.

## Null Hypothesis

The null hypothesis states that there is no true difference between the mean score of two groups, and if a difference is found, then it is the result of sampling error. With this hypothesis, there are four possible outcomes. The researcher can accept the null hypothesis when it is correct, accept the null

hypothesis when it is false, reject the null hypothesis when it is correct, or reject the null hypothesis when it is false.

For example, if the null hypothesis states that there is no difference in the means of group A and group B, and in actuality there is no difference between the two groups, then it would be correct to accept the null hypothesis and conclude that there is no difference between the two groups.

If the null hypothesis states that there is no difference between group A and group B, the researcher rejects the null hypothesis, concluding that there is a difference between the two groups, it is called a type I error (alpha error). When the researcher accepts the null hypothesis when it is actually false, it is a type II error (beta error).

**Question 8-19:**
A type I error in a null hypothesis is a:

a. false rejection.
b. valid rejection.
c. beta error.
d. valid acceptance.

Answer: a. false rejection or false negative, rejecting the null hypothesis. Type II error is a failure to reject a false while a Type I error is rejecting when one should be accepting.

## Significance Levels

The test of significance that the researcher applies to the data determines whether the researcher will accept the null hypothesis.

This test is made at a predetermined probability level. This probability level is usually at the 95% (.05) or the 99% (.01) level of significance. When a researcher states that a difference between groups is significant at the .05 level, this means that this difference would occur 5 times out of 100 by chance rather than by manipulation of the independent variable. It also means that there is a 95% chance that the difference occurred because of the manipulation of the independent variable. When a difference is significant at the .01 level, it means there is a 99% chance that the difference can be attributed to the independent variable.

**Question 8-20:**
The following information was found in a recent journal article. The mean score for group A was significantly higher than the mean score for group B ($p < 01$). This statement by the researcher means there is a:

a. 95% probability that the difference occurred because of the manipulation of the dependent variable.
b. 1% probability that the difference occurred because of the manipulation of the dependent variable.

c. 1% probability that the difference occurred due to the manipulation of the independent variable.

d. 99% probability that the difference occurred due to the manipulation of the independent variable.

Answer: d. 99% probability that the difference occurred due to the manipulation of the independent variable. There is one chance in 100 that the change occurred because of an error component or chance.

## Standard Error

Because sample means are used to make inferences about the population, an estimate of the amount of error involved is needed. The standard error of the mean is this estimate.

The standard error of the mean is the standard deviation of the sample means (Gay, 1996). It is derived by dividing the standard deviation of the sample by the square root of the number of subjects minus one. As the sample size increases, the standard error of the mean decreases. A small standard error of the mean is good because it indicates less sampling error. Standard errors can be computed for other measures of central tendency and variability as well.

## Tests of Significance

Most tests of significance are two-tailed, but some are one-tailed. A two-tailed test of significance is given when the researcher expects that the difference between the groups could be in either direction. For example, if a research hypothesis states there is no difference in behavior improvement between individuals who receive money for reinforcement and those who receive cigarettes for reinforcement, then the researcher may find that the group that receives money has a significant behavior improvement over the group who receives cigarettes OR the group who receives cigarettes for reinforcement may have a significant behavior improvement over the group who receives money. Since the improvement could occur in either direction, a two-tailed test is needed.

If the researcher is fairly certain that the change will occur in one direction only, he or she can use a one-tailed test of significance. The advantage of a one-tailed test is that it needs less of a numerical difference to be significant. An example would be a case in which the null hypothesis states that students who receive positive reinforcement do not show any improvement in behavior over students who do not receive any reinforcement. The researcher expects the only possibility to be that the students who receive reinforcement show improvement over the other students who do not receive reinforcement. The researcher probably does not expect the students who receive reinforcement to do more poorly than the students who do not receive reinforcement. In this case, a one-tailed test for significance is appropriate.

Tests are also either parametric or nonparametric. A parametric test is usually preferred because it is more powerful, so a researcher is less likely to make a Type II error. But for a parametric test to be valid it must meet the following criteria (Gay, 1992, 1996):

1. The variable measured must be normally distributed in the population.
2. The data must represent an interval or ratio scale.
3. The subjects must be randomly elected.
4. The variances of the population comparison groups are equal.

Gay (1992, 1996) points out that with the exception of a sample being selected by random techniques, the other criteria leave room for some violation. However, if the distribution is quite skewed, if the data represent an ordinal or nominal scale, or if any other of the criteria are extremely violated, then a nonparametric test should be used.

Nonparametric tests require no specific shape for the distribution. That is, no assumptions are made about the specific parameters of the distributions. Reber (1985) notes that while non-parametric tests are often known as distribution-free, they are not assumption-free.

## Inferential Tests

PARAMETRIC TESTS:

Parametric statistics are applied to quantitative data such as type, kind, and degree and are interval or ratio data (Cohen, 2001). In addition, the question of group is usually tested with parametric statistics (e.g., t-tests, ANOVA) whereas relations between and among variables are usually correlations or regressions (Tabachnick & Fidell, 1989). A few of the more commonly utilized parametric tests will be highlighted.

### t-test for Independent samples

Significant difference between two groups or two tests (pre/post) that were randomly selected. A t-test for non-independent samples is one in which matching takes place. An example is one in which two samples are the same sample such as a pretest and posttest for the same group (Gay, 1996).

