

DR. ARTHUR'S

NCE

NATIONAL COUNSELOR EXAMINATION

STUDY GUIDE

25+
YEARS

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

Providing NCE Preparation Program Since 1985

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

To secure the
National Board of Certified Counselors (NBCC)
and
Licensed Professional Counselor Certification (LPCC)

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

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Introduction to the NCE Study Guide

I.1 INTRODUCTION

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 (NBCC). 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.

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. 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.

Recently, the questions have been grouped according to five (5) counselor work behaviors. The same 200 questions are grouped into five (5) counselor work behaviors, as well as the eight (8) 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.

I.2 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 area does not appear to be equal.

Human Growth and Development, Social and Cultural Foundations, Helping Relationships, Group Work, Career and Lifestyle Development, Appraisal, Research and Program Evaluation, Professional Orientation, and Ethics are the chapters for study. Originally, the NCE contained 25 questions per section. 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 area appears to be as follows: 8.5% (17) Human Growth and Development, 8% (16) Social and Cultural Foundations, 20.5% (41) Helping Relationships, 10.5% (21) Group Work, 13% (25) Career and Lifestyle Development, 12.5% (25) Appraisal, 10.5% (21) Research and Program Evaluation, and 17% (34) Professional Orientation and Ethics. 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: Fundamentals of Counseling, Assessment and Career Counseling, Group Counseling, Programmatic and Clinical Interventions, and Professional Practice Issues

In 2001 NBCC included work behaviors to the scoring format to represent counselor work areas and behaviors. The same 200 questions designated for the eight content areas are grouped or sorted into the counselor work behaviors and yield percentages of 36%, 15%, 13.5%, 17%, and 18.5% respectively. One only need be concerned with the percentages for the eight content areas.

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

I.2.1 INFORMATION ABOUT THE NCE EXAMINATION AND 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.

- A. Data are being gathered regarding success from individuals who have purchased this manual. In addition, the 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.

- B. I have made the following suggestions based upon my 25 years teaching in a CACREP program and experiences in conducting in excess of 100 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.
- C. The examination is composed of 200 multiple-choice items. 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.
- D. 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.
- E. Your individual score (raw) will 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).
- F. 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.
- G. 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.
- H. 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. The question may look different when you return, plus you may read a future question that will assist your memory and recall. In the past examinees have been able to write on the test booklet so for those left undone write the number down so that it is easier to locate it upon return.

- I. There will be an established process 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.
- J. 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 Exam 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.
- K. 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 areas of most questions. This would indicate that helping relations with 36 + five or 41 contains the most questions per section followed by professional orientations with 29 + five or 34 second. The fewest questions are found in social and cultural foundations (12 + five) and human growth and development (11 + five). The manual is arranged so that these two chapters are at the end. This type of sorting has been the situation since the change in format in 1994 and most recently in 2002.

I.2.2 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-IV. 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-IV) and in addictions. New material for both areas will appear in this revision of the NCE Manual.

- A. 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.

- B. 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.
- C. 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.
- D. 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.
- E. 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.
- F. Answer only the question posed. Do not read into the question or assume what is behind the question.
- G. These are straightforward questions. When answering questions, first think of the basics, how one should begin counseling and proceed from there.
- H. 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.
- I. 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 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.

Question 2:

The counselor's projected emotional reaction to or behavior toward the client is described as:

- a. projection.
- b. catharsis.
- c. quoid and yavis.
- d. countertransference.

Answer: d.

- 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 3:

The overriding client welfare term when resolving an ethical dilemma is:

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

Answer: a. Nonmaleficence refers to doing no harm. For definitions to letters b, c, and d, see Chapter 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 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. 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 is 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 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.

Question 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?

1. industry vs. inferiority
2. autonomy vs. shame
3. initiative vs. guilt
4. identity vs. role confusion

Answer: d. 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 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. 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 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. 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 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. 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.

I.3 CACREP OBJECTIVES

The 200 questions will also reflect the CACREP 2001 Standards. Since the NCE is a cognitive examination sponsored and developed by NBCC, it is reasonable to expect the NCE will represent those objectives. The curriculum objectives for one unit will be illustrated in the introduction chapter and the rest will be illustrated in the study chapters. For this example, unit three-appraisal will serve as an example. The objectives will be abbreviated.

APPRAISAL

Question 10: Objective 1. *Historical perspective.*

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 testing

Question 11: Objective 2. *Basic concepts of standardization or non-standardization.*

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

Question 12: Objective 3. *Statistical concepts.*

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

Question 13: Objective 4. *Reliability.*

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 form may be called parallel

Question 14: Objective 5. *Validity.*

Standard Error of Measurement is to reliability as what is to validity?

- a. standard equivalence
- b. standard deviation
- c. standard error estimate

- d. standard error of validity

Answer: c.

Question 15: Objective 6. *Age, gender, specific population.*

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.

Question 16: Objective 7. *Strategies for selecting, administering, interpreting, instrument, and techniques.*

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. Which one of the following is not a standard score?

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

Answer: d. raw score

Question 17: Objective 8. *Methods of case conceptualization.*

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.

Question 18: Objective 9. *Assessment and diagnose of mental and/or emotional status.*

When a counselor is using an instrument to diagnosis for a dysfunction, 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.

Question 19: Objective 10: *Ethical and legal considerations.*

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.

I.4 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.

I.4.1 ACA FORMATION

I. STANDARD DEVELOPMENT

- A. A.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.
- B. ACES (Association for Counselor Education and Supervision) wanted more rigorous training criteria and broke away to eventually form CACREP, yet NCATE membership was retained.

- C. 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.
- D. CACREP sought membership in NCATE and COPA (Commission on Postsecondary Accreditation)
- E. In 1987, CACREP applied for and received Category A membership on the National Commission for Health Certifying Agencies.

II. NBCC: National Board for Certifying Counselors

- A. 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). A work experience of 2000 hours is required under supervision. For exact requirements 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.
- B. SUBSPECIALTIES
After becoming an NCC and having met specific criteria, one can apply for one of the special examinations now offered through NBCC. Very often an examination is required. A few are: NCGC—National Certified Gerontology Counselor NCSC—National Certified School Counselor CCMHC—Certified Clinical Mental Health Counselor
- C. CONTINUING EDUCATION
To remain in good standing and to retain your NCC, each holder is required to update his/her expertise. 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 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 code of ethics construct for this is informed consent (prior approval and knowledge).

III. 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.

A. FUNDAMENTALS OF COUNSELING

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 and Development, Social/Cultural and Family Foundations, Appraisal of Individuals, and Professional Orientation. 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 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. The process of finding out "Who am I?"

Question 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. 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 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 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 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. Overt interactions are different from the covert messages.

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

Question 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 World View 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. The counselor would, with World View knowledge of the culture, process the identity model and allow for interaction.

2. COUNSELING FOR CAREER DEVELOPMENT

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

Question 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. 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 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. Keep the options open for the student and counsel for exploratory measures.

Question 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. Donald Super's term for the degree of agreement is realism.

Question 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.

Question 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 to rule out any Axis I or II diagnoses.
- c. indicate to him he should seek personal counseling with another counselor while you work with him on a vocational plan.
- d. assess whether his work history has a similar pattern to a parent's work history.

Answer: b. 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 32:

CONTENT: A vocational counselor is counseling with a client who recently experienced, due to de-engineering, a permanent dismissal from work. He does not desire to go on the unemployment rolls and wants permanent and immediate work. The counselor would:

- a. refer him to the Department of Labor.
- b. place a call to VIEW.
- c. refer him to a temporary agency.
- d. recommend the daily newspaper want ads.

Answer: b. A telephone call to VIEW would secure up-to-date information and available job statistics.

3. COUNSELING GROUPS

Question 33:

CONTENT: Group formation and composition is an important part of group work. Group theory recommends that depending upon group goals, membership selection is vital. If the theme of a group is alcohol abuse, the membership is best served when it is:

- a. homogeneous.
- b. heterogeneous.
- c. a closed group.
- d. an open group.

Answer: a. If this is a theme group, then having members who have a problem with alcohol will more than likely aid the group to stay on topic. If it were a heterogeneous grouping, it is possible there would be too few with this topical concern. The fact that the group is open or closed is important but may be secondary to the selection process.

Question 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. 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.

4. COUNSELING FAMILIES

These questions very likely will not require an in-depth working knowledge of family theory process but rather a practical application of dynamics and techniques.

Question 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 therapists or parents would refer to the daughter as the:

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

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

Question 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. Informed consent is probably the first step. Until the seriousness of the problem is determined other alternatives become secondary.

5. PROFESSIONAL PRACTICE

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

Question 37: 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. Not only is this behavior a part of the informed consent procedures but even more important since this client has a history of suicide attempts.

Question 38:

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. Maintain a line of positive regard and respect but politely indicate this material should be taken to therapy.

ADDITIONAL PRACTICE QUESTIONS

Questions in Chapter 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 39:

In a population of clinical clients and documented research findings, which one of the following is not true?

- 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. 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 40:

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 wherein clients are encouraged to talk.

Question 41:

All therapies have a common goal that is:

- a. responsibility assumption.
- b. hope.
- c. emotional bonding.
- d. self-efficacy.

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

Question 42:

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.

Question 43: A new employee in the secretarial pool who is typing psychiatric evaluations consults you because she or he became confused with the DSM-IV axis. She or he had overheard that the new DSM-IV was different than the DSM-III. 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. The GAF is 55. Dependent personality is to be placed on which axis?

- a. I
- b. II
- c. III
- d. IV
- e. V

Answer: b.

Question 44:

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. It is unlikely that NCE examinees will encounter any response calling for "all of the above." This is a teaching question.

Question 45:

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. 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 46:

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. It is unlikely that you will encounter a question formatted as "all of the following except." Most questions are seeking a direct response.

Question 47:

The strongest predictor for client outcome as perceived by the clients is:

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

Answer: b.

Question 48:

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.

Question 49:

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.

Question 50:

To influence a client for change, research data suggests the counselor has a power base. Which one is not considered one of the power bases?

- a. status
- b. referent
- c. expert
- d. legitimate

Answer: a. A more likely format for this question is "What is the power base or the more likely power base?"

Question 51:

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.

Question 52:

Bordin developed a Working Alliance Theory. He believed this alliance is made up of three constituents. Which one is not one of those?

- a. tasks
- b. communication
- c. goals
- d. bonds

Answer: b.

Question 53:

Masters and Johnson developed a 4-stage model for the Human Sexual Response Cycle. The order is:

- a. plateau, excitement, orgasm, resolution
- b. excitement, plateau, orgasm, resolution
- c. excitement, orgasm, plateau, resolution
- d. resolution, excitement, orgasm, plateau

Answer: b.

REFERENCES

Archival Feature: 2001-2002. (2002). ACA Officers and Committees: 2001-2002 (Contacts for state licensing board information). *Journal of Counseling & Development*, 80, 223-250.

Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).

Loesch, L. C., & Nicholas, A. V. (1994). Setting minimum criterion scores for the National Counselor Examination. *Journal of Counseling and Development*, 73, 211-214.

Sweeney, T. J. (1991). CACREP: Precursors, promises, and prospects. *Journal of Counseling and Development*, 70, 667-672.



Professional Orientation

1.1 INTRODUCTION

The professional orientation subtest covers material relevant to the historical development of the profession, professional preparation, role and functions of counselors, 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 code of ethics can be found in most introductory counseling textbooks and an outline is to be found in this chapter. 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 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 chapters and content areas for ethical decision-making. The most recent NCE examinations have included 34 content questions for the professional orientation section, of which 29 count toward your total score. These numbers are subject to change as NBCC makes changes.

1.2 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 2001 Standards. Example questions follow the listed objectives.

- a. professionalism
- b. history and philosophy of counseling
- c. technology, computer literacy, competency
- d. professional roles, functions, relationships
- e. professional organizations (ACA)
- f. professional credentialing-standards
- g. public and private policy processes
- h. advocacy processes
- i. ethical standards

Question 54: Objective a.

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.

Question 55: Objective b.

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.

Question 56: Objective c.

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.

Question 57: Objective d.

Philosophically, counselors share in the belief of helping others with their emotional and mental health. Typically four tenets make up this philosophy. Which one of these four is a tenet?

- 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.

Question 58: Objective e.

The ACA sub-division that is responsible for creating CACREP is:

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

Answer: b.

Question 59: Objective f.

Which of the following corresponds directly to training and an ethical code?

- a. Licensure
- b. Business license
- c. Standard of Care
- d. Certification

Answer: d.

Question 60: Objective g.

One way in which professionals can advocate for the profession of Professional Counseling 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.

Question 61: Objective h.

To ensure that counselors are able to hospitalize suicide ideation clients without securing the cooperation of other mental health providers, counselors need access to a:

- a. 1050.
 - b. 1032.
 - c. 1013.
 - d. 1000.
-

Answer: c.

Question 62: 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.

Question 63:

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 from another person(s).

Answer: d.

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.

1.3 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	Informed Consent
Beers, Clifford	Licensure
Biomedical	Malpractice
Bulimia	Mental Status Exam
Buros, Oscar	Merrill, George
Catharsis	Neurosis
Certification	Parsons, Frank
Confidentiality	Phrenology
Countertransference	Privilege
Davis, Jesse	Public Law 94-192
Dependency (client)	Standard of Care
Duty to Warn	Super, Donald
Eclectic	Supervision
Endogenous	Synergy
Expert Witness	Thanatology
Exception to Privilege	Transference
Galton, Francis	Wounded Healer
Hypochondriasis	Wundt, Wilhelm

1.4 PROFESSIONAL ORGANIZATIONS

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 17 divisions. These 17 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).

ACCA American College Counseling Association

AMHCA American Mental Health Counselors Association

ARCA American Rehabilitation Counseling Association

ASCA American School Counselor Association

AAC Association for Assessment in Counseling

AADA Association for Adult Development and Aging

ACEG Association for Counselors and Educators in Government

ACES Association for Counselor Education and Supervision

AGLBIC Association for Gay and Lesbian Bisexual Issues in Counseling

AHEAD Association for Humanistic Education and Development

AMCD Association for Multicultural Counseling and Development

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

ASGW Association for Specialists in Group Work

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 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 by applying to become a National Certified Counselor (NCC). For those applying for a state license, the ACA code 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.

A profession gains status and maturity through professionalism, 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 64:

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.
- d. American Association for Counseling and Development.

Answer: c. CACREP

1.5 PROFESSION -PROFESSIONALISM

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

1. a specialized body of knowledge and theory-driven research.
2. the establishment of a 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.

VanZandt (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) is 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. on going 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 status of a profession.

1.6 HISTORY OF THE 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 65:

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.

1.7 GUIDANCE-COUNSELING-PSYCHOTHERAPY

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 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 66:

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

1.8 LIFE SPAN STRESS AND PROBLEM AREAS FOR COUNSELORS

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-IV-TR; APA, 2000), information that is essential for the diagnostic and treatment process.

The DSM was originally published in 1952 and was revised in 1994 (APA, 1994) to help providers diagnose their clients' psychological problems. It provides definitions and descriptions of behaviors defined as mental disorders (APA, 1994).

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-IV-TR diagnosis. Each diagnostic classification of a mental disorder in the DSM-IV-TR includes a time frame for each disorder, the number and types of symptoms necessary, and five axes described as follows:

To be ethical, professionals are to use the DSM-IV by professionals with the full knowledge that the DSM-IV is based on the medical model where problems are considered to reside within the individual. The DSM-IV does not consider that the environment has any involvement in the diagnosis. Literature supports that the DSM-IV has traditionally pathologized problems in the counseling of racial and ethnic minorities and women. The use of the DSM-IV perpetuates a paternalistic approach to mental health care and reinforces societal oppression of women and minority clients (Remley & Herlihy, 2005).

Axis I Clinical Syndromes

This axis delineates disorders 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 placed on Axis I.

Axis II Personality Disorders and Mental Retardation

Personality disorders are categorized in three Clusters: A, B, and C. This Axis delineates disorders manifested by chronic, relatively stable abnormalities, mainly including personality disorders such as paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, and dependent. Axis II also includes mental retardation.

Axis III 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.

Axis IV 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.

Axis V Global Assessment of Functioning (GAF)

The GAF provides an adaptive functioning estimate based upon social relations with family and friends, occupational functioning, and use of leisure time. This scale spans 0-100. Two examples: within this span of numbers is 61-70, which indicates mild symptoms but still able to function fairly well; and 51-60, which indicates moderate symptoms and moderate difficulty in social, occupational, or school functioning. Examiners are to know the range of scores for GAF and the direction for illness-wellness.

The DSM-IV-TR 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-IV-TR or 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-IV-TR. The code of ethics recommends caution when applying labels, of any type, to clients.

1.8.1 DSM-IV-TR DISORDERS

1.8.1-1 AXIS 1

A brief introduction and overview to several of the DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) dysfunctions will be presented.

PHOBIA, PANIC, AND ANXIETY DISORDERS

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.

1. **Phobias** (animals, social, agoraphobia) are persistent fear reactions that are out of proportion to the reality of the danger.
2. **Posttraumatic Stress Disorder** symptoms include reliving trauma through dreams and flashbacks, becoming numb, avoiding stimuli similar to the traumatic event, and experiencing over-arousal symptoms of anxiety, irritability, startle reactions, and hypervigilance.
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** is associated by a fear of leaving home since the panic 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.

ANXIETY INFERRED:

Anxiety symptoms are inferred to be underlying these disorders:

1. **Obsessive-Compulsive Disorder (OCD)** is frequently noted when a client experiences uncontrolled compulsive thoughts and engages in rituals and compulsive behaviors in response to those obsessive thoughts. Treatment recommendations include behavior therapy, psychotherapy, and pharmacological (medication) therapy.
2. **Conversion** is when the client experiences a loss of physical functioning that is not the result of a physical disorder, rather it is a psychological disorder.
3. **Dissociative Disorder** is when the identity of the client becomes confused and split. Examples include fugue, Amnestic Disorder, and Dissociative Identity Disorder (previously called multiple personality disorder).

SOMATOFORM DISORDERS:

Six factors comprise the classification of a Somatoform Disorder: 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).

1. **Conversion Disorder** such as hysterical conversion is caused by psychological stress being converted to physical symptoms.
2. **Somatization 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 complaints, and symptoms that emanate from several organs or areas of the body.

DISSOCIATIVE DISORDERS

A dissociative disorder is defined as two or more disconnected mental processes, which co-exist or alternate with each other (Rosenhan & Seligman, 1995). Symptoms include dissociation or split in consciousness, memory lapses and lost time, depersonalization, derealization, identity confusion, identity alteration, and multiple identities.

1. **Amnesia** has several types, categorized as Generalized, Retrograde Posttraumatic, Anterograde, and Selective.
2. **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.

PSYCHOSOMATIC DISORDERS

These disorders are manifestations of the close relationship between physical and emotional conditions. Usually a psychological event precedes the disorder and will continue to contribute to the worsening of the condition. Peptic ulcer and asthma, in some cases, are examples of physical illnesses caused by psychological distress. The diathesis-stress model helps to explain this condition.

AFFECTIVE DISORDERS Subtypes:

1. **Unipolar** depression is manifested by depressive symptoms without mania.

2. **Bipolar** disorder is manifested by mood swings consisting of both depressive and mania symptoms.
3. **Mania** is a "high" characterized by irritability, elation, expansiveness, talkativeness, flight of ideas, and inflated self-esteem (Rosenhan & Seligman, 1995).
4. **Depression** is a "low" mood comprised of emotional, cognitive, motivational, and physical symptoms and behaviors.

SCHIZOPHRENIA

This is a disorder 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.

Subtypes:

1. **Paranoid** type is characterized by auditory and visual hallucinations and delusions of persecution, grandeur, and jealousy (believing that his or her sexual partner is unfaithful).
2. **Disorganized** type is characterized by silliness, incoherence, bizarre, absurd, voluble, and meaningless conversations.
3. **Catatonic** type is manifested by excited or frozen motor behavior.
4. **Residual** type is characterized by an absence of positive symptoms (i.e., hallucinations or delusions). Instead, the client has peculiar behavior, odd thinking, lacks clear role functioning, has poor personal hygiene, and demonstrates negative symptoms (i.e., flat affect, apathy, and anhedonia).
5. **Undifferentiated** type has no specific characteristics that fit into any one of the above categories, yet is manifested by a thought disorder as well as behavioral and affective dysfunctioning.