1. the t-test is utilized with several different distributions (normal or otherwise) and with various sample sizes
2. t-test will test population means and develops a T-ratio
3. scores are interval or ratio
4. population from which sample is drawn is normally distributed
5. variability is equal for population and sample

A pretest is given to 30 students who were randomly selected from all the applicants for the October NCE testing. At the end of training a posttest was administered and a t-test for no significant mean change was computed.

If a pretest is administered to two different groups, taking the October NCE testing a t-test can be conducted for non-independent samples. This could be one group when administered a pre and

posttest, one group two mean scores. Significant difference between two groups can be compared. Subjects are sometimes matched on variables related to the dependent variable in order to equate groups.

### Simple ANOVA (One-way Analysis of Variance)

A test for significant differences among three or more groups (yields an F ratio) (One-Way or Two-way). This is the most common design in which there is a quantitative dependent variable and one or more qualitative independent variables (Cohen, 2001).

1. this is a test for three or more means
2. statistical procedure conducted for several comparisons for three or more sample means and one independent variable and the F ratio is computed resulting in a 'p' value. A certain number of participants are assigned to three or more groups and a treatment is applied. The treatment or the variable under study is the independent variable (example-NCE training) and the NCE score is the dependent variable. The NCE test is administered and means are compared.
3. variability is observed between and among groups
4. quantitative dependent variable
5. less power than ANCOVA

A training group for the NCE took a pretest, posttest, and a post-posttest six months after the examination. The statistical ANOVA was utilized to test for mean differences between and among the administrations. It is possible to conduct three t-tests, however ANOVA allows for this calculation to be conducted at the same time (efficiency).

### Factorial ANOVA

Follows the same design and statistical procedure as explained for the simple ANOVA, but there are multiple independent variables. There is a significant difference among four groups that are subgrouped.

Example: Researchers are interested in investigating the effectiveness of three different types of behavior change intervention strategies in six middle-school grade students. Several variables were considered. These variables included the type of behavior change intervention program, grade level (6 grades), and gender. This would be a 3 X 6 X 2 design (3 interventions, 6 grade levels and 2 gender) with three independent variables. The dependent variable is not listed.

### ANCOVA

"Analysis of Covariance is a statistical procedure that improves the precision of a research design by employing a preexisting variable that is correlated with the dependent variable" (Ary, Jacobs, & Razavieh, 1990, p. 304). It is used to equate unequal already-formed groups to make a fair comparison. It is also used to increase power (see terms for definition of power of a test). The use of covariance is to match groups on controlled variables and a major purpose is to control for pretest differences. This technique is often utilized in causal-comparative studies (Gay, 1996).

Example: A school psychologist set out to investigate whether a cooperative learning program or individual instruction is more effective in teaching geometry to eleventh graders with learning disabilities. Parallel forms of a standardized geometry test were used for a pretest and a posttest.

NON-PARAMETRIC TESTS

Non-parametric statistics measure qualitative attributes, characteristics, and categories. This type of data is considered nominal or ordinal (Cohen, 2001). Three common non-parametric statistics are the median, sign, and chi-square tests.

### Median Test

Non-parametric test used when scores are ordinal, or when the scores are interval or ratio but do not meet the criteria for parametric that is smoothness of distribution. The median test will determine if the proportion of subjects falling above and below the median is different from the control group.

1. two groups have same median
2. scores are ordinal
3. two independent samples are used

### Sign Test

A non-parametric alternative to the t-test for matched pairs. Assign a + for direction above and a - for direction below an identified point. A summary of the + and - signs are subjected to the sign test statistical analysis.

1. correlated samples where subjects are matched
2. use plus and minus signs
3. dependent variable is continuous
4. members are ranked

### Chi Square

A non-parametric test used to find the significance of differences among proportions. The chi-square test examines two sets of frequencies: observed and expected (Ary, Jacobs, & Razavieh, 1996; Cohen, 2001). This type of nonparametric test of significance is used when the data is in the form of frequency counts and represent a nominal scale. One of the two data sets exists or is found in the literature such as the exact number of voters (republicans or democrats who are registered voters) in a precinct.

1. independence of frequency count
2. observed and expected frequency

Some other non-parametric tests are as follows:

### Scheffé

Non-parametric used for multiple comparisons, for example if an F-ratio is significant; Scheffé is used to determine where the significance lies.

**Mann-Whitney U**

Nonparametric used when two dependent samples were drawn from the same population.

**Krushal-Wallis**

Non-parametric used for more than two groups.

**Question 8-21:**
A teacher administered two different forms of a test measuring math achievement to all of her students. Each student took both tests. She wants to know if there is a relationship between the scores on the first form and the second form. What statistical technique should she use?

a. simple ANOVA
b. factorial design
c. t-test for independent samples
d. Pearson r

Answer: d. Pearson r. The Pearson r is the only test listed that describes the relationship.

**Question 8-22:**
If the teacher in question 8-21 wanted to know if there is a difference between the raw scores on each of the two forms, what parametric test should she use?

a. simple ANOVA
b. factorial design
c. t-test for independent samples
d. Pearson r

Answer: c. t-test for independent samples

**Question 8-23:**
What method of research would be used for the following problem? The researcher hypothesizes that premarital counseling contributed to better marital adjustment. The researcher selected a group who had been married for one year and had undergone pre-marital counseling and compared them to a group (also married one year) but had not:

a. experienced pre-marital counseling.
b. experimental method
c. correlational
d. causal-comparative
e. descriptive

Answer: a. experienced pre-marital counseling. Premarital counseling is the independent variable. The control group is not receiving premarital counseling.

**Question 8-24:**
Suppose that you want to test the hypothesis that in seal families with only two seals, the first-born is more gregarious than the second-born. You randomly select matched pairs of puppies with each pair consisting of the first-born puppy and the second-born puppy from a given family. You administer the puppy chow test of gregariousness/ shyness and derive a mean score of 30 first-born puppies and 30 second-born puppies. What would be the appropriate statistical technique?

a. t-test
b. analysis of variance
c. Pearson product correlation
d. chi-square

Answer: a. t-test

**Question 8-25:**
What is the appropriate research design for the following hypothesis? A researcher hypothesized that randomly selected students who received computer assisted instruction will have greater gains in algebra achievement than students who do not receive computer assisted instruction.

a. Pretest posttest control group design
b. Posttest only control group design
c. Nonequivalent control group design
d. Solomon four group design

Answer: a. Pretest posttest control group design

**Question 8-26:**
If we decrease the probability of a Type I error by choosing alpha small, we:

a. increase probability of Type II.
b. increase probability of Type III.
c. increase probability of Type IV.
d. increase probability of Type V.

Answer: a. increase probability of Type II. If everything else is constant when alpha error (Type I) is increased, beta (Type II) error will decrease. As sample size and alpha selection changes, so will this answer.

**Question 8-27:**
A researcher sets out to determine if fifth-grade students in Georgia have a higher or lower self-esteem rating than first-grade students. The researcher randomly selects several fifth-grade and first-grade classes from several different schools across Georgia. This is an example of what type of sampling?

a. stratified
b. systematic
c. cluster
d. k sampling

Answer: c. cluster (random cluster)

**Question 8-28:**
Test A and Test B are musical aptitude tests while Test C and Test D are musical attitude inventories. The following correlations were reported. Which technique will break down the relationship among a set of observations and identify a set of primary components that will explain the relationship among the observations?

| | Test A | Test B | Test C | Test D |
|---|---|---|---|---|
| Test A | 1.00 | 0.88 | 0.15 | 0.56 |
| Test B | 0.88 | 1.00 | 0.75 | 0.75 |
| Test C | 0.10 | 0.20 | 1.00 | 0.40 |
| Test D | 0.56 | 0.75 | 0.40 | 1.00 |

a. factor analysis
b. correlational
c. t-test
d. ANOVA

Answer: a. factor analysis

# OBJECTIVE 8B: Organizational Modifications

Organizational program evaluations refers to "a systematic process of collecting and analyzing information about the efficiency, the effectiveness, and the impact of programs and services" (Astramovic & Coker, 2007, p. 162).

The ethical guidelines as adopted by the American Counseling Association (ACA, 2014) state that counselors monitor their effectiveness as professionals (C.2.d.) and that they submit regularly for professional review and evaluation by their supervisor or employer (F.4., F.6., F.6.a.). Similar responsibility is entrusted to appropriate individuals (clinical director, administrator, and/or individual therapist) to account for or evaluate the effectiveness of a counseling organization or counseling service. Evidence-based practice is a conscious, explicit, and judicious use of current evidence to make decisions (Sackett, Richardson, Rosenberg, & Haynes, 1997).

Royse, Thyer, Padgett, and Logan (2001) cite APA standards for psychological interventions. The treatment must be supported by at least two good between-group design experiments to establish effectiveness. The treatment must be superior to a pill or placebo and equivalent to an existing treatment in experiments with adequate statistical power. A second method is to use a large series of single case designs (Chambless, et al., 1996).

Organizations and counselors have felt the pressure for accountability to research and document effectiveness in program services and counseling interventions and treatment outcomes. Reasons for a lack of outcome information in the literature has to do with counselors and administrators expressing and demonstrating a level of research expertise in methods and in formulating appropriate researchable questions, collecting relevant data, and identifying appropriate analyses (Isaac, 2003; Whiston, 1996). Program effectiveness and counselor effectiveness are linked in a way to provide the impact to clients. Schmidt (1995) detailed time constraints, elusive measures of school outcomes, lack of training in research and evaluation methods, and fear that evaluation results will have a negative impact on the counseling program. Mental health counselors utilizing managed care contracts are required to document detailed records about interventions, monitoring interventions and outcomes for individual sessions (Granello & Hill, 2003). A positive outcome for organizational and counselor outcome studies is a better informed practice, improved quality, assessed goal achievements, provided feedback on decision-making, examined cost-effectiveness, and improved counseling services (Madaus & Kellaghan, 2000).

In addition, as previously noted, regarding objectives for effectiveness studies a critical review is to include:

1. improve quality
2. client satisfaction
3. feedback on effective and ineffective interventions
4. effective and ineffective interventions for different populations (diversity)
5. impact on larger social problems (Royse et al., 2001).
6. highlight local needs

Powell, Steel, and Douglas (1996) provided a list of questions to be asked and researched to improve services and counseling outcomes. The questions are:

1. Are clients being helped?
2. What methods, interventions, and programs are most helpful for clients?
3. How satisfied are clients with services received?
4. What are the long-term effects of counseling programs and services?
5. What impact do the services and programs have on the larger social system?
6. What are the most effective uses of program staff?
7. How well are program objectives being met?