1.8.1-2 AXIS II:

The DSM-IV (APA, 1994) and DSM-IV-TR (APA, 2000) list 10 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-IV, personality disorders are defined as "inflexible and maladaptive patterns of behavior of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress" (p.630).

Turkat (1990) estimates that at least 50% of clients who have an Axis I diagnosis concurrently have an Axis II 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 (p. 630). 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 the Axis II clients will repetitively utilize the same maladaptive coping skills.

PERSONALITY: According to the DSM-IV (APA, 1994, pp. 629-630) 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

CHILDHOOD DISORDERS:

Rosenhan and Seligman (1995) classify childhood disorders into disruptive, emotional, habitual, and developmental categories.

1. **Disruptive** disorders are those types which are referred to as Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, and Oppositional Defiant
2. **Emotional** disorders are depression, phobias, separation anxieties, and reactive attachments
3. **Habitual** disorders have to do with elimination, speech, tic, anorexia nervosa, and bulimia nervosa
4. **Developmental** disorders include mental retardation, learning, autism (p. 601)

In summary, this introduction to personality and behavior disorders is not intended to be an exhaustive review of the DSM-IV nor of the behavioral and personality disorders. It is a brief exposure to the axes of the DSM-IV and to some of the classifications of behavior. The reader will note some redundancy in material. The intent of the redundancy is to reinforce prior reading and to conserve time in searching for specific information.

Question 67:

A disorder of middle and late adulthood that is considered to be influenced by genetic factors is:

- a. Agoraphobia.
 - b. Attention Deficit Disorder.
 - c. Depression.
 - d. Alzheimer's Disease.
-

Answer: d.

1.9 AXIS II: PERSONALITY ASSESSMENT

According to the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) a personality disorder is an "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested by at least two of the following: cognition, affectivity, interpersonal functioning, or impulse control" (p. 630).

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 an Axis II problem from an Axis I problem is the degree of ego-syntonicity. For example, an individual with an Axis I problem sees the problem as egodystonic and unwanted ("I'm depressed and I want help.")

An individual with an Axis II 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.")

Axis II behavior, according to the definition of DSM-IV, is rigid, inflexible, repetitively nonfunctional, destructive or self-destructive, and tends to use 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.

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 both Axis I and II 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).

1.9.1 ASSESSEMENT PHASES

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 between Axis I and II problems because abnormalities in cognition, affect, behavior, and motor activity may be manifestations of an Axis I problem or combined with an Axis II problem. In other words, Axis II-related cognitive impairment, affective dysfunction, and personality or behavioral abnormalities also can be symptoms of Axis I-related depression, anxiety, or panic disorder. Yet most Axis I disorders are readily apparent. For example, emotional distress and physiological manifestations of stress (i.e., cardiovascular and gastrointestinal symptoms are more often seen in Axis I anxiety disorders, mood disorders, and somatization disorders than in Axis II personality disorders) (Everly, 1989). On the other hand, Axis II disorders are typically manifested by a lack of overt distress. Thus, the interviewer can clarify the difference by determining if subjective distress is present (Axis I) or absent (Axis II) and if modulation of affect is acute (Axis I) or long-standing (Axis II).

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 are not obvious. To bring these to 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.

THE INTERVIEW

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, as follows:

Identifying information—name, age, gender, and demographic variables

Chief complaint—description of symptoms that brought the client to seek help, their intensity and duration, duration of existence, 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 and family, efforts taken to modify or control

Past psychiatric history—previous psychiatric symptoms or disorder, including possible substance abuse and treatment received

Medical history—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

Family history—history of emotional, behavioral, or substance-abuse problems within immediate and extended family members

There are basically four types of interviews during which important diagnostic information is obtained: motivational, 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.

Motivational interview

This type of interview is designed to assess the ambivalence many clients come into treatment 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.). Motivational interviewing focuses on the goals of the client to increase internal motivation through exploring and resolving ambivalence about a change. Prochaska's six stages of readiness for change are 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 parsing 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).

Example of unstructured interview to elicit Axis II behaviors:

When the interviewer suspects the client of being pathologically narcissistic and avoiding responsibility for a failed marriage, he or she might ask open-ended questions about his family and other matters that are important to him, follow up with more specific questions, pay attention to his 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.

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-IV.
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.

ASSESSMENT AND MENTAL STATUS EXAMINATION

After meeting the client, the counselor conducts an assessment. This assessment can take many forms such as a social intake, problem identification, structured interview, referral sourcing, and a diagnostic evaluation based on the DSM-IV diagnostic criteria. The interview is not complete until a mental status examination has been conducted, a detailed profile of a client's appearance, speech, thinking pattern, mood, affect, orientation, and behavior as observed during the interview. In many cases, this

information is readily available without systematic questioning. On the other hand, information necessary for the diagnosis of conditions such as delirium, senile dementia, Alzheimer's dementia, 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, mood, psychomotor behavior, and flow of thought, while the cognitive portion contains content of thought, perception, cognition, insight and judgment.

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 Weschsler Intelligence Scale Children (WISC-R)(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, 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.

1.10 ETHICS

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. Cullari's text is a practical guide for students, trainees, and new professionals.

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 2005 Code of Ethics serves five main purposes. The first is to clarify the nature of the ethical responsibilities held by the members. The second is to support the mission of the ACA. Third is to establish principles that define ethical behavior and best practices. 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. Finally, the code is to be the foundation upon which ethical complaints are to be processed (ACA, 2005).

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 eight sections. 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 cite the underlying principles of a code of ethics as: (a) autonomy; (b) beneficence; (c) nonmaleficence; (d) fidelity; (e) justice; and (f) 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-IV 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.

1.11 PROFESSIONAL AND PRIVATE PRACTICE

Master-level graduates are entering into private practice once they attained the proper legal qualifications such as a state license. Some general questions are beginning 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. The following material does not pertain solely to private but also with hospitals, group practices, and agencies providing mental health services. A few suggested areas to begin your preparation are the 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 (Remlihy & Herlihy, 2005).

1. 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
2. What are some characteristics needed to run a successful business?
 1. self-initiative
 2. business sense
 3. organizational and management abilities
 4. ability and willingness to network
3. Considerations:
Office space
 1. where to locate: 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 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
4. 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. 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). 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.

5. Effectiveness studies: Private practices as well as agency programs are evaluating therapist 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.

6. 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.

7. Pros and Cons of a Private Practice

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

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
8. Topics for Private Practice The Code of Ethics stipulates that counselors respect other professionals that have a different license or respond to a different code of ethics. The 1995 ACA Code of Ethics Standard C.6.a cautions against making claims that might be considered libel or slander. Professional groups respond to different training and credentialing requirements and therefore are not subject to ACA Code of Ethics.

Question 68:

You have become aware of negative statements regarding your practice and ethical behavior made by another counselor in a public forum. You have become aware of these statements and believe them to be unfounded and untrue. This may be considered:

- a. slander.
- b. libel.
- c. vicarious liability.
- d. interrogatories.

Question 69:

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

Question 70:

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. gambling addiction
-

Question 71:

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.
-

Question 72:

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)
-

Question 73:

A clinical director is interested in deriving 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.
-

Answers: 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 68: a. 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 69: d. 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 70: b. Supportive marital therapy is not a DSM-IV diagnosis nor a problem area in which managed care

providers reimburse.

Question 71: d. Although there might not be an exact number as few as possible is the choice.

Question 72: a. 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 73: 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.

1.12 OUTLINE OF THE ACA CODE OF ETHICS

The 2005 Code of Ethics, a revision of the 1995 code was used for this outline (ACA, 2005). Major changes are noted throughout the code. Brief stimulus statements are listed for each topic to facilitate your study. If you have difficulty recalling the specifics of each section, return to the code and reread the entire section.

Section A: The Counseling Relationship

A.1. Welfare of Those Served by Counselors

- A.1.a Primary Responsibility
Respect the dignity and promote welfare of clients
- A.1.b Records
Documentation is to be timely and sufficient for the continuity of services, accurately reflects client progress and services. Errors in records are noted according to policies
- A.1.c Counseling Plans
Plans are devised that offer promise of success and matched with abilities and circumstances of the client. Plans are reviewed on a timely basis for effectiveness and respect for client freedom of choice
- A.1.d Support Network Involvement
Recognize that network services are valued and enlist such services for support, understanding, and involvements of others (client consent)
- A.1.e Employment Needs
Includes: abilities, limitations, physical restrictions, temperament, interest and ability patterns, social skills, education, qualifications; and placement in positions commensurate with interest, culture, and welfare

A.2 Informed Consent in the Counseling Relationship

- A.2.a Informed Consent
Freedom to choose: enter, leave, and/or request information about counseling process and counselor. Rights and responsibilities of the counselor and client

A.2.b **Types of Information Needed**

Types include purposes, goals, techniques, procedures, limitations, potential risks and benefits, counselor qualifications, credentials, experiences, etc. Clients understand diagnosis, use of tests, fees, billings, confidentiality and limitations, records, counseling plans, and right to refuse treatment.

A.2.c **Developmental and Cultural Sensitivity**

Communication of services-use of language for client understanding of informed consent-use of interpreter if needed, and adjust services where needed

A.2.d **Inability to Give Consent**

Minors-include where feasible and be mindful of familial legal rights and responsibilities

A.3 **Clients Served by Others**

When clients are being served by others counselors request release to inform the other professionals and develop positive relationship

Question 74:

A client who has been in counseling for three sessions shares that she or 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/she 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 or she is also seeing a second counselor.
- d. secure a written release to contact this counselor to discuss the counseling.

Answer: d. 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.

A.4. **Avoiding Harm and Imposing Values**

A.4.a. **Avoiding Harm**

A.4.b. **Personal Values**

Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values

A.5. **Roles and Relationships With Clients**

A.5.a. **Current clients**

Prohibits sexual and romantic relationships with current clients, partners or family members

- A.5.b. **Former Clients**
5 year separation from last professional contact to include demonstrating forethought and in writing document that such a relationship will be exploitive and/or potential for harm.
- A.5.c. **Nonprofessional Interactions or Relationships**
Former clients, romantic partners and/or their family members should be avoided except if there is potential benefit
- A.5.d. **Potentially Beneficial Interactions**
If involved the counselor is to document in case records, prior to the interaction, potential benefits and anticipated consequences (with consent) If unintentional harm occurs the counselor is to show evidence of an attempt to remedy.
- A.5.e. **Role Changes in the Professional Relationship**
Changes are to be explained and the client offered refusal rights
- A.6. Roles and Relationships at Individual, Group, Institutional and Societal Levels**
- A.6.a. **Advocacy**
Advocate to examine potential barriers and obstacles that inhibit access/or growth of clients
- A.6.b. **Confidentiality and Advocacy**
Obtain client consent to engage in advocacy for client to improve provision of services to remove barriers or obstacles that inhibit client access, growth, and development.
- A.7. Multiple Clients**
Clarification at the outset the nature of the relationships with each client and if duties create conflicting roles the counselor clarifies, adjusts, and/or withdraws.
- A.8. Group Work**
- A.8.a. **Screening**
Selection based upon needs and goals compatible with the group needs and goals.
- A.8.b. **Protecting Clients**
Protect from physical, emotional, and psychological trauma
- A.9. End-of-Life Care for Terminally Ill Clients**
- A.9.a. **Quality of Care**
Includes high-quality care, self-determination, and opportunity for informed consent, and complete and adequate assessment to make competent, rational decisions
- A.9.b. **Counselor Competence, Choice, and Referral**
Personal, moral, and competence issues and include referrals
- A.10. Fees and Bartering**

- A.10.a. Accepting Fees From Agency Clients
Refuse private fee or remuneration from those entitled to services through employing agency or institution.
- A.10.b. Establishing Fees
Consider financial status of clients and locality and to provide comparable services of acceptable fees
- A.10.c. Nonpayment of Fees
Inform nonpaying inform clients that collection agencies are to be employed
- A.10.d. Bartering
Barter only if the relationship is not exploitive or harmful. Consider cultural implications of bartering and discuss relevant concerns (document)
- A.10.e. Receiving Gifts
Recognize implications and in some cultures, small gifts are a token of respect and gratitude. Counselors account for the therapeutic implications of accepting a gift, monetary value of gift, client's motivation, and counselor's motivation or wanting or declining a gift.
- A.11. Termination and Referral**
- A.11.a. Abandonment Prohibited
Do not abandon or neglect clients
- A.11.b. Inability to Assist Clients
Avoid continuing relationship and aware of culturally and clinically appropriate referral resources and if refused the counselor is to discontinue relationship
- A. 11.c. Appropriate Termination
When client no longer needs assistance, not likely to benefit, or is being harmed. Counselor may discontinue services when in jeopardy of harm by client or other person who has relationship with client and when clients do not pay fees.
- A.11.d. Appropriate Transfer of Services
- A.12. Technology Applications**
- A.12.a. Benefits and Limitations
- A.12.b. Technology-Assisted Services
Distance counseling services counselors determine that clients are intellectually, emotionally, and physically capable of using the applications
- A.12.c. Inappropriate Services
When distance counseling is not feasible counselor considers face-to-face counseling
- A.12.d. Access
Provide reasonable access

- A.12.e. Laws and Statutes
Use of technology does not violate the laws of any local, state, national, or international entity
- A.12.f. Assistance
Seek business, legal, and technical assistance when using technology
- A.12.g. Technology and Informed Consent
11 Specific "do the following" See Code of Ethics (2005)
- A.12.h. Sites on the World Wide Web
8 specific items for World Wide Web use

Section B: Confidentiality, Privileged Communication, and Privacy

B.1. Respecting Client Rights

- B.1.a. Multicultural/Diversity Considerations
Respect differing views toward self-disclosure. Communicate when and with whom information is to be shared
- B.1.b. Respect for Privacy
Solicit private information only when it is beneficial
- B.1.c. Respect for Confidentiality
Do not share confidential information without consent
- B.1.d. Explanation of Limitations
Inform clients throughout the process of the limitation of confidentiality and seek foreseeable situations when confidentiality may be breached

B2. Exceptions

- B.2.a. Danger and Legal Requirements
Confidentiality does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal mandates exist
- B.2.b. Contagious, Life-Threatening Diseases
Justified when clients reveal that they have a disease that is contagious and life-threatening to reveal to third parties. The client is informed prior to making this information known to a third party
- B.2.c. Court-Ordered Disclosures
Subpoena to release confidential/privileged information counselor takes action to secure written permission and/or limit any potential harm
- B.2.d. Minimal Disclosure
Inform and include the client in any disclosure and only minimal information

B.3. Information Shared With Others

- B.3.a. Subordinates
Safeguards in place to ensure that subordinates do not violate confidentiality of the clients
- B.3.b. Treatment Teams
If the client is treated by a team the client is informed of such team involvement, information shared with team, and the purpose in the sharing.
- B.3.c. Confidential Setting
Information shared is in a private setting
- B.3.d. Third-Party Payers
Sharing with third-party when clients have approved
- B.3.e. Transmitting Confidential Information
When information is transmitted through technology sources safeguards for confidentiality is ensured
- B.3.f. Deceased clients
Agency policies protect information of deceased clients

B.4. Groups and Families

- B.4.a. Group Work
Importance and parameters of confidentiality
- B.4.b. Couples and Family Counseling
"Who is the Client" is agreed upon and all members have capacity to give consent

B.5. Clients Lacking Capacity to Give Informed Consent

- B.5.a. Responsibility to Clients
Minors or adult clients who lack capacity to give voluntary consent counselors use state and federal laws to ensure confidentiality
- B.5.b. Responsibility to Parents and Guardians
Inform parents and legal guardians about the role and confidentiality, sensitive to cultural diversity, and respect rights of parents and guardians over the welfare of the children.
Collaborative relationship
- B.5.c. Release of Confidential Information
Minors or adult clients who lack capacity to give voluntary consent counselors seek release from third-party. Cultural sensitivity to safeguard confidentiality

B.6. Records

- B.6.a. Confidentiality of Records
Records retained in safe location and access by others is known and protected

- B.6.b. Permission to Record
Guarantee that permission has been authorized
- B.6.c. Permission to Observe
Authorization for-observation, transcripts, record reviewing by others
- B.6.d. Client Access
Reasonable requests for records by competent clients, limit access and portions thereof when known could cause harm to the client. Document such requests and for multiple clients only those parts pertinent to that client are made available
- B.6.e. Assistance With Records
Assistance and consultation are a part of the release for clients
- B.6.f. Disclosure or Transfer
Written permission from clients and ensure that receivers of such information are sensitive to the nature of confidentiality
- B.6.g. Storage and Disposal After Termination
Store and dispose records according to state and federal statutes. Artistic nature-client required
- B.6.h. Reasonable Precautions
Counselor termination of practice-records safeguarded
- B.7. Research and Training**
- B.7.a. Institutional Approval
Accurate information and prior approval
- B.7.b. Adherence to Guidelines
Understanding/adhering to state, federal, agency, and institutional policies-confidentiality
- B.7.c. Confidentiality of Information Obtained in Research
Violations are risks for participants-maintain all records, risks explained, limits are known to participants
- B.7.d. Disclosure of Research Information
Do not disclose information that could identify a research participant unless prior approval is secured. Data is coded to not identify any client
- B.7.e. Agreement for Identification
Presentations or publications where clients may be identified is permissible when the participants have reviewed the information and given permission
- B.8. Consultation**
- B.8.a. Agreements
Consultant role is explained and confidentiality is respected-agreement by all members

- B.8.b. **Respect for Privacy**
Information acquired is for professional purposes for those involved. Data for written and oral reports uses only pertinent data
 - B.8.c. **Disclosure of Confidential Information**
Colleague consultation-ensure that identification of clients is protected
-

Section C: Professional Responsibility

C.1. Knowledge of Standards

Read, understand, and follow ACA Code of Ethics

C.2. Professional Competence

- C.2.a. **Boundaries of Competence**
Practice within boundaries of competence, education, training, supervised experience, state and national credentials, and professional experience. Gain knowledge, awareness, sensitivity, and skills in working with diverse populations.
- C.2.b. **New Specialty Areas of Practice**
Practice only after education, training, and supervised experience.
- C.2.c. **Qualified for Employment**
Accept only when qualified by education, training, supervised experience, state and national credentials, and experience. Same credentials for those hiring.
- C.2.d. **Monitor Effectiveness**
Monitor effectiveness in practice and make improvements when noted and seek supervision for competent practice
- C.2.e. **Consultation on Ethical Obligations**
Seek consultation from other counselors when ethical dilemmas are encountered
- C.2.f. **Continuing Education**
Awareness to current scientific information in field of practice, competence in practicing skills, and current with diverse populations
- C.2.g. **Impairment**
Signs of impairment (physical, mental, emotional) and do not practice when signs are available. Seeks assistance when such impairments are known and if not rectified discontinue practice until safety assessed to practice. Assess other professionals to recognize any impairment
- C.2.h. **Counselor Incapacitation or Termination of Practice**
Leaving a practice using a prepared plan for transfer of clients.

C.3. Advertising and Soliciting Clients

- C.3.a. Accurate Advertising
No false, misleading, deceptive, or fraudulent information
 - C.3.b. Testimonials
Do not solicit from current clients nor former clients or anyone vulnerable to undue influence
 - C.3.c. Statements by Others
Statements made by others are accurate
 - C.3.d. Recruiting Through Employment
Do not use places of employment to recruit or gain clients, supervisees, or consultees for private practice
 - C.3.e. Products and Training Advertisements
Product development, workshops, training events-accurate advertisements and disclosure to clients to make informed choices
 - C.3.f. Promoting to Those Served
Do not use counseling, teaching, training or supervised relationships to promote products
-

Question 75:

A counselor was interviewed by a newspaper reporter regarding a specialty skill. When the article appeared in the newspaper the writer had included an additional area of expertise as a part of the introduction to the therapist. 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. 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 and C.4.a.