Astramovich and Coker (2007) developed a four stage model entitled the accountability bridge counseling program evaluation model for counseling. The four stages for program evaluation cycle are program planning (needs assessment), program implementation, program monitoring and refinement, and outcomes assessment.

**Question 8-29:**
What research design is recommended for evaluating program and counselor effectiveness due to the complexity of measurement in monitoring and improving a particular program or intervention?

a. action
b. experimental
c. quasi-experimental
d. two-fold factorial

Answer: a. action research (Astramovich & Coker, 2007)

## Counseling Effectiveness

Program evaluations help to know when theories work and when they do not. Program evaluations make comparisons. It is generally accepted that before a research design is employed a needs assessment is conducted. The effectiveness of counseling has been scientifically studied since the 1930s (Lambert, 2002). A review of this research reveals that 75% of clients who enter treatment show some benefit (Lambert & Ogles, 2002). Whiston and Coker (2000) identify three important counselor contributions to effective counseling. These include:

1. level of skillfulness, competence
2. ability to think diversely and complexly about client cases (cognition)
3. ability to relate to client (relational)

More so than ever, counselors are challenged to demonstrate treatment effectiveness. Sexton (1999) points out that because of cost and counselor accountability concerns a major focus of research in the field of counseling is intervention effectiveness. The integration of research into practice in order to evaluate the effectiveness of counseling has many positive implications for counselor accountability as well as counselor education/training and supervision.

In 1995 Consumer Reports published findings that revealed that clients "benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy," (Seligman, 1995, p. 965). Unfortunately, the Consumer Reports study also revealed that when the number of therapy sessions or choice of therapist was limited by insurance or managed care, counseling was less effective. Seligman summarized key findings of the Consumer Reports study:

1. Participants reported that treatment by a mental-health professional did help them to feel better.

2. There were robust findings which showed long-term therapy resulted in more improvement than short-term therapy.
3. No significant outcome differences were found between psychotherapy versus psychotherapy with medication.
4. Clients who actively sought therapy did better than more passive clients.
5. No specific approach to counseling did any better than another for any presenting concern. That is, all forms of counseling did equally well.

In summary the Consumer Reports survey is reported to be the most extensive study of psychotherapy effectiveness. Nearly 3,000 participants responded to this lengthy survey. While this was not a tightly controlled experimental study, this study did extensively evaluate the effectiveness of psychotherapy using a population that seeks mental health services. (Seligman, 1995).

## Evaluation Process

A five-step procedure or process for conducting an effectiveness evaluation recommended by Lewis and Lewis (1991) is to:

1. conduct a needs assessment
2. define the goals and objectives of the counselor or agency
3. identify alternative methods for meeting goals
4. make appropriate decisions
5. develop plans for implementation and evaluation

An evaluation of a counseling service should include an internal and external approach. This comprehensive approach is intended for professional improvement and to provide clients a reasonable expectation of the effectiveness of treatment provided by the counselor or agency.

The counselor or agency organizes a plan to gather objective, performance-oriented data in a systematic and nonbiased manner. As referred to in the assessment unit, both formative and summative evaluations are important.

## Purpose of the Evaluation

Gibson and Mitchell (2003) highlight eight functions of an evaluation. In summary, these eight functions reflect what works and doesn't work and to what degree, rate and level progress is noted, feedback for improvement in the practice, enhancement and building credibility, increased insight, placing responsibility for successes and failures at appropriate positions or individuals, increased participation in decision-making, and providing a rationale for improving the overall accountability. These eight functions are appropriate both for the overall agency functioning in providing quality care and for the individual counselor in assessing his/her effectiveness.

In conducting this formative or summative review appropriate research techniques should be employed. Thus, what is important is that each agency or counselor has established goals by which such an assessment can be conducted. For the individual counselor this evaluation can be targeted at his/her particular counseling theory, program, technique, or approach to counseling. Step one is to identify those specific goals followed by how to best identify valid criteria to measure those goals. If the counselor is attempting to treat depression the goal may be a reduction or elimination in the symptoms known to be associated with depression. These criteria might be the symptomology listed in the DSM-5™ or even the Beck Inventory symptoms and as measured by the evaluation scaling. Another step in the process is to seek feedback and follow-through that is, sharing the results.

Covering all aspects of an internal evaluation is far more extensive than will be presented in this unit. However, for the individual agency or counselor typical means to derive effectiveness data have been through controlled studies as well as surveys. In addition, counselors have utilized audio and video taping to gather data that are submitted to an independent evaluator or supervisor for feedback. Other means to gather counselor feedback data can be through two-way mirrors, in session observations by a trained observer, pre-post instrument measures on effectiveness, bug in the ear (BITE), walk ins, and phone-ins. In all situations appropriate approval for such research is conducted through and with the full consent of the clients as well as an internal or external review board for human subjects.

According to Gibson and Mitchell (2003) evaluation can be a before-and-after method, a comparison method, and a how-do-we stand method. Each method has advantages and disadvantages and appropriate selection procedures based and evaluated upon the goals of the counselor, therapy and/or the agency. The before-and-after method evaluation assesses client progress during therapy or counseling. The counselor's evaluation measure might be the Beck Inventory administered during the interview assessment and periodically re-administered to note improvement. This is followed by re-administering the inventory at the time of termination and at some designated time period later. The objective for this counselor would be to secure effectiveness data for working with clients who are experiencing depression. The study could also focus on the regression effect of the treatment by testing at six-month post termination or even longer. Limitations in the results would need to be noted, such as specific threats to internal and external validity. The comparison method, assuming group or individual comparison data is available, compares group improvement with group data that already exists in the literature or even with another treatment procedure. Once again a set of data are to be gathered through instrumentation, observations, and/or interviews and statistically analyzed and compared against a "well" or "improved" group. Finally, the how-do-we-stand method tends to utilize rating scales, checklists, and questionnaires to gather data (Gibson & Mitchell).

External evaluations have become a requirement for some agencies under Public Law 94-63. This law enforced by the federal government requires mental-health facilities to conduct program evaluations. Quality assurance of clinical services, self-evaluations, and resident's review are three types of evaluations required.

# OBJECTIVE 8E: Evidence-Based Practice

Evidence-based Research (EBR)

Evidenced-based studies are undertaken to improve the quality and accountability of treatment. Evidence-based practices are interventions with scientific evidence that they improve client outcome (Drake, Goldman, Leff, Dixon, Mueser, & Torrey, 2001). This type of research and publication provides feedback in the form of an increasing knowledge base from which a counselor sorts out what treatment is most effective for different dysfunctions, different populations, and age groups. The National Institute on Drug Abuse (NIDA) developed a list of empirically based interventions as a guide to practitioners (NIDA, 1999). When these recommended treatments are applied what followed was monitoring, a further advancement for the profession in clinical work and in turn policy decisions.

Federal policies are requiring the use of evidence-based programs in the schools (Robertson, David, & Rao, 2003). Managed care companies have driven the need for treatment outcomes in terms of best client care and cost effectiveness. Third party payers are vigilant that clients receiving treatments are receiving statistically best choices. Managed care companies approve client care based on the number of treatment sessions that are based on literature support for certain treatments. Leiberts (2006) reported on a 30 year survey and within that report cited improvement rates such as 45-58% clients improved after 4-7 sessions and 56-68% improved after 8-16 sessions. Even though these figures may have included a combined set of efficacy and effectiveness studies and perhaps were global in scope and measurements were client reports or measuring scales improvement rates were calculated for specific number of sessions of therapy.

The main goal of comparative effectiveness is to inform health providers so they can make informed decisions. Decisions critical to the clinician includes interviewing, diagnosing, interventions, strategies, and techniques in treating clients. Choices involve selecting the different treatments based on benefits and possible harm of those choices. Effectiveness studies utilize clinical trials, clinical designs, and other research to carve out suitable designs and meet research methodology to conduct studies.

A standardized procedure is to conduct several randomized clinical trials to compare an alternative practice with a different intervention and using a control group. It typically calls for a sophisticated methodology for an ideal efficacy study that would include:

1. clients are randomly assigned to treatment and control conditions
2. controls are rigorous, including placebos, control for influences of rapport, expectations of gain, sympathetic attention
3. treatments are manualized
4. clients are seen for a fixed number of sessions
5. target goals are operationalized
6. raters are blind to which group the client is a member
7. clients meet criteria for a single diagnosed disorder

8. clients are followed for fixed period of time after termination (Seligman, 1995).

Measurement (incremental change) can be conducted with a phase model that will measure change between a log-normal relationship and a normalized probability of client improvement. Efficacy studies using this model allow for a measurement that delineates a certain therapy revealing improvement in a certain number of sessions for a certain disorder (Howard, Kopta, Krause, & Orlinsky, 1986).

Leibert (2006) sites the work of Jacobson and Truax (1991) and Hill and Lambert (2004) who utilize conceptualization to determine what determines effectiveness. Two criteria are important to these authors. The first is that a norm exists for a measure of functional and dysfunctional populations so that when a client is nearer the functional than dysfunctional the criteria is met for significance. Secondly, the amount of client change exceeds the expected random markers inherent in the measuring system and that is statistically reliable and reflects the change index. When both measures are met the change is considered clinically significant (Ogles et al., 2002).

In summary, the most scientific approach to research involves efficacy studies. This type of study is a tightly controlled experiment involving random assignment, control groups, standardized measures, and use of practice manuals for an intervention (James & Mennen, 2001). Evidence-based research and outcome-based studies generate a research-to-practice protocol and fosters a learning environment in which clinicians, researchers, agency personnel and informed policy benefit through this collaboration (Grella, Hser, Teruya, & Evans, 2005). When relying on outcome research, efficacy, or effectiveness studies caution is the rule throughout the process and during follow-up. Researchers and clinical practitioners should be aware of values, nature of the data and evidence, and limitations of the reported results or evidence (Drake, Goldman, Lehman, Dixon, Mueser & Torrey, 2001).

# OBJECTIVE 8F: Ethical Strategies for Interpreting & Reporting

ACA Code of Ethics G.4.

In reporting research in each stage of the research process (G.1.a.), is to plan, conduct, and report with accuracy including all aspects of the report. This report provides for a cost-benefits statement and to refrain from any deviations with the data, design, bias or altering the outcome (G.4.a.). The same holds true for unfavorable results that are to be reported (G.4.b.). Should an error be reported in a publication the researcher takes appropriate action to correct (G.4.c.). The participants identity are to remain confidential and in most cases data is collapsed (G.4.d.). If an outside researcher request data from another researcher for the purpose of a replication study the primary researcher is obligated to make available original research to qualified professionals (G.4.e.). In the event research is published with multiple authors credit can be in the form of acknowledgements, footnote statements, and minor authorship (G.5.d.). Whatever form of credit is honored for the research contribution is to be agreed upon prior to the research (G.5.e.). Submissions are to one journal at a time (G.5.g.) and are not published in another journal without acknowledgement and permission (ACA, 2014).