C.4. Professional Qualifications

- C.4.a. Accurate Representation
State only accurate information and correct any known misrepresentation. Clearly identify work that is volunteer and that which is paid, describe continuing education, and specialized training

- C.4.b. Credentials
Claim only current license or certification and in good standing
- C.4.c. Educational Degrees
Identify earned and honorary degrees
- C.4.d. Implying Doctoral-Level Competence
Highest degree only. Do not utilize "Dr" when attained in another field
- C.4.e. Program Accreditation Status
State program accreditation at time of graduation
- C.4.f. Professional membership
Clearly state professional membership (professional and regular)
- C.5. Nondiscrimination**
Do not engage in discrimination based on age, culture, disability, religion, spirituality, gender, gender identity, sexuality orientation, marital status, language preference, and socioeconomic status.
- C.6. Public Responsibility**
- C.6.a. Sexual Harassment
Do not engage in sexual harassment
- C.6.b. Reports to Third Parties
Counselors are accurate, honest, and objective in reporting their professional activities and judgments to third parties
- C.6.c. Media Presentations
Reasonable precautions are taken when reporting advice to media (all sorts) are based on professional literature and practice, consistent with the ACA Code of Ethics, and that a professional relationship has been established
- C.6.d. Exploitation of Others
Do not exploit others in professional relationships
- C.6.e. Scientific Bases for Treatment Modalities
Counselors use techniques and procedures that are based on theory or have a scientific or empirical foundation. If they do counselors must indicate those techniques are unfounded
- C.7. Responsibility to Other Professionals**
- C.7.a. Personal Public Statements
Counselor state they are speaking from a personal perspective when doing so

Section D: Relationships with Other Professionals

D.1. Relationship with Colleagues, Employers, and Employees

- D.1.a. Different Approaches
Respectful of practices by other professional groups and those that differ from that of the counselor
- D.1.b. Forming Relationships
Develop and strengthen interdisciplinary relations from other disciplines
- D.1.c. Interdisciplinary Teamwork
Focus is retained on how to best serve the clients when interdisciplinary relations are involved. This includes participation in the decision-making process for the well-being of the client using values and experiences of the counseling profession
- D.1.d. Confidentiality
Clarifying role expectations are required when participating in legal, institutional policy, or extraordinary circumstances (parameters of confidentiality)
- D.1.e. Establishing Professional and Ethical Obligations
Team decisions raise ethical dilemma attempt to resolve in consideration of well-being of client. If unresolved pursue other avenues for well-being
- D.1.f. Personnel Selection and Assignment
Select competent staff and responsibilities compatible with their experiences and skills.
- D.1.g. Employer Policies
Accepting employment means agreeing with policies and practices of the agency. Adhere to the Standards of Conduct for changing institutional policy for growth of client.
- D.1.h. Negative Conditions
Inform employers of inappropriate policies and practices. Recommend change through constructive action. When changes are not forthcoming and potential harm exists action may be to report to respective certification or state licensure boards, and possible termination from employment
- D.1.i. Protection from Punitive Action
Do not harass or dismiss an employee who has acted in a responsible and ethical manner to expose inappropriate employer policies or practice

Question 76:

A client who terminated three months ago has verbally requested a copy of all materials contained within his/her permanent record. The counselor is employed in an agency that provides counseling services. 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 him/her.
- c. tell the client that the counselor would be willing to let them 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. Reviewing agency policy is a primary step followed by whatever appropriate action is stated in the policy. Letter c. is an ethically appropriate action; however, it does not involve your obligations to the agency, your employer. See D.1.g.

Question 77:

A counselor is interviewing for a therapist position at a local therapy center. The counselor is aware of a particular behavior 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 needs to work. 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 you do not believe in that behavior.
- d. not apply for the position.

Answer: d. The answer to this question is a bit sticky, however letter d. is the ideal 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. See ACA Code D.1.g.

D.2. Consultation

- D.2.a. Consultant Competency
Counselors have appropriate resources, competencies, and referral resources when needed
- D.2.b. Understanding Consultees
Consultants describe problem definition, goals for change, and consequences of intervention
- D.2.c. Consultant Goals
Relationship promotes consultee adaptability and growth toward self-direction
- D.2.d. Informed Consent in Consultation
Review in writing and verbally the rights and responsibilities of both consultants and consultees. Consultant uses understandable language in describing purposes of service, costs, potential risks and benefits, and the limits of confidentiality.

Section E: Evaluation, Assessment, and Interpretation

E.I. General

- E.1.a. **Assessment**
Are to be valid and reliable measurements in comparative or absolute terms Interpretation in qualitative and quantitative assessments
- E.1.b. **Client Welfare**
Do not misuse assessment results and interpretations Respect client's rights to know results
- E.2. Competence to Use and Interpret Assessment Instruments**
- E.2.a. **Limits of Competence**
Use only instruments counselors have been trained and are competent. Appropriate steps are taken to ensure counselors are trained in techniques used when under supervision
- E.2.b. **Appropriate Use**
Appropriate application, scoring, interpretation, and use of assessment instruments relevant to client needs (whether technology or counselor scored and interpreted)
- E.2.c. **Decisions Based on Results**
Decision-making based on assessment results ensure counselors have understanding or educational, psychological, and career measurement (validation, research, and guidelines)
- E.3. Informed Consent in Assessment**
- E.3.a. **Explanation to Clients**
Nature and purposes of assessment and use of results are explained using language of the client.
- E.3.b. **Recipients of Results**
Welfare, understandings, and prior agreements in who receives results. Share accurate and appropriate interpretations results with any group or individual
- E.4. Release of Data to Qualified Professionals**
Release results only to those qualified to interpret results
- E.5. Diagnosis of Mental Disorders**
- E.5.a. **Proper Diagnosis**
Assessment instruments are carefully selected
- E.5.b. **Cultural Sensitivity**
Socio-economic and cultural experiences are considered when diagnosing-culture affects how problems are defined
- E.5.c. **Historical and Social Prejudices in the Diagnosis of Pathology**
Recognize misdiagnosing, pathologizing, and social prejudices-role of mental health in perpetuating these prejudices
- E.5.d. **Refraining From Diagnosis**
Refrain from making diagnosis when the diagnosis may cause harm

E.6. Instrument Selection

- E.6.a. Appropriateness of Instruments
Validity, reliability, psychometric limitations, and appropriateness
- E.6.b. Referral Information
Third party referral for assessment-specific questions, objective data
- E.6.c. Culturally Diverse Populations
Caution in selecting instruments for culturally diverse-avoid lack of sufficient psychometric data

E.7. Conditions of Assessment Administration

- E.7.a. Administration Condition
Same conditions in standardization however, may alter for clients with disabilities, conditions are noted in interpretations. May be considered invalid results
- E.7.b. Technological Administration
Accurate results when using technology
- E.7.c. Unsupervised Assessments
Unless specified unsupervised assessments are not permitted
- E.7.d. Disclosure of Favorable Conditions
Favorable conditions are made known to the client

Question 78:

The counselor is using a computerized report for a test interpretation with a client. The code of ethics and the manual indicate that the interpreter must:

- 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. A manual is to be present in order to answer any questions that come about as a result of the interaction.

E.8. Multicultural Issues/Diversity in Assessment

Caution in using normed tests on other populations with client. Effects of age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status (administration, interpretation, place results in perspective with other factors)

E.9. Scoring and Interpretation of Assessments

- E.9.a. Reporting
Note reservations for validity/reliability due to circumstances and inappropriateness of norms
- E.9.b. Research Instruments
Caution in interpreting results of research instruments not revealing sufficient technical data to support results. Purposes are to be stated
- E.9.c. Assessment Services
Providing scoring and results confirm validity, describe purpose, norms, validity, reliability, and application of procedures. Automated results considered professional-professional
- E.10. Assessment and Security**
Integrity and security of tests. Do not reproduce or modify published assessments without permission from publisher
- E.11. Obsolete Assessments and Outdated Results**
Do not use obsolete or outdated
- E.12. Assessment Construction**
Use scientific procedures, standards, and current professional knowledge
- E.13. Forensic Evaluation: Evaluation for Legal Proceedings**
- E.13.a. Primary Obligations
Primary obligation for evaluation is to produce objective findings based on information and techniques appropriate to the evaluation. Limit reports to testimony
- E.13.b. Consent for Evaluation
Informed in writing (purpose not counseling, who receives report) unless court orders evaluation without written consent. Children or vulnerable adults written consent from parent or guardian
- E.13.c. Client Evaluation Prohibited
Do not evaluate for forensic purposes present clients and vice versa
- E.13.d. Avoid Potentially Harmful Relationships
Avoid potentially harmful professional or personal relationships with family members, romantic partners, and close friends

Section F: Supervision, Training, and Teaching

F.1. Counselor Supervision and Client Welfare

- F.1.a. Client Welfare
Monitor services provided by other counselors-in-training (client welfare and supervisee clinical performance and professional development). Meet regularly to review case notes and clinical work.

- F.1.b. Counselor Credentials
Clients aware of qualifications of the supervisee
- F.1.c. Informed Consent and Client Rights
Inform supervisee of client rights and privacy/confidentiality, professional disclosure information, and how supervision process works. Information is provided as to the records and how they will be used.
- F.2. Counselor Supervision Competence**
- F.2.a. Supervisor Preparation
Counselors are trained in supervision methods and techniques, continuing education to include both counseling and supervision.
- F.2.b. Multicultural Issues/Diversity in Supervision
Aware of role of multiculturalism in supervisory relationship
- F.3. Supervisory Relationships**
- F.3.a. Relationship Boundaries With Supervisees
Professional, personal, and social relationships boundaries are maintained. Avoid nonprofessional relationship with current supervisees. If in other roles minimize potential conflicts and explain responsibilities
- F.3.b. Sexual Relationships
Do not engage in sexual or romantic relationships
- F.3.c. Sexual Harassment
Do not condone or subject supervisees to sexual harassment.
- F.3.d. Close Relatives and Friends
Do not supervise close relatives or friends
- F.3.e. Potentially Beneficial Relationships
Power differential: Precautionary steps taken when there is potential benefit from a nonprofessional relationship. Open discussions are encouraged and documentation of rationale, benefits, and consequences of this relationship.
- F.4. Supervisor Responsibilities**
- F.4.a. Informed Consent for Supervision
Integrate informed consent and participation (policies and procedures they adhere too and due process)
- F.4.b. Emergencies and Absences
Clearly state procedures for contact and alternative supervisors
- F.4.c. Standards for Supervisees
Make supervisee aware of standards and legal responsibilities

- F.4.d. Termination of the Supervisory Relationship
Supervisors or supervisees have the right to terminate with adequate notice (reasons provided, efforts to resolve differences if exist, referrals if necessary).
- F.5. Counseling Supervision Evaluation, Remediation, and Endorsement**
- F.5.a. Evaluation
Document on-going performance appraisal and feedback
- F.5.b. Limitations
Aware of limitations of supervisees that might impede performance, assist in remedial help, recommend dismissal when not able to provide competent services, seek consultation, and document the decisions.
- F.5.c. Counseling for Supervisees
Refer and do not counsel supervisees (impact of interpersonal competencies, relationship, and professional functioning)
- F.5.d. Endorsement
Endorse supervisees for certification, licensure, employment, or completion of training only when they believe supervisee is competent.
- F.6. Responsibilities of Counselor Educators**
- F.6.a. Counselor Educators
Skilled as teachers and practitioners (knowledgeable in ethical, legal, and regulations; applying knowledge, and aware of responsibilities) Serve as role models
- F.6.b. Infusing Multicultural Issues/Diversity
Integrate multiculturalism material into all courses
- F.6.c. Integration of Study and Practice
Integrate academic materials and supervised practice
- F.6.d. Teaching Ethics
Teach ethical responsibilities and standards
- F.6.e. Peer Relationships
Rights of peers are not compromised when supervisees lead counseling groups or provide clinical supervision.
- F.6.f. Innovative Theories and Techniques
When teaching theories/techniques without empirical foundations define as "unproven"
- F.6.g. Field Placements
Policies are defined for field placements. Roles and responsibilities are stated for students, site supervisor, and program supervisor.

- F.6.h. Professional Disclosure
Counselors-in-training disclose status to clients at field placement they are students and explain limits to confidentiality and secure permission to use any information

F.7. Student Welfare

- F.7.a. Orientation
Prospective students (type and level of skill/knowledge acquisition required, program training goals, objectives and mission, bases for evaluation, training components, types of supervision settings, evaluation and dismissal policies, and up-to-date employment prospects)
- F.7.b. Self-Growth Experiences
Requirements for self-disclosure or self-growth are stated in admission and materials. Students are made aware of ramifications of self-disclosure when primary role of counselors is a teacher, trainer, and/or supervisor. Evaluation of experiential training experiences state academic standards that do not depend on student's self-disclosure. Professional help may be recommended.

Question 79:

When students apply for admission to a training program in counseling 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.
- d. will have to compete with social workers, family therapists, and psychologists for work positions.

Answer: c. 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 Code F.7.a.

F.8. Student Responsibilities

- F.8.a. Standards for Students
Follow ACA Code of Ethics and adhere to laws, regulatory policies, and rules and policies
- F.8.b. Impairment
Refrain from offering counseling services when physical, mental, or emotional problems are likely to harm clients

F.9. Evaluation and Remediation of Students

- F.9.a. Evaluation
Levels of competence are expressed prior, during, and throughout training (didactic and clinical competencies)
- F.9.b. Limitations
Inability to achieve competence the counselor educator will assist in remedial assistance, professional consultation, document decisions, and recourse in a timely manner
- F.9.c. Counseling for Students
Counseling as a part of remediation provide acceptable referrals
- F.10. Roles and Relationships Between Counselor Educators and Students**
- F.10.a. Sexual or Romantic Relationships
Do not engage in sexual or romantic relationship with students
- F.10.b. Sexual Harassment
Do not condone or subject students to sexual harassment
- F.10.c. Relationships With Former Students
Power differential with open discussions and with former students when engaging in social, sexual, or intimate relationship
- F.10.d. Nonprofessional Relationships
Avoid nonprofessional relationship in which risks of potential harm to students that may compromise the training experience or grade. Do not accept any form of fees, commissions, reimbursement, from a site for student or supervisee placement.
- F.10.e. Counseling Services
Do not serve as counselors to current students
- F.10.f. Potentially Beneficial Relationships
Power differential: if potentially beneficial precautions are taken.
- F.11. Multicultural/Diversity Competence in Counselor Education and Training Programs**
- F.11.a. Faculty Diversity
Committed to recruiting and retaining a diverse faculty
- F.11.b. Student Diversity
Recruit and retain a diverse student body. Demonstrate a commitment to multicultural/diversity competence
- F.11.c. Multicultural/Diversity Competence
Integrate multicultural/diversity competency into training and supervision

Section G: Research and Publication

G.1. Research Responsibilities

- G.1.a. Use of Human Research Participants
Plan, design, conduct, and report research with respect to ethical principles, federal and state laws, institutional regulations, and scientific standards
- G.1.b. Deviation From Standard Practice
Consult and observe stringent safeguards to protect rights of participants when deviations take place
- G.1.c. Independent Researchers
When independent researchers do not have access to an IRB they consult researchers who do have access.
- G.1.d. Precautions to Avoid Injury
Welfare of participants to protect them from injurious psychological, emotional, physical, and or social effects
- G.1.e. Principal Researcher Responsibility
Responsibility lies with principal researcher. Others share in ethical obligations and responsible for their own actions
- G.1.f. Minimal Interference
Avoid causing disruptions in the lives of participants
- G.1.g. Multicultural/Diversity Considerations in Research
Sensitive to research procedures that take into account cultural considerations.
- G.2. Rights of Research Participants**
- G.2.a. Informed Consent in Research
Contains language and includes purpose and procedures, untried procedures, discomforts and risks, benefits or changes, alternative procedures advantageous, answers to inquiries concerning procedures, limitations to confidentiality, format and target audiences for dissemination of information, and free to withdraw.
- G.2.b. Deception
Do not perform research where deception exists unless alternative procedures are not possible. Justification for such research needs to be made known and regardless of value should harm to client be made research is not conducted. If no harm occurs such deception is to be made immediately known upon completion of the research.
- G.2.c. Student/Supervisee Participation
Information about participants It is made clear that participation in research does not affect academic standing or supervisory relationship. Alternatives are provided for those desiring not to participate.
- G.2.d. Client Participation
Informed consent notes freedom to choose clause and protect client from adverse affects from declining or withdrawing

- G.2.e. Confidentiality of Information
Information secured about research participants is confidential. Explanations are given when this cannot be guaranteed.
- G.2.f. Persons Not Capable of Giving Informed Consent
Persons not capable of giving informed consent obtain agreement from legally authorized persons
- G.2.g. Commitments to Participants
Honor all commitments to research participants
- G.2.h. Explanations After Data Collection
Full clarifications are provided participants after the study (remove misconceptions)
- G.2.i. Informing Sponsors
Inform sponsors regarding research procedures and outcomes.
- G.2.j. Disposal of Research Documents and Records
Destroy records or documents within a reasonable period of time of the study
- G.3. Relationships With Research Participants**
- G.3.a. Nonprofessional Relationships
Avoid nonprofessional relationships with research participants
- G.3.b. Relationships With Research Participants
Do not develop a relationship with research participants (sexual or romantic)
- G.3.c. Sexual Harassment and Research Participants
Do not condone or involve research subjects with sexual harassment
- G.3.d. Potentially Beneficial Interactions
Nonprofessional interaction between researcher and participants: report why beneficial, rational for, initiated with consent of participant-unintentional harm occurs due to nonprofessional interaction, researcher shows evidence of an attempt to rectify the harm.
- G.4. Reporting Results**
- G.4.a. Accurate Results
Plan, conduct, and report research accurately, include a limitation section, do not participate in misleading and/or fraudulent research, distort data, misrepresent data or bias their results. All variables are mentioned and conditions that may have affected results, and to describe extent of applicable for diverse populations
- G.4.b. Obligation to Report Unfavorable Results
Report results that are unfavorable are not withheld
- G.4.c. Reporting Errors
Significant errors require counselors to take appropriate steps to correct errors

- G.4.d. Identity of Participants
Disguise the identity of respective participants-where participants self-identify, take active steps to ensure data are adapted/changed to protect the identity and welfare of all parties
 - G.4.e. Replication Studies
Obligated to make available sufficient original research data to qualified professionals for replication studies
-

Question 80:

A researcher has completed all aspects of an investigation regarding cultural diversity. In reporting the results, because humans are involved who may be offended by some of the results, the researcher should report:

- a. both favorable and unfavorable results.
 - b. only those results which address the objectives of the study.
 - c. only the favorable results which lead to additional researching.
 - d. the strengths of the study.
-

Answer: a. The researcher is obligated to report both favorable and unfavorable results. See G.4.b.

G.5. Publication

- G.5.a. Recognizing Contributions
Give recognition to previous work on topic, observe copyright laws, and full credit to those to whom credit is due
- G.5.b. Plagiarism
Do not plagiarize
- G.5.c. Review/Republication of Data or Ideas
Prior publications are made known to publishers and reviewers when submitting
- G.5.d. Agreement of Contributors
Agreements are made in advance of the work when conducting research for publication.
- G.5.e. Student Research
Students are principal authors when work is substantially the work of the student.
- G.5.f. Duplicate Submission
Submit to only one journal at a time. Permission from previous publication is submitted for a partial publication
- G.5.g. Professional Review
Reviewers respect confidentiality and proprietary rights of those who submitted. Standards are utilized to make decisions, do so in a timely manner, and based on research methodologies.

Section H: Resolving Ethical Issues

H.1. Standards and the Law

- H.1.a. Knowledge
Know ACA Code of Ethics and other professional codes to include those of licensure boards. Lack of this knowledge is not a defense.
- H.1.b. Conflicts Between Ethics and Laws
When conflicts known counselors inform ACA and take action to resolve. If unable to resolve respect adherence to the law, regulations, or governmental authority.

H.2. Suspected Violations

- H.2.a. Ethical Behavior Expected
Ethical behavior is expected of all counselors. Appropriate action is required should information indicate a violation of ethics
- H.2.b. Informed Resolution
If aware of ethical violation the first action is to attempt resolution informally as long as confidentiality rights are not breached
- H.2.c. Reporting Ethical Violations
Further action is required if an ethical behavior has harmed or likely to harm a person or organization is not resolved through individual interaction. This action can be a referral to state or national ethical committees, or state licensing boards. This standard is not valid if confidentiality rights would be breached or when counselors have been retained to review such behaviors
- H.2.d. Consultation
Consult with others when uncertain of an ethical violation
- H.2.e. Organizational Conflicts
If ethical conflict with an organization is a threat to the ACA Code of Ethics counselors are encourage to consult with others who are knowledgeable about ethics
- H.2.f. Unwarranted Complaints
Do not initiate or participate in filing of ethics complaint due to reckless disregard for the facts
- H.2.g. Unfair Discrimination Against
Complainants and Respondents Do not deny employment, advancement, admission based on ethic complaint. Outcome of proceedings might be otherwise

H.3. Cooperation With Ethics Committees

Enforce and cooperate in reviews regarding the ACA Code of Ethics

Question 81:

Counselor A becomes aware that Counselor B is taking advantage of certain clients. A few of Counselor B's clients are stockbrokers and conversations early in each session 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. determine this is not an informed choice, 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 ok since the counselor told you that this material is covered by the confidential rule or privilege and the client is not harmed.

Answer: a. Since the Counselor 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. See H2. An aspect of professionalism is to police or monitor the profession or members.

1.12.1 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 & Koepl, 1993).

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

Question 82:

A counselor when sharing informed consent procedures with a client is involving more than one of the principles that underlie the 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 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.

1.12.2 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

- a. discussing with the client reasons for terminating
- b. providing the client opportunities to make changes whereby the counseling may continue
- c. providing a written notice of termination
- d. including one to three sessions for termination
- e. providing a number of referrals
- f. providing places to contact in case of an emergency
- g. providing a summary of the termination that is placed in the file but not transferred to another therapist
- h. 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.

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

4. Allegiance dilemmas:

- a. school of thought vs. client welfare
- b. professional community vs. new reference groups

3. Role dilemmas:

- a. educator vs. healer
- b. scientist-practitioner vs. psychotherapist

- c. clinician vs. researcher

4. Responsibility dilemmas:

- a. client welfare vs. client autonomy

2. Impasse dilemmas:

- a. dealing with vs. risking harm
- b. therapist vulnerability vs. resolution

1.12.3 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.

- I.
 - A. Interpret: Determine if one's actions are bringing about consequences that affect client welfare.
 - B. Formulate: Course of action
 - Intuitive level: development perspective and prior learning
 - 1. Critical-evaluation level: 3 tiers
 - a. Ethical rules composed of autonomy, nonmaleficence, beneficence, justice truthful, confidentiality, informed consent, faithful
 - b. Integrating competency: decide how client will act
 - c. Implement: perseverance, resoluteness, and character
- II. 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, behavioral).
- III. A third developmental process was presented by Van Hoose and Kottle (1985) that was developed using stages from the work of Piaget and Kohlberg. Van Hoose's five stage model is as follows:
 - 1. Punishment Orientation
 - 2. Institutional Orientation
 - 3. Societal Orientation

4. Individual Orientation
5. Conscience Orientation

1.12.4 ENFORCEMENT

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.

1.12.5 LEGAL ISSUES

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 checks 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 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.
3. Have a lawyer available for consultation.

1.12.6 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 (Buckley Amendment)

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.

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:

- statement of child's present levels of educational performance
- annual goals and short-term instructional objectives

- statement of specific education services provided in which child can participate in regular programs
- projected date for initiation and anticipated duration
- appropriate objective criteria for determining on an annual basis whether instructional objectives are being met

1.12.7 ETHICAL ISSUES

A. PRIVACY/CONFIDENTIALITY/ PRIVILEGE

ACA Code B.1

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 than 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—exceptions are possible danger—duty to warn relationship—may not know until after communication

Question 83:

For the past six months the counselor has been counseling regularly with a 17-year-old male. During this session he reveals some material that when combined with previous work with him causes the

counselor to consider a breach of confidence. Of the following, an ethically sound reason to break confidence is when:

- 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.

Alternatives a. and c. permit the counselor to break confidence. 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.

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 84:

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 a manager with whom he has conducted some managerial training. The manager 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 the managers company as a manager in the same division as he. The counselor had first heard this in a session with Mark Brice although by now it is public knowledge that he 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. 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

1. 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:
 - a. child abuse
 - b. child custody
 - c. 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. Generally, minors are not granted involuntary informed consent. There are some exceptions, however, where therapists make 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; or (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.

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: (a) use by the counselor of psychotherapy notes for providing treatment, payment, or health care operations; (b) 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; (c) use or disclosure by the covered entity to defend a legal action or to other proceedings brought by the individual; (d) use with respect to the oversight of the originator of the psychotherapy notes, such as peer review and (e) 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)

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 (Remely & Hurley, 2010). This does not include case notes if retained as separate from the student file and not made available to anyone else.

RECORDS ACA Code B.6 form the above

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.

There are three types of records: institutional, private, and practitioner's notes and working notes.

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.

Private practitioner's records are not covered by specific legislation for client access but are retrievable through court proceedings.

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.

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, & Knapp, 1987; VandeCreek & Knapp, 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).

COMPETENCE ACA Code C.2

Section C of the ACA code 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. This is accomplished through continuing education activities. Pipes and Davenport (1990) describe competence as accurately representing your training, recognizing limits of confidence, 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 a thorough 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:

- a. relationship must have existed
- b. negligence or dereliction of duty
- c. 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 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 one's knowledge and practice.

Question 85:

At a local mental-health facility the admissions clerk introduces a beginning counselor intern to his/ her first client. In so doing the clerk identifies the intern as the therapist. On the way to the office the client calls the intern Dr. Last Name. The intern continues on with his/ her conversation 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. Section C.4.a.

Question 86:

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. The most professional and ethical answer is to immediately correct the misinformation.

Question 87:

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. Section A-2.

RESEARCH ACA Code G:

The 1995 revision of the ethical code for research is essentially the same as the 1988 ethical code. The issue of nonmaleficence is 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 of the procedures, techniques, duration, dissemination of results, and the freedom to withdraw at any time. 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 of 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 88:

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. 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.

Question 89:

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. is legally correct. 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 90:

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

- a. privacy
 - b. informed consent
 - c. volunteerism
 - d. research design
-

Answer: a.

Question 91:

The Milgram study of obedience and the Tuskegee syphilis study raised an ethical dilemma. This dilemma had to do with what?

- a. informed consent
- b. design error

- c. sampling strategies
- d. dual role

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

E. TESTING AND EVALUATION

ACA Code 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 found in Chapter 3) 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 92:

A counselor has become convinced of the usefulness of the Myers-Briggs Type Indicator and has begun to use the results in marriage counseling. 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 what?

- a. counselor should interpret these results separately for each client
- 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: b.

Question 93:

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. avoid this type of exposure as a private therapist. It will alienate potential clients and dilute your effectiveness should they become clients.
- 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: b. All of the other options reflect a form of deception, self-interest, and lack of recognizing competence areas.

F. MULTIPLE RELATIONSHIPS (DUAL RELATIONSHIPS)

ACA Code A.

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.

Boundary Issues:

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 percent. The 1995 ACA Code specifies a time period of two years along with a supervisory review before a relationship with a former client is renewed (ACA, 1995).

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.

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.

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 (as cited in Corey, et al., 1988) 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, and 6) deficits due to naiveté. Cottone and Tarvydas (2003) cite the research of Borys and Pope and Smith and Fitzpatrick who 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 94:

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. 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 the 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.

Question 95:

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. The supervisor has crossed the line of supervising and is involved in psychotherapy or boundary violation.

Question 96:

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. 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. Do no harm. This is an example of a dual role.

Question 97:

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. Once again this may appear to be unfair to the partner; however, the therapist has a professional relationship contract with the client.

1.13 PUBLICATIONS

Informing professionals is an important function of ACA, subdivisions, and affiliates. The major publication is *Counseling Today*. This professional publication is 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.

1.14 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

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.

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).

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

STANDARD OF CARE:

Because of the multiple theories of psychotherapy, a standard of care is hard to establish (Beis, 1984). However, a counselor is usually held to the standard of other good counselors in the community and other similar communities. A standard of care is established by a professional group but is often interpreted during court proceedings by the testimony of expert witnesses. Although a standard of care is interpreted by best care principles the quality of work consists of the clinician's ability to diagnose and/or assess, treat and intervene, and effect curative agents known for different conditions.

Specific standards are defined in the court of law in the form of accused negligence or malpractice (Huber & Baruth, 1987).

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.

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.

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.

REFERENCES

- American Counseling Association Code of Ethics and Standard of Practice. (1995, June). *Counseling Today*, 32 (12), 33-40.
- American Counseling Association (2005). ACA Code of ethics. Alexandria, VA: ACA.
- American Counseling Association Ethics Committee (1991). Report of the ACA committee: 1198-1991. *Journal of Counseling and Development*, 70(2), 278-280.
- American Psychiatric Association. (1994). Diagnostic statistical manual of mental disorder (4th ed.). Washington, DC: APA.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (DSM-IV-TR). (4th ed.). Washington, DC: Author.
- Anderson, B. S. (1992). A case for standards of counseling practice. *Journal of Counseling & Development*, 71, 22-26.
- Anderson, D., & Freeman, L.T. (2006). Report of the ACA ethics committee: 2004-2005. *Journal of Counseling & Development*, 84 (2), 225-227.
- Aubrey, R. F. (1977). Historical development of guidance and counseling and implications for the future. *The Personnel and Guidance Journal*, 55(6), 288-295.
- Barlow, D. H., & Durand, V. M. (2002). Abnormal psychology: An integrative approach. Belmont, CA: Wadsworth Thomson Learning.
- Beauchamp, T., & Childress, J. (1979). *Principles of biomedical ethics*. New York: Oxford University.
- Beauchamp, T., & Childress, J. (1994). *Principles of biomedical ethics* (5th ed.). Oxford: Oxford University Press.
- Beis, E. B. (1984). Mental health and the law. Rockville: Aspen.
- Bergin, J. D., Maynard, W., Prillaman, C., & Nadkarni, M. (1997). *Medicine recall*. Baltimore, MD: Williams & Wilkins.
- Bergner, R. M. (1998). The linchpin concept. *American Journal of Psychotherapy*, 52(3), 287-301.
- Bersoff, D. N., & Koeppel, P. M. (1993). The relationship between ethics codes and moral principles. *Ethics and Behavior*, 3, 345-357.
- Bowman, V. E., Hatley, L. D., & Bowman, R. L. (1995). Faculty-student relationships: The dual role controversy. *Counselor Education and Supervision*, 34(3), 232-242.
- Brammer, L. M., & Shostrom, L. (1960). *Therapeutic psychology*. Englewood Cliffs, NJ: Prentice-Hall.
- Brammer, L. M., & Shostrom, L. (1977). *Therapeutic psychology* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Brown, D., & Srebalus, D. J. (2003). Introduction to the counseling profession (3rd ed.). Boston: Allyn & Bacon.
- Browning, C. H., & Browning, B. J. (1996). *How to partner with managed care*. Los Alamitos, CA: Duncliff's International.
- Burke, J. F. (1989). Contemporary approaches to psychotherapy and counseling: The self-regulation and maturity model. Pacific Grove, CA: Brooks/Cole.
- Capuzzi, D., & Gross, D. R. (2001). Introduction to the counseling profession. Boston: Allyn & Bacon.
- Coleman, E., & Schaefer, S. (1986). Boundaries of sex and intimacy between client and counselor. Special issue: Professional ethics. H. Stadler (Ed.) *Journal of Counseling and Development*, 64(5), 341-344.
- Corey, G., Corey, M. S., & Callanan, P. (1988). *Issues and ethics in the helping profession*. Monterey: Brooks/Cole.
- Corey, G., Corey, M.S., & Callanan, P. (2003). *Issues and ethics in the helping profession*. (6th ed.). Pacific Grove: Brooks/Cole.

- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13). counseling.org
- Cottone, R. R., & Tarvydas, V. M. (2003). *Ethical and professional issues in counseling* (2nd ed.). Upper Saddle River, NJ: Merrill Prentice Hall.
- Cullari, S. (2001). *Counseling and psychotherapy: A practical guidebook for students, trainees, and new professionals*. Needham Heights, MA: Allyn & Bacon.
- Day, S. X. (2004). *Theory and design in counseling and psychotherapy*. Boston, MA: Houghton Mifflin Co.
- Dryden, W. (1987). *Therapists' dilemmas*. New York: Hemisphere
- Edgerton, J. E., & Campbell III, R. J. (1994). *American psychiatric glossary* (7th ed.). Washington, DC: American Psychiatric Press.
- Everly, G. S. (1989). *The clinical guide to the treatment of the human stress response*. New York: Plenum.
- Fong, M. L. (1993). Teaching assessment and diagnosis within a DSM-III-R framework. *Counselor Education and Supervision*, 32, 276-286.
- Fong, M. L. (1995). Assessment and DSM-IV diagnosis of personality disorders: A primer for counselors. *Journal of Counseling and Development*, 73, 635-639.
- Fretz, B. R., & Mills, D. H. (1980). *Licensing and certification of psychologists and counselors*. San Francisco: Jossey-Bass.
- Garcia, J., Glosoff, H. L., & Smith, J. L. (1994). Report of the ACA ethics committee: 1993-1994. *Journal of Counseling & Development*, 73(2), 253-255.
- Garcia, J., Salo, M., & Hamilton, W. M. (1995). Report of the ACA ethics committee: 1994-1995. *Journal of Counseling & Development*, 74(2), 221-223.
- Gibson, R. L., & Mitchell, M. H. (1995). *Introduction to counseling and guidance* (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Gibson, R. L., & Mitchell, M. H. (2003). *Introduction to counseling and guidance* (6th ed.). Upper Saddle River, NJ: Merrill-Prentice Hall.
- Gladding, S. T. (1988). *Counseling: A comprehensive profession*. Columbus, OH: Merrill Publishing.
- Gladding, S. T. (1996). *Counseling: A comprehensive profession*. Englewood Cliffs, NJ: Prentice-Hall.
- Goodman, M., & Teicher, A. (1988). To touch or not to touch. *Psychotherapy*, 25(4), 492-500.
- Granello, P. F., & Witner, J. M. (1998). Standards of care: Potential implications for the counseling profession. *Journal of Counseling and Development*, 64, 635-637.
- Gregory, R. J. (2000). *Psychological testing: History, principles, and applications* (3rd ed.). Boston: Allyn & Bacon.
- Gregory, S., & Lee, S. (1986). Psychoeducational assessment of racial and ethnic minority groups: Professional implications. *Journal of Counseling and Development*, 64, 635-637.
- Gustafson, K. E., & McNamara, J. R. (1987). Confidentiality with minor clients: Issues and guidelines for therapists. *Professional Psychology: Research and Practice*, 18(5), 503-508.
- Herlihy, B., & Corey, G. (1997). *Boundary issues in counseling: Multiple roles and responsibilities*. Alexandria, VA: American Counseling Association.
- Herlihy, B., & Sheeley, V. L. (1987). Privileged communication in selected helping professions: A comparison among statutes. *Journal of Counseling and Development*, 65(9), 479-483.
- Herr, E. L., & Cramer, S. H. (1992). *Career guidance and counseling through the lifespan: Systematic approaches* (4th ed.). New York: Harper Collins.

- Herr, E. L., & Cramer, S. H. (1996). *Career guidance and counseling through the lifespan: Systematic approaches* (5th ed.). New York: Harper Collins College Publishing.
- Hodges, K., & Cools, J. N. (1990). Structured diagnostic interviews. In A. M. LaGreca (Ed.), *Through the eyes of a child* (pp. 109-149). Needham Heights, MA: Allyn & Bacon.
- Hohenshil, T. H. (1996). Editorial: Role of assessment and diagnosis in counseling. *Journal of Counseling & Development*, 75, 64-67.
- Hotelling, K. (1988). Ethical, legal, and administrative options to address sexual relationships between counselor and client. *Journal of Counseling and Development*, 67(4), 233-236.
- Huber, C. H., & Baruth, L. G. (1987). Ethical, legal and professional issues in the practice of marriage and family therapy. Columbus, OH: Merrill.
- Keese, G. S. (Ed.). (1990, Winter). Reflections from the past. *CACREP Connection*. Alexandria, VA: ACA Headquarters.
- Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology: Professional standards and cases*. New York: Random House.
- Knapp, S. (2001). Ethics for psychotherapists. In S. Cullari, *Counseling and psychotherapy: A practical guidebook for students, trainees, and new professionals* (pp.1-28). Needham Heights, MA: Allyn & Bacon.
- Knapp, S., & VandeCreek, L. (1982). Tarasoff: Five years later. *Professional Psychology*, 13, 511-516.
- Knapp, S., & VandeCreek, L. (1983). Privileged communications and the counselor. *Journal of Counseling and Development*, 61(2), 83-85.
- Knapp, S., & VandeCreek, L. (1987). *Privileged communication in the mental health professions*. New York: Van Nostrand Reinhold.
- Knapp, S., & VandeCreek, L. (1997). Jaffee v. Redmond: The Supreme Court recognizes a psychotherapist-patient privilege in federal courts. *Professional Psychology: Research and Practice*, 28 (6), 567-572.
- Kocet, M. M., & Freeman, L. T. (2005). Report of the ACA ethics committee: 2003-2004. *Journal of Counseling & Development*, 83 (2), 249-252.
- Kolb, D. (1976). *Learning style inventory: Technical manual*. Boston: McBerad.
- Lamb, D. H., Strand, K. K., Woodburn, J. R., Buchko, K. J., Lewis, J. T., & Kang, J. R. (1994). Sexual and business relationships between therapists and former clients. *Psychotherapy*, 31(2), 270-278.
- Lanyon, R. I., & Goodson, L. D. (1982). *Personality assessment* (2nd ed.). New York: Wiley.
- Lazare, A., Putnam, S. M., & Lipkin, Jr., M., (1995). Three functions of the medical interview. In M. Lipkin, Jr., M., S. M. Putnam, & A. Lazare (Eds.), *The medical interview: Clinical care, education and research* (pp. 1-19). New York: Springer-Verlag.
- Leslie, R. S. (2002, March/April). New federal privacy regulations: What you need to know and do. *Family Therapy Magazine*, 1(2), 41-43.
- Macbeth, J. E., Wheeler, A. M., Sither, J. W., & Onek, J. N. (1994). *Legal and risk management issues in the practice of psychiatry*. Washington, DC: Psychiatrists Purchasing Group.
- Marshall, J. R. (1994). *Social phobia: From shyness to stage flight*. New York: Basic Books.
- Meara, N. M., Schmidt, L. D., & Day, J. D. (1996). Principles and virtues: A foundation for ethical decisions, policies, and character. *The Counseling Psychologist*, 24 (1), 4-77.
- Morrison, J. (1993). *The first interview: A guide for clinicians*. New York: The Guilford Press. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. *The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research*. (DHEW Publication No. (05) 78-0012). Washington, DC: U.S. Government Printing Office, 1987.

- Nugent, F. A. (2000). *Introduction to the profession of counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.
- O'Connor-Slimp, P. A., & Burian, B. K. (1994). Multiple role relationships: Consequences and recommendations. *Professional Psychology, Research, and Practice*, 25(1), 39-45.
- Overholser, J. (1989). Accurate diagnosis of the DSM-III personality disorders: Some critical factors. *Journal of Contemporary Psychotherapy*, 19, 5-23.
- Overholser, J., & Fine, M. A. (1990). Defining the boundaries of professional competence: Managing subtle cases of clinical incompetence. *Professional Psychology: Research and Practice*, 21, 462-469.
- Pelsma, D. M., & Borgers, S. B. (1986). Experienced-based ethics: A developmental model of learning ethical reasoning. *Journal of Counseling and Development*, 64(5), 311-331.
- Piazza, N. J., & Baruth, N. E. (1990). Client record guidelines. *Journal of Counseling and Development*, 68(1), 313-316.
- Pipes, R. B., & Davenport, D. S. (1990). *Introduction to psychotherapy: Common clinical wisdom*. Englewood Cliffs, NJ: Prentice-Hall.
- Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling: A practical guide for psychologists* (2nd ed.). San Francisco: Jossey-Bass.
- Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological Association. *American Psychologist*, 47(3), 397-411.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change. *American Psychologist*, 47(9), 1102-1114.
- Reaves, R. P. (1999). *Avoiding liability in mental health practice*. Montgomery, AL: Association of State and Provincial Psychology Board.
- Remar, R. B., Bounds, J. C., Rogers & Hardin, (2011). *Issues of special importance to mental health professionals*. Atlanta, GA: Institute of Continuing Legal Education in Georgia.
- Remley, T. P., & Herlihy, B. (2001). *Ethical, legal, and professional issues in counseling*. Upper Saddle River, Merrill Prentice-Hall.
- Remley, T. P., & Herlihy, B. (2005). *Ethical, legal, and professional issues in counseling* (2nd ed.). Upper Saddle River: Merrill Prentice Hall.
- Remley, T. P., Jr., & Herlihy, b. (2010). *Ethical, legal, and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.
- Richie, M. H., Piazza, N. J., & Lewton, J. C. (1991). Current use of the DSM-III-R in counselor training. *Counselor Education and Supervision*, 30, 205-211.
- Robinson, F. (1965). Counseling orientations and labels. *Journal of Counseling Psychology*, 12, 338.
- Rosenhan, D. L., & Seligman, M. E. P. (1995). *Abnormal psychology* (3rd ed.). New York: W. W. Norton & Company.
- Sacks, J. L. (1992). AACD to become ACA. *Guidepost*, 34, 12, 1, 10.
- Schoener, G. R. (1984). Sexual exploitation of clients by therapists. Special issue: Women and mental health-new directions for change. *Women and Therapy*, 3(3-4), 63-69.
- Schoener, G. R. (1995). Assessment of professionals who have engaged in boundary violations. *Psychiatric Annals*, 25, 95-98.
- Schwitzer, A. M. (1996). Using the inverted pyramid heuristic in counselor education and supervision. *Counselor Education & Supervision*, 35(4), 258-268.
- Schwitzgebel, R. K., & Schwitzgebel, R. L. (1980). *Law and psychological practice*. New York: Wiley & Sons.
- Shah, S. (1969). Privileged communications, confidentiality, and privacy. *Professional Psychology*, 1, 56-59.