Wester's (2011) overview of publishing ethical research covers the scope of ethics and research. Each is encouraged to read the article to understand the scope of the entire research process from generating research ideas to publication. Safeguards such as ACA Code of Ethics, IRB's, federal government regulations (1974 research act), and HIPAA are in place for guaranteeing respect, informed consent, disclosure, selection of subjects, minimizing risks, methodology procedures, statistical techniques, power, effect, recognizing authorship and recognition for those contributing members. Five ethical principles are emphasized in this article in conducting research with human subjects.

The initial point in conducting ethical research is early attention to conclusion validity. According to Wester (2011) respect for participants includes five principles

1. autonomy (respect and dignity for choice)
2. protection of vulnerable populations (informed consent-participants unable to understand or not feel pressured to participate)
3. beneficence (protection from harm from beginning to after the study)
4. justice (benefits and risks are distributed fairly)
5. fidelity (keeping promises, be truthful, loyal, and follow through wih commitments)

Wester cites Rosenthal (2008) and Bruce (2002) that research is to satisfy social validity, that is, what impact the study will have on the population and society. The salient points in the process of conducting ethical research are:

1. research idea-social validity
2. design-consideration for risk and benefits
3. data analysis-power, effect size, significance level, type I error
4. conclusion validity accuracy of data
5. article for publication-credit is applied
6. do not seek out a different statistical technique until significance is found
7. to not falsify data or meaning

A meta-analysis study conducted by Lau, Cisco and Delgado-Romero (2008) regarding research productivity patterns were reported in five nominated research journals regarding multicultural psychology. Using a snowball sampling method the five journals with highest ratings were the Journal of Cross-Cultural Psychology (JCCP), the Cultural Diversity and Ethnic Minority Psychology Journal (CDEMP), the Journal of Multicultural Counseling and Development (JMCD), the Journal of Black Psychology (JBP), and the Hispanic Journal of Behavioral Science (HJBS). Although there were several important implications and limitations to this report the findings for the five nominated journals for the years 1994-2007 suggest that for multicultural psychology there may be a reduced effect or impact on the field from the research journals from such a limited number of journals devoted to this research.

# Publications

The Journal of Counseling and Development devotes a special research section in the Table of Contents. The articles reflect a broad range of domains researched across culturally relevant topics. Research is devoted to information regarding a variety of topics to include diverse populations, race, gender, age, culture, identity, biases, client issues, counselor training, supervision, ethical awareness and practice.

Informing professionals is an important function of ACA, subdivisions, and affiliates. The major publications are the Journal of Counseling and Development and Counseling Today. These professional publications are distributed to all members of ACA. Counseling Today covers information regarding activities of the profession as well as members. The specific objectives for Counseling Today can be found in each monthly publication. The monthly publication advertises materials, workshops, and legislative actions, and provides current information regarding voting for membership positions within ACA and subdivisions of ACA.

The Journal of Counseling and Development (JCD) is considered a flagship journal for the profession. This journal is published four times a year. Manuscripts considered by publication fall into the areas of theory, practice, research, assessment and diagnosis, profiles, trends, books and media, and best practices. This journal will inform the membership of a yearly summary of ethical complaints and actions received and acted upon by ACA's ethical board.

In summary, counselors are to plan, design, conduct and report research that follow ethical principles, federal and state laws, and scientific standards for human subjects (G.1.a.), when deviating from standard practice the researcher is to seek consultation (G.1.d.), when an IRB is not accessible the researcher is to locate and receive guidance from knowledgeable researchers who are trained (G.1.c.), and to take precautions to avoid harm to participants (G.1.e.). The researcher is to always inform the participants of accuracy, procedures, benefits, alternative procedures, answer questions, describe limitations, format, and that subjects are free to leave the study at any time (G.2.a., 1-9). Confidentiality is maintained before, during and after the study (G.2.d.). Data is to be collapsed and procedures for disposal of documents and records are retained for a period of time (B.6. h.). In reporting research results of primary importance is accuracy (G.4.a.), obligation to report unfavorable results and errors (G.4.b., G.4.c.), disguise identity of participants (G.2.d., G.4.d.), recognize contributors ((G.5.d., G.5.e ), and to submit to only one journal at a time and articles published in whole or part submitted to another journal only with permission from previous publisher (G.5.g.).

The resources guide for those designing, implementing research and publishing articles is the Publication Manual of the American Psychological Association (2010).

**Question 8-30:**
The results segment of a published article is to contain all of the following except:

a. outcomes of the intervention
b. pilot data

c. target outcomes population description

d. population description.

Answer: d. population description. Population description is to be included in the methods section.

**Question 8-31:**

The discussion segment of a published article is to contain all of the following except:

a. case examples

b. connections to the purpose, goals and outcome of intervention

c. collected data on intervention into context

d. evaluate the data in terms of diversity and multicultural competence

Answer: a. case examples. Case examples, if included, are to be in the methods portion of the publication.

**Question 8-32:**

A publication is intended to further the findings in the specified problem; however, what aspect included in the discussion advances the importance of research in the field (objective 1)?

a. limitations of the study

b. correct statistical procedures

c. previous topical research

d. researcher's background in identified topic

Answer: a. limitations for the study. If a research is to be replicated it is important to be aware of variables the researcher was and was not capable of controlling.