- Shertzer, B., & Stone, S. C. (1981). *Fundamentals of guidance*. Boston: Houghton Mifflin.
- Sieber, J. E. (1982). *The ethics of social research: Surveys and experiments*. New York: Springer.
- Smith, J. L. (1993). Report of the ACA ethics committee: 1992-1993. *Journal of Counseling and Development*, 72(6), 220-222.
- Soisson, E. L., VandeCreek, L., & Knapp, S. (1987). Thorough record keeping: A good defense in a litigious era. *Professional Psychology: Research and Practice*, 18, 492-502.
- Stadler, H. A., & Paul, R. D. (1986). Counselor education preparation in ethics. *Journal of Counseling and Development*, 64(5), 328-330.
- Stevens, M. J., & Morris, J. (1995). A format for case conceptualization. *Counselor Education & Supervision*, 35(1), 82-95.
- Sweeney, T. J. (1995). Accreditation, credentialing, professionalization: The role of specialties. *Journal of Counseling & Development*, 74(2), 117-125.
- Thompson, C. L., & Rudolph, L. B. (1983). *Counseling children*. Monterey: Brooks/Cole.
- Truant, G. S. (1998). Assessment of suitability for psychotherapy. *American Journal of Psychotherapy*, 52(4), 397-399.
- Turkat, I. D. (1990). *The personality disorder: A psychological approach to clinical management*. New York: Pergamon.
- United States Department of Education (2008). *Family Educational Rights and Privacy Act (FERPA)*. Retrieved September 14, 2011, from <http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html>
- Vacc, N. A., & Juhnke, G. A. (1997). The use of structured clinical interviews for assessment in counseling. *Journal of Counseling and Development*, 75, 470-480.
- VandeCreek, L., & Knapp, S. (1997). Record keeping. In J. R. Matthews & C. E. Walker (Eds.), *Basic skills and professional issues in clinical psychology* (pp. 155-172). Needham Heights, MA: Allyn & Bacon.
- VanHoose, W. H., & Kottler, J. A. (1985). *Ethical and legal issues in counseling and psychotherapy* (2nd ed.). San Francisco: Jossey-Bass.
- VanZandt, C. E. (1990). Professionalism: A matter of personal initiative. *Journal of Counseling and Development*, 68(3), 243-245.
- Vasquez, M. (1988). Counselor-client-sexual contact: Implication for ethics training. *Journal of Counseling and Development*, 67(4), 238-241.
- Welfel, E. R. (1998). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues*. Pacific Grove, CA: Brooks/Cole.
- Widiger, T. A., Frances, A. J., & Trull, T. J. (1989). Personality disorders. In R. J. Craig (Ed.), *Clinical and diagnostic interviewing* (pp. 221-236). Northvale, NJ: Aronson.



Research and program evaluation

2.1 INTRODUCTION

Research and program 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 E and G of the Code of Ethics of the American Counseling Association (ACA, 2005). 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 an ethics guidance program. The 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.

2.2 CACREP OBJECTIVES

Research objectives are outlined in the CACREP 2001 Standards. Each objective is abbreviated and full statements are to be found on-line.

- a. importance of research and difficulties in conducting research
- b. research methods and outcome-based research
- c. technology and statistical methods
- d. principles and program evaluations
- e. use of research to improve counseling effectiveness
- f. ethical and legal considerations

Example research questions for the listed objectives:

Question 98: 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. Controls are not to be managed, therefore whatever happens to them can influence results.

Question 99: Objective b.

A research study designed to determine public attitude toward depression would be most like which research method?

- a. Historical
- b. Descriptive
- c. Causal-comparative

- d. Experimental

Answer: b. Descriptive-review section on methods.

Question 100: 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?

- a. F-ratio table
- b. S-significance table
- c. I-interval table
- d. H-hypotheses table

Answer: a. F and T-ratio tables are found in most research textbooks. Using technology significance findings are tabulated using SPSS.

Question 101: 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. A meta-analysis combines small data sets and look for findings

Question 102: 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 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.

2.3 TERMS

Terms are defined at the end of this chapter.

Action Research	Meta Analysis
Analogue	Non-parametric statistic
Applied Research	Observer Effect
Attrition	Observational effect
Cohort Design	Parameter
Confidence Intervals	Pilot Study
Control Group	Placebo effect
Covariance	Population
Degrees of Freedom	Power
Dependent Variable	Quasi-experimental
Double Blind Procedure	Randomized-post-test
Ex Post Facto Design	Regression
External Validity	Stratified random
F-ratio chart	True Score
History	Type I (Alpha)
Inferential Statistics	Type II (Beta)
Maturation	

2.4 RESEARCH

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.

2.4.1 QUESTIONS

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.

SOURCES OF KNOWLEDGE:

Ary, Jacobs, and Razavieh (1996) list five methods in which answers are derived for 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.

2.4.2 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.

2.4.2-1 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, the person giving information was not there when it happened.

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

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

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

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

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 103:

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 independent variable is what is being manipulated such as a program of treatment.

Question 104:

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 attitude toward customers.
- d. an unknown variable which is not described.

Answer: b. 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.

Qualitative Method:

Ary, Jacobs, and Razavieh (1990, 1996) discuss qualitative inquiry as a generic term for a variety of approaches to research and evaluation. 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 particular context on the events. Qualitative inquiry differs from quantitative inquiry in the study of social and behavioral phenomena in their basic aim and methods (Ary, et al., 1996).

2.4.2-2 PURPOSE OF RESEARCH

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. It is the most like 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) Functions 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.

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.

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.

2.4.3 THREATS TO EXPERIMENTAL 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.

1. **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.
2. **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.

3. **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.
4. **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.
5. **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).
6. **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 105:

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.

Question 106:

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.

2.4.4 HYPOTHESIS

- "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).
- "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):

- provides a reasonable explanation
- states the expected relationship between two variables as clearly as possible and defines the variables in measurable terms
- must be testable

A research hypothesis is either directional or nondirectional. A statistical hypothesis is stated in a null form:

Directional hypothesis: 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

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** 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.

2.4.5 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.

2.4.6 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.

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 107:

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 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 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.

2.4.7 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.

Descriptive research: 10% for large populations and 20% for small populations.

Correlational: minimum of 30 subjects

Causal comparative: minimum of 30 subjects

Experimental: minimum of 30 subjects, (unless tightly controlled, then less may be appropriate)

2.4.8 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) is where a certain number of people are provided by request for an interview. This group does not represent the people more difficult to access.

2.4.9 RESEARCH DESIGNS

TRUE EXPERIMENTAL DESIGNS are the most highly recommended designs for experimental research because of the control that they provide (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:

- manipulate or vary the conditions systematically and note the variation
- make the event occur at a time when they are ready to make accurate observations and note accurate measurements
- repeat observations under the same conditions to verify, describe, or replicate results

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), independent-dependent variable, and the scale of measurement. 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.

1. **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.

2. **Posttest Only Control Group Design**

Controls for all sources of internal validity except mortality. Controls for all external validity.

3. **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 (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:

1. **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.

2. **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.

3. **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.

Question 108:

Identify which of the following research hypotheses suggests a true experimental research design:

- 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
- b. teenagers with learning disabilities are more likely to have behavior problems documented in school records than are teenagers without learning disabilities

- c. children 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. This research hypothesis calls for an experimental design because an independent variable is being manipulated.

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 109:

A group of researchers is interested in three different therapy approaches 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 the three 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. Without more specifics a 3 x 2 factorial would be recommended. The first independent variable (therapy) has three approaches while the second independent variable (gender) has two, male and female.

2.4.10 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 (see chapter three). 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).

2.4.11 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 110:

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
-

Question 111:

Which measurement scale provides a true zero point as well as equal intervals?

- a. nominal
 - b. ordinal
 - c. interval
 - d. ratio
-

Question 112:

Which scale of measurement is the least sophisticated?

- a. nominal
 - b. ordinal
 - c. interval
 - d. ratio
-

Question 113:

Which measurement scale is typical of classroom tests?

- a. nominal
 - b. ratio
 - c. interval
 - d. ordinal
-

Answers: 110. c. 111. d. 112. a. 113. c.

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.

2.4.12 STATISTICS

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.

Descriptive Statistics

Important types of descriptive statistics include the following (Gay, 1992, 1996):

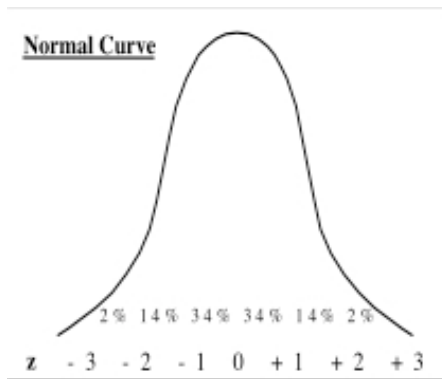
1. **Measures of central tendency**—used to describe the average score of a group of scores. Examples: The mode, the mean, and the median.
2. **Measures of variability**—describe how spread out a group of scores are or how they spread themselves away from the central tendency (mean). Examples: The range and standard deviation are more commonly utilized.

Once these statistical techniques and terms are understood, the researcher will begin to make comparisons in order to understand the information.

1. **Measures of relative position**—compare a subject's performance to that of the other subjects. Examples: percentile ranks, standard scores (z scores, T scores, stanines, etc.)
2. **Measures of relationship**—describe the degree of relationship between two sets of scores. Examples: correlations such as the Spearman rho and the Pearson r.

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 ($\pm \infty$), 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 further 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. 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).

2.4.13 NORMAL CURVE

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.

2.4.13-1 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.

Mean: 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 one 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 ($30 \div 5$) equal to 6. Thus, a mean of 6

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.

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 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.

The following five individuals under the age of 18 are, respectively, with ages of: 1, 1, 2, 4, and 17. 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 $25 \div 5$ or 5, which is an age above four of the children. The median would be equal to 2 and is a score within or nearer to four of the five while the mode would be equal to 1.

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.

Question 114:

Which measure of central tendency is most appropriate to use with nominal data?

- a. mean
- b. median
- c. mode
- d. quartile

Question 115:

Which central tendency is the most frequently occurring score?

- a. mean
- b. median
- c. mode

- d. quartile

Question 116:

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: 114. c. 115. c. 116. b. 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.

2.4.13-2 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 are 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 divergence is 5, this means that the normal curve distribution will depart from the mean in 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 2×5 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 117:

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 deviation is the most appropriate index of variability in this situation, because extreme scores do not influence extreme scores.

2.4.13-3 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 validly performed on them.

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 $z = \frac{x - \bar{x}}{s}$ (x is the score, \bar{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 line is below.

_____ . _____ . _____ . _____ . _____ . _____ . _____
4.00z -3.00z -2.00z -1.00z 0.00 +1.00z +2.00z +3.00z +4.00z

Question 118:

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. 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 that 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 119:

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. 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 (2×10) 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 120:

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. The raw score converted to a z score would be: $z = \text{score minus mean } (85-100) \text{ divided by standard deviation of } 15$. Thus, $-15 \div 15 = -1.00$. 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 ($\pm 3, 34, 14, 2$) 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.

2.4.14 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 121:

A correlation coefficient of .89 can be described as:

- a. strong positive.
- b. strong negative.
- c. mild positive.
- d. mild negative.

Answer: a .89 is sufficiently high and near 1.00 to indicate a strong positive correlation.

Question 122:

Two evaluators ranked five dogs for running form. 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. 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.

2.4.15 INFERENCE 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.

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 123:

A type I error is a:

- a. false rejection.
 - b. valid rejection.
 - c. beta error.
 - d. valid acceptance.
-

Answer: a.

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 124:

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. There is one chance in 100 that the change occurred because of an error component.

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.

1. 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).

- a. the t-test is utilized with several different distributions (normal or otherwise) and with various sample sizes
- b. t-test will test population means and develops a T-ratio
- c. scores are interval or ratio
- d. population from which sample is drawn is normally distributed
- e. 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 given and a t-test for no significant mean changes 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. Significant difference between two groups can be compared. Subjects are sometimes matched on variables related to the dependent variable in order to equate groups.

2. 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 for two 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-post test 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.

3. 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 behavior change strategies in middle-school students. Several variables were considered. These variables included type of behavior change program. Length of time program was implemented, specific age of subjects, grade-level in middle school, and gender.

4. 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.

1. 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.

- a. two groups have same median
- b. scores are ordinal
- c. two independent samples are used

2. 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.

- a. correlated samples where subjects are matched
- b. use plus and minus signs
- c. dependent variable is continuous
- d. members are ranked

3. 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**.

- a. independence of frequency count
- b. 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.

Kruskal-Wallis—non-parametric used for more than two groups.

Question 125:

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. The Pearson r is the only test listed that describes the relationship.

Question 126:

If the teacher wanted to know if there is a difference between the raw scores on each form, what should she use?

- a. simple ANOVA
 - b. factorial design
 - c. t-test for independent samples
 - d. Pearson r
-

Answer: c

Question 127:

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. Premarital counseling is the independent variable. The control group is not receiving premarital counseling.

Question 128:

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.

Question 129:

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.

- a. Pretest posttest control group design
- b. Posttest only control group design
- c. Nonequivalent control group design
- d. Solomon four group design

Answer: a.

Question 130:

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. 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 131:

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 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.

Question 132:

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	0.10	0.56
Test B	0.88	1.00	0.20	0.75
Test C	0.15	0.75	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.

2.5 ORGANIZATIONAL AND COUNSELOR EFFECTIVENESS

The ethical guidelines as adopted by the American Counseling Association (ACA, 1997) state that counselors monitor their effectiveness as professionals (c2d) and that they submit regularly for professional review and evaluation by their supervisor or employer (d1d). 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).

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 (as cited in Sexton, 1999) identify three important counselor contributions to effective counseling. These include:

- a. level of skillfulness, competence
- b. ability to think diversely and complexly about client cases
- c. ability to relate to client

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 showed 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 showed 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: (a) conduct a needs assessment, (b) define the goals and objectives of the counselor or agency, (c) identify alternative methods for meeting goals, (d) make appropriate decisions, and (e) 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 Chapter Three 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 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-IV 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 data can be through tow-way mirrors and in session observations by a trained observer as well as pre-post instrument measures on effectiveness. 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.

2.6 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.

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:

$$90\% = 1.65 \text{ SEM} \quad 95\% = 1.96 \text{ SEM} \quad 99\% = 2.56 \text{ SEM}$$

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. The understand meta analysis 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.

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.

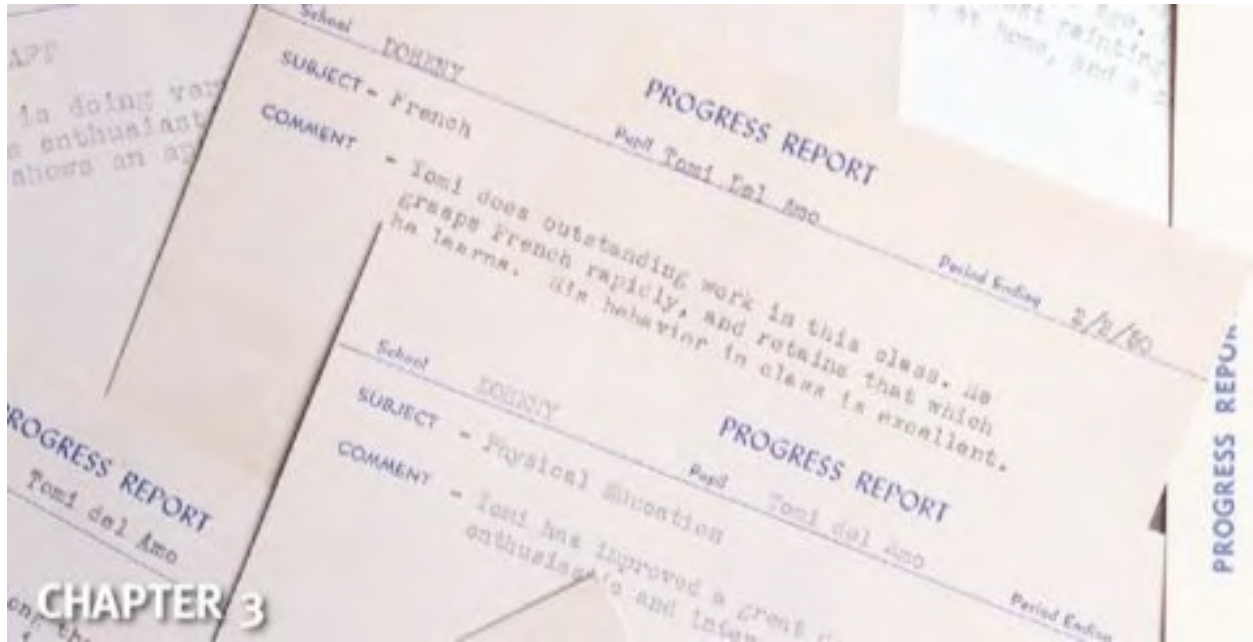
TRUE SCORE: A true score is considered to be a hypothetical score based upon no measurement error. An individual's average of all scores on a test that has been taken several times, can be estimated, but never precisely known.

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. A Type II error (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.

REFERENCES

- Aiken, L.R. (1997). *Psychological testing and assessment* (9th ed.). Boston: Allyn & Bacon.
- American Counseling Association Code of Ethics and Standard of Practice. (1995, June). *Counseling Today*, 32(12), 33-40.
- American Counseling Association. (1997). *The American Counseling Code of Ethics and Standard of practice*. Alexandria, VA: American Counseling Association.
- American Counseling Association (2005). *ACA Code of ethics*. Alexandria, VA: ACA.
- Ary, D., & Jacobs, L.C. (1976). *Introduction to statistics: Purpose and procedures*. New York: Holt, Rinehart, and Winston.
- Ary, D., Jacobs, L., & Razavieh, A. (1990). *Introduction to research in education*. Orlando, FL: Harcourt Brace College Publishers.
- Ary, D., Jacobs, L., & Razavieh, A. (1996). *Introduction to research in education*. New York: Harcourt Brace College Publishers.
- Barkley, W.M. (1982). Introducing research to graduate students in the helping professions. *Counselor Education and Supervision*, 21, 327-331.
- Bledsoe, J.C. (1963). *Essentials of educational research*. Athens: University of Georgia.
- Bracht, G.H., & Glass, G.V. (1968). The external validity of experiments. *American Educational Research Model*, 5, 437-474.
- Campbell, D.T., & Stanley, J.C. (1963). Experimental and quasi-experimental designs for research. In N. L. Gage (Ed.), *Handbook of research on teaching*. Chicago: Rand McNally & Company.
- Chambless, D., Sanderson, W., Shoham, V., S., Pope, K., Crits-Cristoph, P., Baker, M., Johnson, B., Woody, S., Sue, S., Beutler, L., Williams, D., & McCurry, S. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, 49(2), 5-18.
- Cohen, B.H. (2001). *Explaining psychological statistics* (2nd ed.). New York: John Wiley and Sons.

- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Drew, C.J., & Hardman, M. L. (1985). *Designing and conducting behavioral research*. New York: Pergamon Press.
- Gay, L.R. (1992). *Educational research: Competencies for analysis and application* (4th ed.). New York: Macmillan Publishing Company.
- Gay, L.R. (1996). *Educational research: Competencies for analysis and application* (5th ed.). Englewood Cliffs, NJ: Merrill.
- Gibson, R.L., & Mitchell, M.H. (2003). *Introduction to counseling and guidance* (6th ed.). Upper Saddle River, NJ: Merrill-Prentice Hall.
- Glass, G.V., & Stanley, J. C. (1970). *Statistical methods in education and psychology*. Englewood Cliffs, NJ: Prentice Hall.
- Heppner, P.P., Kivlighan, D.M., & Wampold, B.E. (1992). *Research design in counseling*. Pacific Grove: Brooks/Cole.
- Johnson, D.W., & Johnson, F.P. (1997). *Joining together: Group theory and group skills* (6th ed.). Boston: Allyn and Bacon.
- Lambert, M.J. (2002). The effectiveness of psychotherapy: What has a century of research taught us about the effects of treatment? <http://www.cwru.edu/affl/div29/labert.htm>
- Lambert, M.J., & Ogles, B.M. (2002). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York: Wiley.
- Leedy, P.D. (1985). *Practical research: Planning and design* (3rd ed.). New York: Macmillan.
- Leedy, P.D. (1993). *Practical research: Planning and design* (5th ed.). New York: Macmillan.
- Lewis, M.D., & Lewis, J. A. (1991). *Management of human service programs* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Reber, A.S. (1985). *The penguin dictionary of psychology*. London: Penguin Books.
- Royse, D., Thyer, B., Padgett, D.K., & Logan, T.K. (2001). *Program evaluation: introduction* (3rd ed.). Belmont, CA: Brooks/Cole.
- Sackett, D.L., Richardson, W.S., Rosenberg, W., & Haynes, R. R. (1997). *Evidence-based medicine: How to practice and teach EBM*. New York: Churchill-Livingston.
- Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The consumers report study. *American Psychologist*, 50(12), 965-974.
- Sexton, T.L. (1999). *Evidence-based counseling: Implications for counseling practice, preparation, and professionalism*. Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services.
- Tabachnick, B.G., & Fidell, L.S. (1989). *Using multivariate statistics* (2nd ed.). New York: Harper Collins Publisher, Inc.
- Whiston, S. C., & Coker, J.K. (in press). Reconstructing clinical training: Implications from research. *Counselor Education and Supervision*.
- Wiseman, D.C. (1999). *Research strategies for education*. Belmont, CA: Wadsworth Publishing.



Appraisal

3.1 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). 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 appraisal.

3.2 PREVIEW QUESTIONS

Questions 133-148 are a sample of questions for appraisal. The material for the content of these questions can be found in this chapter of study. Questions 140-148 are more time consuming than will be found on the NCE.

Question 133:

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 and standard deviation are two variability measures.

Question 134:

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. percentilev

Answer: c.

Question 135:

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.

Question 136:

Likert scales, which are typically used to measure attitudes, yield which type of measurement?

- a. nominal
- b. ordinal
- c. interval
- d. ratio

Answer: b.

Question 137:

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.

Question 138:

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.

Question 139:

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.

Question 140-143:

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
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

140. Which of these students scored better in English and Social Studies?

141. Which of these students scored lowest in math?

142. Which students scored below the class mean(s) in each subject area?

143. In all four subjects, which student had the highest score in comparison to the rest of the class scores?

Answers:

140. a. Linda = English +2.0, +1.5 Social Studies

141. Bob (70) = -1.00

142. None in English, none in Social Studies, Bob in Math, and Sue in Science

143. Linda exceeded all students with the highest score attained in each subject

Questions 144-148:

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
---------------	-------------------------------	-------------------------	-------------------------------

144. On which section were the scores more homogenous?

- a. #3 b. #4 c. #6 d. #7

145. Which section of the test had the greatest spread of effect?

- a. #3 b. #4 c. #6 d. #7

146. When compared to the mean of the group, on which subtest did Mark score better?

- a. #1 b. #5 c. #6 d. #7

147. On which subtest in comparison to the norm group did he score highest?

- a. #1 b. #2 c. #5 d. #4

148. Overall, Mark's percentile when compared to the group was?

- a. 50% b. 53% c. 68% d. 84%

Answers: 144. b (#4) 145. d (#7) 146. b (#5, 2.5 s.d.) 147. c (#5, 2.5 s.d.) 148. d (84%)

3.3 CACREP OBJECTIVES

Appraisal or assessment objectives for CACREP Standards 2001 are:

- a. historical perspective
- b. norms, individual and group testing and computer methods
- c. statistical concepts, central tendency and variability
- d. reliability
- e. validity
- f. specific populations
- g. administration and selection of evaluation tools
- h. case conceptualization and diagnoses
- i. legal and ethical issues

Appraisal objectives have been abbreviated to conserve space.

Question 149: Objective a.

Sir Francis Galton was credited for several constructs, terms, and evaluative tools. Which of the following is mainly his contribution?

- a. correlation
- b. normal curve

- c. ratio IQ
 - d. descriptive statistics
-

Question 150: Objective b.

The technique most closely associated with behavioral observations of individuals in a group task is:

- a. round robin
 - b. sociometric
 - c. social observation
 - d. t-test
-

Question 151: 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
-

Question 152: 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
-

Question 153: Objective e.

Reliability is to standard error of measurement as validity is to standard:

- a. error of statistics
 - b. error of estimate
 - c. error of variance
 - d. error of the mean
-

Question 154: Objective f.

Using achievement instruments with a specific population it is important to:

- a. secure signed releases

- b. use norm included instruments
 - c. use age adjusted norms
 - d. use only raw scores
-

Question 155: 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
-

Question 156: Objective h.

What type of instrument is used for assessing an assault of the brain?

- a. Stanford Binet
 - b. Bender Gestalt
 - c. Halstead-Reitan
 - d. Rorschach
-

Question 157: Objective i.

When administering and interpreting results, the code of ethics states 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
-

Answers: 149. b. 150. b. 151. c. 152. d. 153. b. 154. b. 155. d. 156. c. 157. a.

3.4 TERMS

Several terms relating to individual analysis and testing are listed. Definitions are found at the end of this chapter.

Achievement	Likert Scale
Aptitude	Mainstreaming
Coefficient Alpha	Omnibus
Confidentiality	Power Trust
Convergent Validity	Public Law 94-142
Criterion Referenced	Q-Sort
Crystallized Intelligence	Regression
Cultural Equivalence	Reliability
Discriminant Validity	Semantic Differential
Expectancy Table	Sociometry
Factor Analysis	SOMPA
Fluid Intelligence	Standard Error Measure
Flynn Effect	Standardization
Forced Choice	Stem and Leaf
Formative Evaluation	Summative Evaluation
Guttman Scale	Truth in Testing
Halo Effect	Validity
Item Analysis	Variability

3.5 THE HISTORY OF TESTING

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 born. 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 of 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: not being objective, halo error, personal response tendencies, being obtrusive, and 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).

One example of an observational scale is The Vineland Adaptive Behavior Scale, which utilizes observational testing to assess mental retardation. 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.

3.6 APPRAISAL OF INDIVIDUALS

The art and science of understanding, measuring, and making decisions about the psychological characteristics of people are the essence of this chapter. 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 and is considered and 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 is the 36 correct result. 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.

3.6.1 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.
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 recent publication of *The Bell Curve* by Richard Herrnstein 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:** 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?

3.7 TESTING

3.7.1 CLASSIFICATION OF TESTS

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).

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, that 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.

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.

3.7.2 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 Harrow (1972) emphasized the psychomotor domain in developing individual behavioral objectives. Harlow developed a taxonomy that utilized classification levels and subcategories to classify behaviors.

Various types of tests will be described below using the dichotomous classification of cognitive versus noncognitive.

3.7.3 COGNITIVE TESTS

3.7.3-1 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 (ITBS), 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.

3.7.3-2 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 they 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.

3.7.3-3 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-III-R, 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.

Left Hemisphere	Right Hemisphere
Verbal functions	Nonverbal
Memory	Perceptual
Language comprehension	Spatial visualization
Analytic, sequential	Visual learning
Sequential-serial	Visual-motor organize
Ideas	Holistic-gestalt
Temporal analysis	Intuitive problem solving
Right-left orientation	Humorv
Sequential processing	Creative associative
Conceptual	Sound
Motor functions	Fluid thinking
Field-dependent	Field thinking
Crystallized thinking	Incidental learning
Speech-writing	Impersonal orientation

The above functionings 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 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 through 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. The specific skills and knowledge for this specialty are beyond the scope of the NCE.

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.

3.7.4 NONCOGNITIVE TESTS

Noncognitive instruments are of different types and development. The following scheme 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 respondent agrees with one statement the respondent he/she 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.

INTERVIEWING 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 the 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).

3.7.4-1 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)

3.7.4-2 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.

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.

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.

Inventoried

Responses to noncognitive instruments such as the *Strong Interest Inventory* (SII).

Tested

Responses to inquiries regarding information about a specific occupation.

3.7.4-3 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.

3.7.4-4 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 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.

3.7.5 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. An example is the Attention Deficit Disorders Evaluation Scale.

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.

Behavioral Interviews—A clinical interview is a behavioral interview 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 or 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.

3.7.6 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 general guidelines adhere to degree, training, and supervision to utilize certain tests.

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 (Aiken, 1997).

3.7.7 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.

3.8 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.

3.8.1. 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.

3.8.2 NORMAL CURVE

For a pictorial view of the bell-shaped curve, refer to Chapter 2. 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.

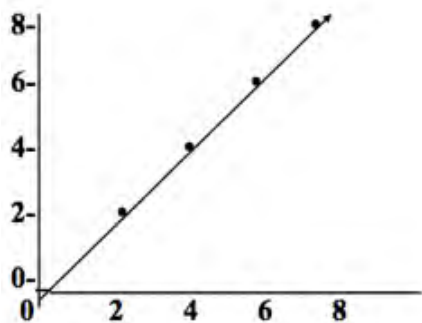
Sample data are often small in frequency and therefore do not fulfill the requirements for a perfect distribution of scores. The data can be understood by looking at how they may be skewed. If the information groups itself on the right side of the normal curve, one can infer from the data, if interpreted as test results, the test was too easy. If the data are grouped on the left side of the curve, they can be inferred that the test was too difficult. 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.

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.

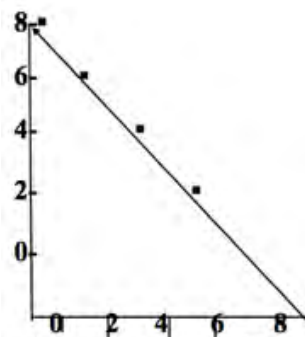
3.8.3. SCATTERPLOT (1), (2), and (3)

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.



(1) Positive $r = +1.00$

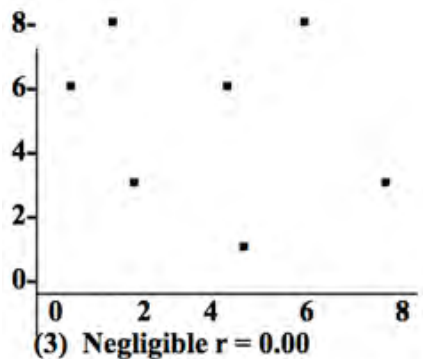
Assuming the vertical line represents one set of test scores and the horizontal line represents a second set of scores. Thus, the student that had a 2 on the first test had a 2 on the second test. Each subsequent student attained the same score and the same position. This is a perfect correlation of +1.00.



(2) Negative $r = -1.00$

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 now visible on this scatterplot.



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 Chapter Two.

3.8.4. STATISTICS

Two broad areas of statistics are reviewed

1. **DESCRIPTIVE**—A summarizing of a set of data (Cohen, 2000) thus tabulating, depicting and describing a collection of data.
2. **INFERENTIAL**—Statistics to make inferences about a population from researching a sample (Cohen, 2000).

Describing individual appraisal makes use of descriptive statistics. The two descriptive statistical areas are central tendency and variability.

1A. 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.

- a. **Mean** To calculate the mean, add the measures (x) or test scores and divide by the number (n) of test scores.

$$1 + 5 + 4 + 9 + 6 = 25 \quad n = 5$$
$$X = 25/5 = 5 \quad \text{Mean} = 5$$

- b. **Median** - This is the point above which 50% of the scores fall and below which 50% of the scores fall.

$$1, 4, 5, 6, 9 \quad \text{Median} = 5$$

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 5 (correct) when the numbers are ordered.

- c. **Mode** - The mode is the most frequently occurring score. There can be one or more modes.

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 for the mode is 6 that is repeated two times, more than any other digit.

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.

1B. 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.

- a. **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:

$$4, 5, 6, 8, 9, \text{ the range would be calculated as follows: } 9 - 4 = 5, 5 + 1 = 6$$

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.

- b. **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.

- c. **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 2×5 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.

3.8.5. 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 \pm 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 158:

Mark took the Canterbury Test for story-telling training. He scored 66 out of 100 questions on this cognitive examination. He retok 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. The true score is a hypothetical construct.

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.

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.

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 we will say is 3 and the degree of confidence you wish to predict. For this example let us predict with 95% confidence, 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:

$$\begin{aligned} &2 \text{ units (or the 95\% prediction)} \times (3) \text{ or} \\ &2 \times 3 = \text{equals } 6 \end{aligned}$$

The estimated observed range at 95% or 19 out of 20 times would be ± 6 (2×3) 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:

1. **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.
2. **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.

3. **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.

4. **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 ρ 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 159:

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 measures are spuriously high because of the odd/even split and will approach 1.00.

3.8.6. 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:

1. 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).
2. 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).
3. 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.

4. **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.
5. 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:

1. **Correlation**—used for criterion and construct-related validities.
2. **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 squared (.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.
3. **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.
4. **Expectancy Tables**—Decision theory utilizes cutoff scores for personnel decisions. These tables are easy to read and interpret.
5. **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.

1. **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.
2. **Valid acceptance:** Accepting when true
3. **Valid rejection:** Rejecting when true

4. 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.

3.8.7. 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).
 - i. Age norms
 - ii. Grade norms
 - c. 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.

3.9 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. 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) evolved for the concern for 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.

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 suggest one begin with the concrete and move to the abstract, avoiding "off the cuff" remarks (1988).
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 are:

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 are:

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 between 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.

3.10 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.

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.

3.10.1 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

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. However such records are maintained (i.e., computer storage, etc.), access should be subject to strict controls to insure confidentiality (Anastasi, 1976).

Client Welfare

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.

MINORITIES AND TESTING

Another ethical issue in testing is the civil rights of minorities. The first step in cross-cultural counseling should be to understand the values and world view 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).

Another cultural 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). 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 continues on to indicate 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.

3.11 RESOURCES IN TESTING FOR INDIVIDUAL AND GROUP ASSESSMENT

1. *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.
2. *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).
3. *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).

3.12 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).

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 INTELLIGENCE: 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.

REFERENCES

- Aiken, L. R. (1997). *Psychological testing and assessment* (9th ed.). Boston: Allyn & Bacon.
- American Educational Research Association, American Psychological Association, and National Council on Measurement in Education. (1985). *Standards for educational and psychological testing*. Washington, DC: American Psychological Association.
- Anastasi, A. (1976). *Psychological testing* (4th ed.). New York: Macmillan Publishing Company.
- Anastasi, A. (1988). *Psychological testing* (6th ed.). New York: Macmillan Publishing Company.
- Ary, D., & Jacobs, L. C. (1976). *Introduction to statistics: Purposes and procedures*. New York: Holt, Rinehart & Winston.
- Ary, D., Jacobs, L. C., & Razavieh, A. (1966). *Introduction to research in education*. Fort Worth, TX: Harcourt Brace College Publishers.
- Berent, S. (1981). Lateralization of brain function. In J. M. Sattler, *Assessment of children* (3rd ed.). San Diego: Jerome H. Sattler.
- Cannell, J. J. (1988). Nationally normed elementary achievement testing in America's public schools: How all 50 states are above the national average. *Educational Measurement: Issues and Practices*, 7(2), 5-9.
- Cannell, J. J. (1989). *The Lake Wobegon Report: How public educators cheat on achievement tests*. Albuquerque, NM: Friends for Education.
- Cohen, B. H. (2000). *Explaining psychological statistics* (2nd ed.). New York: John Wiley and Sons.
- Cohen, R. J., & Swerdlik, M. E. (1999). *Psychological testing and assessment: An introduction to tests and measurement* (4th ed.). Mountain View, CA: Mayfield Publishing Company.
- Cordes, C. (1986). Test tilt: Boys outscore girls on both parts of the SAT. *APA Monitor*, 6, 30-31
- Corey, G., Corey, M. S., & Callanan, P. (1988). *Issues and ethics in the helping profession*. Monterey, CA: Brooks/Cole.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Domino, G. (2000). *Psychological testing: An introduction*. Upper Saddle River, NJ: Prentice-Hall.
- Drummond, R. J. (1996). *Appraisal procedures for counselors and helping professionals* (3rd ed.). Englewood Cliffs, NJ: Merrill.

- Edwards, A. L. (1970). *The measurement of personality traits by scales and inventories*. New York: Holt, Rinehart & Winston, Inc.
- Garcia, J. (1981). The logic and limits of mental testing. *American Psychologist*, 36(10), 1172-1180.
- Gardner, H. (1993). Multiple intelligence: Theory in practice. In R. J. Drummond, *Appraisal procedures for counselors and helping professionals* (3rd ed., p. 120). Englewood Cliffs, NJ: Merrill.
- Gladding, S. T. (1988). *Counseling: A comprehensive profession* (2nd ed). Columbus, OH: Merrill
- Gladding, S. T. (1996). *Counseling: A comprehensive profession* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Glaser, R. (1963). Instructional technology and the measurement of learning outcomes. *American Psychologist*, 18, 519-522.
- Goldberg, L. R. (1970). Man versus model of man: A rationale, plus some evidence, for a method of improving clinical inferences. *Psychological Bulletin*, 73, 422-432.
- Gregory, R. J. (1996). *Psychological testing: History, principles, and applications* (2nd ed.). Boston: Allyn & Bacon.
- Gregory, R. J. (2000). *Psychological testing: History, principles, and applications* (3rd ed.). Boston: Allyn & Bacon.
- Guilford, J. P. (1967). The nature of human intelligence. In R. J. Drummond, *Appraisal procedures for counselors and helping professionals* (3rd ed., p. 115-116). Englewood Cliffs, NJ: Merrill.
- Guttman, L. (1944). A basis for scaling quantitative data. *American Sociological Review*, 9, 139-150.
- Hanna, K. (1988). Using percentile bands for meaningful descriptive test score interpretations. *Journal of Counseling and Development*, 66(10), 477-483.
- Harrow, A. J. (1972). *A taxonomy of the psychomotor domain: A guide for developing behavioral objectives*. New York: McKay Co.
- Hood, A. B., & Johnson, R. W. (2002). *Assessment in counseling: A guide to the use of psychological assessment procedures* (3rd ed.). Alexandria, VA: American Counseling Association.
- Kaplan, R. M., & Saccuzzo, D. P. (2001). *Psychological testing: Principles, applications, and issues* (5th ed). Belmont, CA:Wadsworth/Thompson Learning.
- Keith, T. Z., & Reynolds, C. R. (1990). Measurement and design issues in child assessment research. In C. R. Reynolds & R. W. Kamphaus (Eds.), *Handbook of psychological and educational assessment of children: Intelligence & achievement* (pp. 290-311). New York: Guilford.
- Krathwohl, D. R. (1964). *Handbook II: Affective Domain*(pp. 176-185). New York: David McKay Co.
- Lawshe, C. H. (1975). A quantitative approach to content validity. *Personnel Psychology*, 28, 563-575.
- Maloney, M. P., & Ward, M. P. (1976). *Psychological assessment: A conceptual approach*. New York: Oxford University Press.
- Mehrens, W. (1986). Response to computer applications for testing and scoring. *Measurement and Evaluation in Counseling and Development*, 19, 15-26.
- Mehrens, W. A., & Lehman, I. J. (1984). *Measurement and evaluation in education and psychology* (3rd ed.). New York: Holt, Rinehart, & Winston.
- Messick, S. (1988). The effectiveness of coaching for the SAT: Review and reanalysis of research from the fifties to the FTC. In A. Anastasi, *Psychological testing* (6th ed.). New York: Macmillan Publishing.
- Miller, G. M. (1988). Deriving meaning from standardized tests: Interpreting test results to clients. In S. T. Gladding, *Counseling: A comprehensive profession* (517-519). Columbus: Merrill.
- Murphy, L. L., Conoley, J. C., & Impara, J. C. (Eds.). (1994). *Tests in print* (Vols. 1-2). Lincoln, NE: Buros Institute of Mental Measurement.