**Question: 8-33:**

A concern that research participants may raise or state a concern in signing an informed consent to participate in a study is that in signing that document they may be:

a. giving up their right to fair treatment or legal means regarding maltreatment.

b. required to submit some amount or undetermined amount of payment to participate.

c. held accountable for the outcome of the study.

d. harmed in some way unbeknownst to them.

Answer: a. giving up their right to fair treatment or legal means regarding maltreatment (Mann, 2008; Wester (2011).

**Question 8-34:**

An article appearing in a professional counseling journal reported a power effect size very low. It is likely the reader would expect the researcher to report the decision to:

a. accept the null hypothesis
b. reject the null hypothesis
c. accept the null hypothesis and describe the limitations
d. reject the null hypothesis and describe the limitations of internal validity

Answer: b. reject the null hypothesis

# Unit 8 – Terms

ACTION RESEARCH:
This type of research is designed to solve a problem through the scientific method.

ANALOGUE:
This type of research is conducted under situations or conditions that approximate real counseling contexts. This situation is an experimental simulation of some aspect of the counseling process. The client, the counselor, or the counseling process is manipulated. When discussing analogue research, the topic of naturalistic vs. experimental research usually ensues.

Generalizability is the major disadvantage while the advantages are control, achieving high level of specificity in the operational definition, isolating specific events, and reducing the ethical and practical obstacles in research (Heppner, Kivlighan, & Wampold, 1992).

APPLIED RESEARCH:
This type of research tests a theory and gathers data to support a theory.

ATTRIBUTE VARIABLES:
Attribute variables are characteristics of an independent variable but rarely manipulated such as age, gender, social economic level, grade, certain held experiences, and hobbies.

ATTRITION:
The effect of subjects dropping from the study. The term mortality is often used synonymously with attrition.

COHORT DESIGN:
A type of design whereby subjects are assumed to be similar because they have followed each other through a formal or informal institution. An example would be class after class (year after year) of sorority sisters in a particular sorority at Furman University. This type of design is good for drawing causal inferences from non-equivalent groups.

CONFIDENCE INTERVALS (BAND):
The confidence placed around the fixed value of a population mean. The sample means deviate around this value. Specific values are:

90% = 1.65 SEM  95% = 1.96 SEM  99% = 2.56 SEM

The NCE is more than likely to use whole-number standard errors of measurement; that is, ± 1 or ± 2 rather than 1.65 and 1.96. Instead of using 90% at ± 1.65 times the SEM, it is easier to use ± 1.0 times the SEM for the 68% or two out of three times. Confidence limits are utilized when one desires to know how they would have scored were there not any errors in the process of testing.

CONTROL GROUP:
A group of subjects who do not receive the active treatment. There are different types of control groups such as the no-treatment, waiting list, placebo, and matched. The placebo group believes that it is receiving the treatment.

COVARIANCE:
Covariance permits the researcher control by identifying and taking into account sources of variances not wanted because of concomitant variables. Covariance will take into account or adjust for initial differences in two or more dependent variables. Example: A teaching method for the NCE (independent variable) is lecture-PowerPoint manual study and the researcher wants to adjust for years of study (masters and specialist) at the beginning of the program. Covariance allows for this initial adjustment as long as random assignment is made to the groups and that groups are randomly assigned to treatments. The researcher may want to know how effective the treatment is and realizes the specialist degree students may have more learning thus reducing the effects of the lecture method (statistically eliminating effects of variables or covariates).

DEGREES OF FREEDOM:
The number of scores that are free to vary when conducting a test for significance. Degrees of freedom are calculated by the number in the sample (n) minus one. The restrictions, which are placed upon the data, determine the degrees of freedom.

DEPENDENT VARIABLE:
The effect. It changes as the result of what has been done to it by the independent variable.

DOUBLE BLIND PROCEDURE:
The researcher and participants do not know the hypothesis or who belongs to the treatment or control groups. A single blind is when the subject does not know if he/she is receiving one ingredient or the other (Wiseman, 1999).

EX POST FACTO DESIGN:
A passive design where the independent variable cannot be manipulated. Some of these variables are personality, gender, and race. The after-the-fact quality of an ex post facto design means that the research takes place after the groups have been formed. This design often looks like the posttest-only design (lacks random assignment).

EXTERNAL VALIDITY:
External validity refers to the generalizability of the results. To what group of individuals, setting, and time do the results belong. This generalization is for the population as well as generalizations across specific populations. The interaction of a selection and the treatment refers to generalization across

persons, while the interaction of the setting and the treatment refers to the generalization across settings, and the interaction of history and the treatment refers to the generalization across time.

F-RATIO CHART:
The F-ratio chart is utilized to read the significance level for critical values for the F-test. The F-test is the ratio of two estimates of variance. The use of F-ratio distributions is best used for ANOVA (Cohen, 2001).T-ratio distributions are best used for t-tests.

HISTORY:
History is a threat to internal validity of a research design. History refers to any event that takes place during the time when the treatment is being administered, which may affect the observations. These events can take place in one's work, school, home life, recreation, etc. The best control for this type of threat is to use two groups so that the event affects both groups equally.

INFERENTIAL STATISTICS:
A means to make inferences about a population based on the data from a sample. Inferential statistics is a probability statement that enables one to state the certainty of the results utilizing the descriptive statistics. A degree of confidence is attained as to how closely the data from the sample are close estimates of the value that would be found for a population. If not, then the difference of the two means is accountable to chance. Parametric and non-parametric are two classifications of inferential statistics.