- Neukrug, E. (1999). *The world of the counselor: An introduction to the counseling profession*. Pacific Grove, CA: Brooks/Cole Publishing Company.
- Newmark, C. S. (Ed). (1989). *Major psychological assessment instruments*, (Vol. II). Boston: Allyn & Bacon.
- Osgood, C. E., Suci, G. J., & Tannenbaum, P. H. (1957). *The measurement of meaning*. Urbana, IL: University of Illinois Press.
- Plake, B. S., Conoley, J. C., Kramer, J. J., & Murphy, L. U. (1991). The Buros Institute of Mental Measurement: Commitment to the tradition of excellence. *Journal of Counseling and Development*, 69, 449-455.
- Powell, Z-H. E. (1994). The psychological impacts of computerized adaptive testing methods. *Educational Technology*, 34(8), 41-46.
- Reber, A. S. (1985). *The Penguin dictionary of psychology*. London: Penguin Books.
- Sattler, J. M. (1990). *Assessment of children* (3rd ed., rev., rep.). San Diego: Jerome M. Sattler, Publisher.
- Sax, G. (1974). *Principles of educational measurement and evaluation*. Belmont, CA: Wadsworth Publishing Co.
- Thorndike, R. M. (1997). *Measurement and evaluation in psychology and education* (6th ed.). Upper Saddle River, NJ: Prentice-Hall.
- Tinsley, H. E. A., & Bradley, R. W. (1986). Test interpretation. *Journal of Counseling and Development*, 64(7), 462-466.
- Trombley, W. (1986). Test makers now search for answer. *Los Angeles Times*, Los Angeles, CA: August 26, I-1, 22-23.
- Tryon, G. S. (1980). The measurement and treatment of test anxiety. *Review of Educational Research*, 50, 343-372.
- Ward, A. W., & Murray-Ward, M. (1999). *Assessment in the classroom*. Belmont, CA: Wadsworth Publishing Company.
- Whiston, S. C. (2000). *Principles and applications of assessment in counseling*. Belmont, CA: Brooks/Cole.
- Zajonc, R. B., Markus, H., & Markus, G. B. (1979). The birth order puzzle. *Journal of Personality and Social Psychology*, 37, 1324-1341.



Lifestyle and Career Development

4.1 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 chapter 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 chapter for study 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 think you are more knowledgeable than the brief presentation in this manual, continue on to the next chapter. There are approximately 26 questions devoted to content, which 21 are core questions in Lifestyle and Career Development.

4.2 CACREP OBJECTIVES

CACREP 2001 Standards identifies nine objectives for Career Development. The objectives below are modified for this review:

- a. career development theories and decision-making models
 - b. labor market, resources, computer-based information systems
 - c. career development program planning, implementation, administration, and evaluation
 - d. interrelationships among and between work, family, and other life roles (diversity and gender)
 - e. planning, placement, follow-up, and evaluation
 - f. assessment instruments and techniques
 - g. technology based application and strategies, and world-wide web
 - h. processes, techniques, and resources
 - i. ethical and legal consideration
-

Question 160: Objective a.

The concept of career maturity is of primary importance to the theory of:

- a. decision-making.
 - b. social.
 - c. cyclical.
 - d. trait-factor.
-

Question 161: 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
-

Question 162: 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.
-

Question 163: 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.
-

Question 164: 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.
-

Question 165: Objective f.

Many types of instruments are used for career assessment. One type reports results in idiosyncratic form. These types of reports are usually reported as a:

- a. graph.
 - b. T-score.
 - c. sten.
 - d. stanine.
-

Question 166: 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.
-

Question 167: Objective h.

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.

Question 168: Objective i.

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.

Answers: 160. c. 161. c. 162. d. 163. d. 164. c. 165. c. 166. b. 167. a. 168. d.

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.

4.3 TERMS

The following list of terms is provided to promote vocabulary knowledge. Brief definitions are provided at the end of the chapter.

Avocation	Interest
Burnout	Leisure
Career awareness	MAPS
Career guidance	NOICC
Career lattice	Obsolescence
Career maturity	Occupational
Career pattern study	Outlook Handbook
CASVE cycle	Occupational
Congruency	stress
Consistency	O*Net
Crystallization	P x E Fit Cyclical
Counseling	RAISEC
Differential Aptitude Test	Role Salience
Differentiation	Rust Out
Disability	Shadowing
DISCOVER	Standard Occupational
DOT	Classification
Dual-Career	Transition
Handicap	Unemployment
Holland's HOC	Work

4.4 INTRODUCTION

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, listing 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.

1. 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.
2. 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+).
3. 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).
4. 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	

4.5 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. 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*. He died in 1908; however, 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 see 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 items 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:

- a. career awareness
- b. career exploration
- c. value clarification
- d. decision-making skills
- e. career orientation
- f. career preparation

Forerunners for Professionalism: APGA developed professional standards and NVGA set up procedures for credentialing of career counselors

4.6 GUIDANCE: CAREER AND LIFE SPAN

4.6.1 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. The 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.

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, 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**.

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).

DISMISSAL

1. carelessness
2. laziness
3. absence/tardiness
4. disloyalty
5. distraction
6. too little/much ambition

ADJUSTMENT

1. punctuality
2. honesty
3. reliability
4. dependability
5. initiative
6. cooperation

4.6.2 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, 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 were derived from 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 (2) Factor theory based on motivators and hygiene Motivators—recognition, achievement, responsibilities and work Hygienes—negative perceptions of company, extrinsic to job
3. McClelland: People work for one of three basic needs.

NACH Need for achievement, intrinsic rewards, success as measured against some internalized standard of excellence

NAFF Need for affiliation, close interpersonal relationship and friendship

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.

Leisure

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:

1. Helps people learn how to play their part in society
2. Helps to achieve societal aims
3. Helps 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.

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.

4.6.3 CAREER GUIDANCE

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.

1. **Career Guidance: Elementary Years** The focus during these years is on developmental experiences in order to:
 - a. become aware of choices
 - b. anticipate and plan for choices
 - c. take into consideration own personal characteristics
 - d. foster self-awareness and to utilize the school experience to explore and prepare for the future

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).

A. 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.

B. **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).

2. **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.

A. **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.

B. **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: 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.

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.

A. **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.

4. **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):

- A. 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
- B. 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

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.

4.6.4 DUAL CAREER

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 in the counselor-client hour to be child care, role conflict, geographic moves, competition, personal factors, relationship factors, and family-oriented work policies.

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.

Question 169:

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. Goals for senior-high-school students tend to be those of self-knowledge, educational and occupational exploration, and career planning.

4.7 CULTURE

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 (1998) paraphrases the work of Matsumoto in describing work-related values that the counselor is to determine when conducting career counseling with clients. These are:

- power distance

- uncertainty avoidance
- individualism/collectivism
- masculinity

Each of the dimensions above has been covered within other units of this manual with the exception of "uncertainty avoidance." Matsumoto's dimensions 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:

- provide a balance in self-oriented help and self-in-relation help.
- expand helping responses
- understand cultural based roles
- develop alternatives to conventional counseling roles.

A summary of developmental strategies for African Americans, Asian Americans, Hispanic Americans, and Native Americans will be listed to assist in counselor-related skills (Zunker, 1998).

African American

- Develop self-concept
- Learn to be more internally directed
- Learn about job opportunities
- Clarify motivational aspirations
- Learn to cope with the white society

Asian Americans

- Learn self-assertion skills
- Learn to understand organization systems and bureaucracies
- Improve interpersonal skills
- Learn to understand work environments
- Using parents as role models

Hispanic Americans

- Learn goal-setting and problem-solving skills
- Develop working-parent skills
- Improve financial management of resources

Native Americans

- Use parents and relatives as counseling facilitators
- Use Native American role models

- Emphasize individual potential in the context of future goals.

Sue (1978, p. 293) recommends that to be a culturally effective counselor is to develop an:

- ability to recognize which values and assumptions the counselor holds regarding desirability and undesirability of human behavior.
- awareness of the genetic characteristics of counseling that cut across many schools of counseling theory.
- understanding of the sociopolitical forces that have influenced the identity and perspective of culturally different.
- ability to share the worldview without negating its legitimacy
- an approach of true eclecticism in counseling.

4.8 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 "discrepancy"

4.8.1 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.

- A. Frank Parson
- B. E. G. Williamson

Decision Theory:

A process by which the individual uses concepts to choose a vocational alternative that offers the best result.

- A. H. B. Gelatt
- B. Hershenson and Roth
- C. Martin Katz (SIGI)
- D. Tiedeman, Tiedeman and O'Hara

Psychological Emphases:

Emphasis is with one's psychological makeup and how the interaction affects choice (motivation, self-esteem, needs).

- A. Anne Roe
- B. John Holland
- C. Robert Hoppock

Developmental Emphases:

These theories reflect a longer time period for development and career choice.

- A. E. Ginzberg
- B. Donald Super
- C. Tiedeman and O'Hara
- D. 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.

- A. Carl Rogers
- B. 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.

- A. John Krumboltz
- B. Carl Thorensen
- C. Albert Bandura

Sociological Emphases:

Sociological factors, such as one's social group and social structure, exert an influence on vocational development and choice.

- A. Miller and Form
- B. Status Attainment Theory
- C. Wisconsin Model
- D. Economic Theory
- E. Dualist Theory
- F. 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), inactive-unstructured (Tiedeman), inactive-structured (Roe, Parsons), and active-structured (Holland).

4.8.2 VOCATIONAL THEORIES

1. TRAIT-AND-FACTOR

A. 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.

B. 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.

Emphasized: Self-understanding, realistic planning, and decision-making skills are emphasized.

Process: The process is considered to be rationalistic, a cognitive model.

1. Analysis—collect data about attitudes, interests, family background knowledge, educational progress, aptitudes
2. Synthesis—collate and summarize by means of case study and test profiles
3. 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 he developed four (4) 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: interest more than aptitude, interest less than ability, interests and abilities the same but in different fields.
 - d. Unwise choice: Disagreement between abilities and interests and requirements of the occupation
4. Prognosis—judging consequences and probabilities of adjustment
5. Counseling—advising client what to do to effect desired adjustment
6. Follow-up—repeat above steps

Relationship: is one of teacher/student

Stages:

- a. Listen to the client—Rapport
- b. Test interpretation
- c. Dissemination of occupational information

Techniques: Williamson advocated five techniques for interviewing.

- a. Establishing rapport
- b. Cultivating self—understanding
- c. Advising—planning a program of action
- d. Carrying out the plan
- e. Referral

Occupational Information: Serves three functions

- a. Informational
- b. Readjustive—reality testing for choice
- c. 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 Winrach (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 changed with the work of 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 170:

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. 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

This system developed by Dawis, Dohm, Lofquist, Chartrand, and Drue (1987) describes the person-environment interaction of Theory of Work Adjustment (TWA) in dimensions, levels of work abilities, and values. These 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. others 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:
 - i. encoding—perceive information and appraise its meaning
 - ii. goal setting—establish concrete, realistic goals and organize them in sequence
 - iii. develop plan and alternate solutions, multiple avenues and considerations of pattern matching consequences
 - iv. 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

2. 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 losses. 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:

Information about alternative action

Information about possible outcomes

Information about probabilities linking actions to outcomes

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-Tiedman and Tiedman trace the history of the present decision theory to Tiedman 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-Tiedman & Tiedman, 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:

Tiedman 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 (Tiedman & 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. Tiedman 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)

DIFFERENTIATION: 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 (1). This is followed by a clearer distinction among fields by considering information (2). The person begins to make judgments regarding the advantages, disadvantages, and relative values (3). This process brings about some preliminary decision making (4) 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 (1). Later the person questions these purposes and may try to change the group (2). 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 (3). 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. Endorse your 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. The first is the problem condition composed of: a) problem forming, b) problem solving, and c) solution using. The second is psychological states of a) accommodation, b) clarification, and c) exploration. The third is self-comprehension composed of a) doing with awareness, b) doing, and c) learning about. Their pyramidal model of decision-making comprehension is made up of 4 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

Computer application: Information Systems for Vocational Systems (ISVS)

In summary, this theory advocates a "from within to without" perspective.

Question 171:

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.

3. THE DEVELOPMENTAL CAREER THEORISTS

A. 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 (4) 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)
 - change from play to work orientation (function to pleasure)
 - frustrated by sense of inadequacy and impotency
 - ignore reality, abilities, potentials, and time perspective (Osipow, 1983).
 - b. TENTATIVE: 4 stages (11-17):Tentative choices.
 - Interest (11-12)
 - Capacity (abilities 13-14)
 - Value (clearer perceptions of occupational styles 15-16)
 - Transition choices to responsibility (17)

Behaviors:

- need to identify a career direction/likes-dislikes, intrinsic enjoyment
- father's identification (interest stage)
- evaluate ability to perform well in area of interest (capacity stage)

- service to society, different lifestyle, giving to others, begin to look for a way to use skills (value stage)
- need to make immediate, concrete, and realistic decisions (transition stage)
- c. REALISTIC: Choices are made. A compromise between reality and personal factors
 - Exploration: college entrance, narrows career choice to two or three possibilities but in a stage of ambivalence and indecisiveness
 - Crystallization: commitment to a specific career field
 - Specification: selects a job or professional training (takes steps to implement)

Behaviors:

- narrows goal and vocational flexibility, increased ambiguity
- selection of a path from alternatives (exploration stage)
- clear idea of what to avoid, decisions are firm and commitment grows (crystallization stage)
- specification (specification stage)

7. Two basic personality types:

- a. Work-oriented
- b. Pleasure-oriented

B. 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 figures (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

1. **Growth Stage:** 0-14, self-concept-identification with important people. Needs, fantasies, interests, capacities, social participation. and reality testing:
 - a. Fantasy substage: 4-10, role playing
 - b. Interest substage: 11-12, likes role playing
 - c. Capacity substage: 13-14, abilities are Prominent
2. **Exploration Stage:** self-examination and exploration (15-24):
 - a. Tentative substage: 15-17, tentative choices
 - b. Transition substage: 18-21, enters world of work, implements self-concept in school
 - c. Trial substage: 22-24, beginning job
3. **Establishment Stage:** 25-44, permanent place
 - a. Trial substage: 25-30, change may be made
 - b. Stabilization substage: 31-44, develop a secure place
4. **Maintenance Stage:** 45-64, building
5. **Decline Stage:** 65-plus, mental and physical decline
 - a. 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 (2) affective components of career planning and career exploration/curiosity and three (3) 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) 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 based upon 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

C. 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 have been 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

4. 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.

A. 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: 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

B. 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.

Socialization—organization influences (changes) the person

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).

- a. self-perceived talents and abilities
- b. self-perceived motives and needs
- c. self-perceived attitudes and values

Hall (1990) lists the five types of anchors:

- a. autonomy—large organizations
- b. creativity—entrepreneurial activity
- c. functional competence—professional specialization
- d. security—stable setting
- e. general management—corporate ladder

Late career—mentor, balance, retiring

Question 172:

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. Super identified trait transition, implementing, specifying, and crystallizing as the substages of exploration.

5. PSYCHODYNAMIC EMPHASIS

A. 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. iWork 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 follows 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

6. PSYCHOLOGICAL EMPHASIS

A. 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). Weinrach (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 find first 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.

B. 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 of 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 provides 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

1. Most individuals can be typed or classified as one of six personality types. These types are realistic, investigative, artistic, social, enterprising, and conventional. A type is a product of interaction of cultural and personal forces including: peers, biological hereditary, parents, social class, culture, and 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).
2. There are six (6) environments. They are the same types as personality types: realistic, investigative, artistic, social, enterprising, and conventional. These types hang together (people of this type) and create an environment.

3. 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.
4. 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.

7. COMPOSITE THEORY

A. 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 173:

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. Use the hexagon to determine order (adjacency)

Question 174:

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 utilized Maslow's hierarchy of needs in developing her theory on personality and career choice.

Question 175:

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.

Question 176:

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.

4.8.3 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 (3) 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 (3) 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 suitability. Gottfredson calls this the ZONE OF ACCEPTABLE ALTERNATIVES. 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.

4.9 CAREER GUIDANCE

4.9.1 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:

Clark Hull	Minnesota Vocational Interest Inventory
E. K. Strong	Strong Vocational Interest Blank and Strong Interest Inventory
G. F. Kuder	Kuder preference, occupational, vocational
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:

Myers-Briggs	Myers-Briggs Type Indicator
Raymond Cattell	16 Personality Factor Questionnaire
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:

Allport-Vernon:	Study of Values
Donald Super:	Work Values Inventory

4.9.2 VOCATIONAL AND CAREER RESOURCES

Occupational Descriptions

1. 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.

2. Occupational Outlook Handbook (OOH)—The OOH is published every two years and can be accessed through the Internet. 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).
3. Occupational Outlook Quarterly. This literature contains information on new occupations, the job, youth, women, veterans, minority group members, labor market, and training opportunities (Drummond & Ryan, 1995).
4. 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
- 5. Vocational, Trade, and Technical Schools (Examples)
 - a. Lovejoy's Career & Vocational
- 6. U.S. Employment Services (Job Service)
- 7. National Level
- 8. 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.

4.9.3 UTILIZING COMPUTER RESOURCES IN CAREER COUNSELING

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 Bowsbey (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. **NOICC***
National Occupational Information Coordinating Committee. The NOICC is one of the most commonly used systems.

Question 177:

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. 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.

4.10 PROGRAM DEVELOPMENT

Niles and Harris-Bowlsby (2002) outline important features in establishing and designing a career development program. The steps included are to:

- define the target population and characteristics (high school, college, corporation, etc.).
- determine the needs of the identified population.
- create measurable objectives to meet the needs.
- determine how to deliver the career planning services.
- determine the content of the program.
- determine the cost of the program.
- promote and explain services.
- promote and deliver the full-blown program of services.
- evaluate the program.
- 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, some information may already be available (1), a short questionnaire may be developed and administered and processed by a focus

group (2), consultants may be hired (3), and to ask managers and administrators to identify problems that need solutions (4).

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.

4.11 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).

4.12 QUESTIONS

Question 178:

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
-

Question 179:

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.
-

Question 180:

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
-

Question 181:

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
-

Question 182:

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)

Question 183:

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

Answers to Questions: 178. a. 179. c. 180. c. 181. a. 182. b. 183. c.

References

- Americans with Disabilities Act handbook*. (1991). Washington, DC: U.S. Government Printing Office.
- Ashforth, B. E., & Lee, R. T. (1990). Defensive behavior in organizations: A preliminary model. In R. L. Lowman, *Counseling and psychotherapy of work dysfunctions* (p. 1-24). Washington, DC: American Psychological Association.
- Astin, H. S. (1984). The meaning of work in women's lives: A sociopsychological model of career choice and work behavior. *Counseling Psychologist*, 12(4), 117-126.
- Bailey, L. J., & Stadt, R. (1973). Career education: New approaches to human development. In E. L. Herr & S. H. Cramer, *Career counseling and guidance through the life span* (5 th ed.). New York: Harper Collins.
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Bandura, A. (1986). Social foundations of thought and action: A social-cognitive theory. Englewood Cliffs, NJ: Prentice-Hall.
- Bordin, E. S. (1990). Psychodynamic model of career choice and satisfaction. In D. Brown, L. Brooks, & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey-Bass.
- Brewer, J. M. (1942). *History of vocational guidance*. New York: Harper & Brothers.
- Brooks, L. (1990). Recent developments in theory building. In D. Brown, L. Brooks, & Associates. *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey-Bass.
- Brown, D. (1996). Brown's values-based, holistic model of career and life-role choices and satisfaction. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3 rd ed., pp. 337-338). San Francisco: Jossey-Bass.