A process of order in which an organism develops physically or mentally. The order is sequential and at a fixed rate for the species.

META ANALYSIS:
A process of combining different studies involving similar variables by estimating the effect size in each study. This way sample sizes can be combined thus increasing the power. To understand knowledge of power and effect size is important (Cohen, 2001).

NON-PARAMETRIC STATISTICS:
A distribution-free type of test where the population values are free of certain assumptions. Non-parametric tests are used when data are in frequency or rank form.

OBSERVER EFFECT:
Gay (1996) refers to this effect as the other side of the observer bias, that is, "when the impact of the observer's participation on the situation is being observed" (p. 222). This type of research is when the observer is observing in a natural situation.

OPERATIONAL DEFINITION:
An operational definition is the researcher's way of defining the constructs in a study. A working definition is achieved which allows the researcher to move from general ideas and constructs to more specific and measurable events.

PARAMETER:
A parameter is a value that summarizes a measurable characteristic of a population. "When data are calculated for an entire population it is referred to as parameters" (Gay, 1996, p. 432).

PILOT STUDY:
This is a min-study utilized in which the process aids in the development of a full-blown research design and study.

PLACEBO EFFECT:
Corrects the John Henry and Hawthorne effects by giving the control group a placebo so that the extraneous effects of treatment are the same for both groups when one group is led to believe it is receiving the treatment, although being administered a nonspecific and ineffective treatment.

POPULATION:
The group of interest to the researcher. The population is a larger group from which a sample is taken to determine an effect.

POWER:
Power is referred to as the probability that a true relationship does exist. Power is dependent upon the statistical test used, alpha level, directionality of the statistical test, the effect size, and the number of subjects (Heppner, Kivlighan, & Wampold, 1992).

QUASI-EXPERIMENTAL DESIGN:
Quasi-experimental designs manipulate one or more independent variables but do not randomly assign subjects to groups. The two classes of quasi-experimental designs are nonequivalent and cohort designs.

RANDOMIZED POSTTEST ONLY:
This is considered to be one of the most powerful designs because it controls for the most threats to internal validity. It is the strongest design for determining a causal relationship from the independent variable to the dependent variable.

REGRESSION:
Regression is a statistical technique used to predict a variable (success) when a second variable (skill) is known, that is, the relationship between success and skill. Regression is usually presented as a linear equation. Regression designs are multiple, stepwise, hierarchical, and simultaneous. Finally, it is defined as a tendency of scores to move toward the mean.

RESEARCH BLINDING:
Research subjects do not have data or information that might influence or distort perceptions. This procedure is used to reduce the effects of bias. A placebo is introduced so that participants do not know who is receiving the placebo or another independent variable, say a drug or non-drug pill.

SNOWBALL SAMPLING:
This procedure allows for the researcher to recruit subjects from among their acquaintances. The method is to start with a small number of participants and build over time. As in all sampling

procedures strengths and weaknesses exist. A strength is to fairly select participants known to be helpful and a disadvantage is community bias, not random, and if the sample is an accurate example of a target population.

SOCIAL VALIDITY:
Social validity is considered in research to insure that the outcome has benefit to the profession or society. Examples of social validity might be to expand a theory (teaching/practice), isolate symptoms (diagnosis), and medication side-effects for the greater good of the client and the profession.

STRATIFIED RANDOM:
Stratified random is when one desires to be certain the norm group is truly representative of the population for which a test is designed. The researcher will classify the target population along certain variables such as age, sex, socio-economic levels, and educational levels and then randomly select a certain percentage per level, based upon census data.

TRUE SCORE:
A true score is considered to be a hypothetical score based upon no measurement error. An individual's average of all scores on a test that has been taken several times, can be estimated, but never precisely known.

TYPE I (Alpha) & TYPE II (Beta) ERRORS:
A Type I (alpha) error occurs when the null hypothesis is true, but the researcher rejects the null hypothesis based on the results of a test of significance. When a researcher rejects the null hypothesis when it is really true a false claim is made. A Type II error (beta) is when the null hypothesis is false, but the researcher accepts it based on results of a test of significance.

TYPE II (Beta):
Type II (Beta) is when the null hypothesis is false, but the researcher accepts it based on results of test of significance. A Type I error is a false negative result meaning a treatment may be excluded by a test score when in fact it may be valid (obtaining a false positive measurement). A Type II error is a false positive result meaning the inclusion of a treatment when in fact the treatment does not produce a change (obtaining a false negative measurement). This indicates that the instrument or test may be imperfect.

WILLOWBROOK STUDY:
The purpose of this study was to determine if gamma globulin was an effective intervention for untreated hepatitis. Children diagnosed with hepatitis virus were fed extracts of stools from infected individuals and later subjects received injections of more purified virus preparations. This study was conducted between the years 1963-1966 at the Willowbrook State Hospital in Staten Island, New York. Additional other documented violations of ethical research practices include the 1932 Tuskegee Study, Nuremberg Codes (injections with typhus fever, petroleum), Milgram's experiment, and Laud Humphrey's "Tearoom Sex" study (Babbie, 2004), Cincinnati Project (military-radiation personnel could sustain), and Johns Hopkins Lead Paint Study (low income housing families given housing but not told).

# Unit 8 - References


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