- Brown, D., Brooks, L., & Associates. (1990). *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey Bass.
- Brown, D., Brooks, L., & Associates. (1996). *Career choice and development* (2nd ed.). San Francisco: Jossey-Bass.
- Chaplin, J. P. (1968). *Dictionary of psychology*. New York: Dell Publishing.
- Cherniss, C. (1980). *Staff burnout: Job stress in the human services*. Beverly Hills, CA: Sage Publication.
- Cochran, L. (1997). *Career counseling: A narrative approach*. Newbury Park, CA: Sage.
- Crites, J. O. (1981). *Career counseling: Theoretical and practical perspectives*. New York: McGraw-Hill.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Dawis, R. V., Dohm, T. E., Lofquist, L. H., Chartrand, J. M., & Drue, A. (1987). *Minnesota occupational classification system III: A psychological taxonomy of work*. Minneapolis, MN: Vocational Psychology Research Department of Psychology, University of Minnesota.
- Drummond, R. J., & Ryan, C. W. (1995). *Career counseling: A developmental approach*. Englewood Cliffs, NJ: Merrill.
- Edelwich, J., & Brodsky, A. (1982). Training guidelines: Linking the workshop experience to needs on and off the job. In W. S. Paine (Ed.), *Job stress and burnout* (pp. 133-154). Newbury Park: CA: Sage.
- Fitzgerald, L. F., & Betz, N. E. (1983). Issues in the vocational psychology of women. In W. C. Walsh & S. H. Osipow (Eds.), *Handbook of vocational psychology: Vol. 1, Foundations* (pp. 83-159). Hillsdale, NJ: Lawrence Erlbaum.
- Fitzgerald, L. F., & Betz, N. E. (1994). Career development in cultural text: The role of gender, race, class, and sexual orientation. In M. L. Savickas & R. W. Lent (Eds.), *Convergence in career development theories* (pp. 103-117). Pal Alto, CA: CPP.
- Fitzgerald, L. F., & Weitzman, L. (1992). Women's career development: Theory and practice from a feminist perspective. In Z. Leibowitz & D. Lea (Eds.), *Adult career development: Concepts, issues and practices* (pp. 125-157). Alexandria: National Career Development Association.
- Forney, D. S., Wallace-Schutzman, F., & Wiggers, T. T. (1982). Burnout among career development professionals: Preliminary findings and implications. *Personnel and Guidance Journal*, 60, 435-439.
- Freidenberger, H. (1974). Staff burnout. *Journal of Social Issues*, 30(1), 159-165.
- Fukuyama, M. A., Probert, B. S., Neimeyer, G. J., Nevill, D., & Metzler, A. E. (1988). Effects of DISCOVER on career self-efficacy and decision-making of undergraduates. *The Career Development Quarterly*, 37, 56-62.
- Gelatt, H. B. (1962). Decision-making: A conceptual frame of reference for counseling. *Journal of Counseling Psychology*, 36(2), 252-256.
- Ginzberg, E. (1966). *Life styles of educational American women*. New York: Columbia University Press.
- Gladding, S. T. (1992). *Counseling: A comprehensive profession* (2nd ed.). New York: Macmillan Publishing.
- Gladding, S. T. (1996). *Counseling: A comprehensive profession* (3rd ed.). New York: Macmillan Publishing.
- Gottfredson, L. S. (1983). Creating and criticizing theory. *Journal of Vocational Behavior*, 23, 203-212.
- Gould, R. (1978). *Transformations: Growth and change in adult life*. New York: Simon & Schuster.
- Gray, J. D. (1980). Counseling women who want both a profession and a family. *The Personnel and Guidance Journal*, 59 (1), 43-45.
- Gregory, R. J. (1996). *Psychological testing: History, principles, and applications* (2nd ed.). Boston: Allyn and Bacon.
- Gunter, B. G., & Gunter, N. (1980). Leisure styles: A conceptual framework for modern leisure. *The Sociological Quarterly*, 21, 361-374.

- Hackett, G., & Betz, N. (1981). A self-efficacy approach to the career development of women. *Journal of Vocational Behavior*, 18, 326-339.
- Hall, D. T. (1990). Career development theory in organizations. In D. Brown, L. Brooks, & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey Bass.
- Hansen, L. S. (2000). Integrative life planning: A new worldview for career professionals. In J. Kummerow (Ed.), *New directions in career planning and the workplace*. Palo Alto, CA: Consulting Psychologists Press.
- Harris-Bowlsbey, J., Riley-Dikel, M., & Sampson, J. P., Jr. (1998). *The Internet: A tool for career planning*. Columbus, OH: National Career Development Association.
- Herr, E. L., & Cramer, S. H. (1992). Career guidance and counseling through the life span: Systematic approaches (4th ed.). New York: Harper Collins.
- Herr, E. L., & Cramer, S. H. (1996). Career guidance and counseling through the life span: Systematic approaches (5th ed.). New York: Harper Collins.
- Hinkle, J. S. (1992). Computer-assisted career guidance and single-subject research: A scientist-practitioner approach to accountability. *Journal of Counseling & Development*, 70(3), 391-395.
- Holland, J. (1985). Making vocational choices: A theory of vocational personalities and work environment. Englewood Cliffs: Prentice-Hall, Inc.
- Holmberg, K., Rosen, D., & Holland, J. (1990). *Leisure activities finder*. Odessa, FL: Psychological Assessment Resources, Inc.
- Howard, J. H. (1975). Management productivity, rushing out or burning out. *The Business Quarterly*, 40, 44-49.
- Howe, L. K. (1977). *Pink Collar Workers*. New York: Putnam.
- Jepsen, D. A. (1991). Applying developmental concepts in career counseling. *Guidepost*, January 17.
- Johnston, J. A., Buescher, K. L., & Heppner, M. J. (1988). Computerized career information and guidance systems: Caveat emptor. *Journal of Counseling and Development*, 67, 39-41.
- Kater, D. (1985). Management strategies for dual career couples. *Journal of Career Development*, 12(1), 75-80.
- Katz, M. R. (1993). Computer-assisted career decision-making: The guide in the machine. Hillsdale, NJ: Erlbaum.
- Knowles, M. (1977). The adult learner becomes less neglected. *Training*, 14(9), 16-18.
- Kroll, A. M. (1976). Career education's impact on employability and unemployment: Expectations and realities. *Vocational Guidance Quarterly*, 24(3), 209-218.
- Krumboltz, J. D. (1979). A social learning theory of career decision making. In A. M. Mitchell, G. B. Jones, & J. D. Krumboltz (Eds.), *Social learning and career decision making* (pp. 19-49). Cranston, RI: Carroll Press.
- Lefstein, L. M., & Lipsitz, J. (1986). 3:00-6:00 p.m.: Program for young adolescents. In E. L. Herr & S. H. Cramer, *Career guidance and counseling through the lifespan* (5th ed., p. 381). New York: Harper Collins.
- Leiter, M. P. (1993). The impact of family resources, control coping, and skill utilization on the development of burnout: A longitudinal study. In R. L. Lowman, *Counseling and psychotherapy of work dysfunction* (p. 124). Washington, DC: American Psychological Association.
- Lent, R. W., Brown, S. D., & Hackett, G. (1996). Career development from a social cognitive perspective. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed.; pp. 373-416). San Francisco: Jossey-Bass.
- Levinson, D. J. (1978). *The seasons of a man's life*. New York: Knopf.
- Levinson, D. J. (1983). The psychological development of men in early adulthood and in the mid-life transition. In S. H. Osipow, *Theories of career development* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall, Inc.

- Lofquist, L. H., & Dawis, R. V. (1978). Values as secondary to needs in the theory of work adjustment. *Journal of Vocational Behavior*, 12, 12-19.
- Lowman, R. L. (1993). *Counseling and psychotherapy of work dysfunctions*. Washington, DC: American Psychological Association.
- Maccoby, M., & Terzi, K. A. (1981). What happened to the work ethic? In J. O'Toole, J. L. Scheiber, & L. C. Wood (Eds.), *Working changes and choices*. Sacramento: Regents of the University of California.
- Maslach, C. (1978). The client role in staff burnout. *Journal of Social Issues*, 34(4), 111-124.
- Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. S. Paine (Ed.), *Job stress and burnout* (pp. 29-40). Newbury Park, CA: Sage.
- Matsumoto, D. (1996). *Culture and psychology*. Pacific Grove, CA: Brooks/Cole.
- Miller, M. J. (1996). Career counseling for the elementary school child: Grades K-5. In E. L. Herr & S. H. Cramer, *Career guidance and counseling through the life span* (5th ed., p. 381). New York: Harper Collins.
- Miller-Tiedeman, A., & Tiedeman, P. V. (1990). Career decision making: An individualistic perspective. In D. Brown, L. Brooks & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey-Bass.
- Mitchell, L. K., & Krumboltz, J. D. (1990). Social learning approach to career decision making: Krumboltz's theory. In D. Brown, L. Brooks, & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey Bass.
- National Occupational Information Coordinating Committee (1989). The National Career Development Guidelines. In E. L. Herr, & S. H. Cramer, *Career guidance and counseling through the life span* (5th ed.). New York: Harper Collins.
- Neff, W. S. (1977). *Work and human behavior* (2nd ed.). Chicago: Addine.
- Niles, S. G., & Harris-Bowlsbey, J. (2002). *Career development interventions in the 21st century*. Upper Saddle River, NJ: Merrill Prentice Hall.
- Osipow, S. H. (1983). *Theories of career development* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Overs, R. P., Taylor, S., & Adkins, C. (1977). *Avocational counseling manual: A complete guide to leisure guidance*. Washington, DC: Hawkins & Associates.
- Paine, W. S. (1982). Overview of burnout stress syndromes and the 1980s. In W. S. Paine (Ed.), *Job stress and burnout* (pp. 11-25). Newbury, CA: Sage.
- Patton, W., & McMahon, M. (1999). *Career development and systems theory: A new relationship*. Pacific Grove, CA: Brooks/Cole.
- Perrone, P. A. (1973). A longitudinal study of occupational values in adolescents. *Vocational Guidance Quarterly*, 22(2), 116-123.
- Peterson, G. W., Sampson, J. P., & Reardon, R. C. (1991). *Career development and services: A cognitive approach*. Pacific Grove, CA: Brooks/ Cole.
- Peterson, G. W., Sampson, J. P., & Reardon, R. C. (1996). A cognitive information processing approach to career problem solving and decision making. In D. Brown, L. Brooks, & Associates (Eds.), *Career choice and development* (3rd ed., pp. 423-467). San Francisco: Jossey-Bass.
- Pope, M., & Sveinsdottir, M. (2005). Frank, We hardly knew ye: The very personal side of Frank Parsons. *Journal of Counseling & Development*, 83 (1), 105-115.
- Rapoport, R., & Rapoport, R. (1978). The dual-career family. In L. S. Hansen & R. S. Rapoza (Eds.), *Career development and the counseling of women*. Springfield, IL: Charles C. Thomas.

- Reardon, R. C., Lenz, J. G., Sampson, J. P., & Peterson, G. W. (2000). *Career development and planning: A comprehensive approach*. Pacific Grove, CA: Brooks/Cole.
- Roe, A. (1956). *Psychology of occupations*. New York: Wiley.
- Roe, A. (1979). Early determinants of vocational choice. In S. G. Weinrach (Ed.), *Career counseling: Theoretical and practical perspectives*. New York: McGraw-Hill.
- Roe, A., & Siegelman, M. (1964). *The origin of interests*. APGA Inquiry Studies, No. 1. Washington, DC: American Personnel and Guidance Association.
- Roe, A., & Siegelman, M. (1972). *The origin of interests*. Washington, DC: American Personnel and Guidance Association, 199-201.
- Roth, R. M., Hershenson, D. B., & Hilliard, T. (1970). *The psychology of vocational development: Readings in theory and research*. Boston: Allyn & Bacon.
- Rounds, J. B., & Tracey, T. J. (1990). From trait-and-factor to person environment fit counseling: Theory and process. In W. B. Walsh & S. H. Osipow (Eds.), *Career counseling* (pp. 1-44). Hillsdale, NJ: Erlbaum.
- Schein, E. H. (1978). *Career dynamics: Matching individual and organizational needs*. Reading, MA: Addison-Wesley.
- Schlossberg, N. K., & Leibowitz, Z. (1980). Organizational support systems as buffers to job loss. *Journal of Vocational Behavior*, 17, 204-217.
- Sharf, R. S. (2002). *Applying career development theory to counseling* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- Sheehy, G. (1976). *Passages: Predictable crises of adult life*. New York: Dutton.
- Shubachs, A., Rounds, J. B., Jr., Dawis, R. V., & Lofquist, L. H. (1978). Perceptions of work reinforcer systems: Factor structure. *Journal of Vocational Behavior*, 13, 54-62.
- Sue, D. (1978). Counseling across cultures. *Personnel and Guidance Journal*, 56, 451.
- Super, D. E. (1970). *Work Values inventory*. Boston: Houghton Mifflin.
- Super, D. E. (1990). A life-span, life-space approach to career development In D. Brown, L. Brooks, & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey Bass.
- Super, D. E., & Crites, J. O. (1962). *Appraisal of vocational fitness by means of psychological tests* (rev. ed.). New York: Harper & Row.
- Tausky, C. (1984). *Work and society: An introduction to industrial sociology*. Itasca, IL: Peacock.
- Thorndike, R. L., & Hagen, E. (1959). *10,000 couriers*. New York: Wiley.
- Tiedeman, D. V., & O'Hara, R. P. (1963). *Career development: Choice and adjustment*. New York: College Entrance Examination Board.
- Tolbert, E. L. (1980). *Counseling for career development* (2nd ed.). Boston: Houghton Mifflin Co.
- U. S. Department of Labor. (1996-1997). *Dictionary of Occupational Titles* (5th ed. rev.). Washington, DC: U.S. Government Printing Office.
- U. S. Department of Labor (2002, November 21). About O*NET. Available online <http://www.Onetcenter.org/overivew.html>.
- Vaillant, G. E. (1977). *Adaptation to life*. Boston: Little, Brown & Co.
- Vaitenas, R., & Weiner, V. (1983). Developmental, emotional and interest factors in voluntary mid-career changes. In S. H. Osipow, *Theories of career development* (3rd ed., pp. 394-396). Englewood Cliffs, NJ: Prentice-Hall.
- Watts, A. G. (1996). Work shadowing. In E. L. Herr & S. H. Cramer, *Career guidance and counseling through the lifespan* (5th ed., p. 464). New York: Harper Collins.

- Weinrach, S. G. (1979). *Career counseling: Theoretical and practical perspectives*. New York: McGraw-Hill.
- Weinrach, S. G., & Srebalus, D. J. (1990). Holland's theory of careers. In D. Brown, L. Brooks, & Associates, *Career choice and development: Applying contemporary theories to practice* (2nd ed.). San Francisco: Jossey-Bass.
- Wilcox-Matthew, L., & Minor, C. W. (1989). The dual-career couple: Concerns, benefits, and counseling implications. *Journal of Counseling and Development*, 68(2), 194-198.
- Wilson, P. J. (1986). School counseling programs: A resource and planning guide. In E. L. Herr & S. G. Cramer, *Career guidance and counseling through the life span* (5th ed., p. 392). New York: Harper Collins.
- Yost, E. B., & Corbishley, M. A. (1987). *Career counseling: A psychological approach*. San Francisco: Jossey-Bass.
- Zunker, V. G. (1986). *Career counseling: Applied concepts of life planning*. Monterey Brooks/ Cole.
- Zunker, V. G. (1998). *Career counseling: Applied concepts of life planning* (5th ed.). Pacific Grove, CA: Brooks/Cole.
- Zunker, V. G. (2002). *Career counseling: Applied concepts of life planning*. (6th ed.). Pacific Grove, CA: Brooks/Cole.
- Zytowski, D. G. (1969). Toward a theory of career development for women. *Personnel and Guidance Journal*, 47, 660-664.



Helping Relationship

5.1 INTRODUCTION

The nature of the helping relationship 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 and Section C: Professional Responsibility. 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.

5.2 PREVIEW QUESTIONS

Question 184:

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
-

Question 185:

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.
-

Question 186:

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
-

Question 187:

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 motivations

Question 188:

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.
-

Question 189:

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.
-

Answers: 184: b. 185: b. 186: a. 187: e. 188: e. 189: b.

5.3 TERMS AND PEOPLE

Definitions and descriptions for these terms can be found at the conclusion of this chapter:

Abreaction	Basic ID
Bibliotherapy	Brief Therapy
Catharsis	Cognitive Restructuring
Compensation	Constructivism
Control Theory	Counter-transference
Eclecticism	Empowerment
Evidenced based Outcome Therapies	Feminist Therapy
Figure/Ground	Hakomi Body-Centered Therapy
latrogenesis	Impasse
Integrative Therapy	Logotherapy
Masculine Protest	Morita Therapy
Narcissism	Narrative Therapy
Negative Reinforcement	Paraprofessional
Phenomenology	Positive Reinforcement
Punishment	Secondary Reinforcers
Self-monitoring	Social Learning Theory
Solution-focused	Solution-Focused Brief Therapy
Transference	Unfinished Business

5.4 CACREP OBJECTIVES

CACREP objectives for helping relationship are not presented in full. Therefore, you may want to visit their website for the full standard objectives. The specific objectives related to consultation will be covered in Chapter eight of this manual.

- characteristics of counselor/consultant behaviors that influence helping processes
- interviewing and counseling skills, counseling theories
- systems perspective in understanding family systems, practicing consultation
- integration of technological strategies
- ethical and legal considerations

Question 190: Objective a.

To customize a therapy relationship, client characteristics are important. Clients that 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.
-

Question 191: 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.
-

Question 192: 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.
-

Question 193: 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
-

Question 194: 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

Question 195: Objective e.

The Belmont principles for ethical decisions when conducting research in a counseling setting isolates three of the following. Which one is not included in the Belmont Principles?

- a. Justice
- b. Respect
- c. Beneficence
- d. Fairness

Answers: 190: b. (Norcross, 2004) 191: d. 192: a. (Norcross, 2004) 193: c. (Day, 2004) 194: d. (Day, 2004) 195: d.

5.5 PHILOSOPHICAL FOUNDATIONS OF COUNSELING THEORY

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:

- a. synthesizes a particular body of knowledge.
- b. provides a framework for making observations and understanding observations.
- c. increases the understanding about a particular body of knowledge.
- d. provides tools for making predictions, evaluating outcomes, and improving techniques.
- e. encourages future research.

COUNSELING THEORY:

- a. is a framework for understanding and predicting human behavior.
- b. is a set of concepts used to explain the concerns, actions, perceptions, emotions, and motivations of human beings.
- c. is a guide of principles that counselors use as the basis for their interventions.
- d. 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).

EFFECTIVENESS OF COUNSELING

There have been many studies related to the outcome of therapy. 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. Truax and Carkhuff (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&Cattani, 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

EFFECTIVE COUNSELORS

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.

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, and (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).

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).
 - Clients with high resistance benefit from self-control methods, minimal therapist directiveness, and paradoxical interventions.
 - 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.
 - Clients manifesting impairment in 2 or more areas of functioning are likely to benefit from treatment that is lengthier and from psychoactive medication.
 - 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
 - Internalizing clients tend to benefit from interpersonal and insight-oriented therapies.
 - Externalizing clients tend to benefit from symptom-focused and skill-building therapies.
4. Stages of change (precontemplation, contemplation, preparation, action, and maintenance)
 - Cognitive-affective in the precontemplative and contemplative stages
 - Behavioral in action and maintenance
5. Personality: Anaclitic (relatedness) / sociotropic and introjective (integrated identity)/ autonomous styles
 - Anaclitic/sociotropic clients tend to benefit from therapies that offer closer interaction and personal interactions
 - Introjective/autonomous clients tend to do better in therapies that offer separation and autonomy.
6. Expectations

7. Assimilation of problematic experiences

- Clients follow a regular developmental sequence in working through problematic experiences (8 stages).

5.6 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 generated by this approach to human nature, then 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:

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.

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.

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:

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.

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.

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.

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.

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.

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.

5.7 PSYCHOLOGICAL SKILLS TRAINING

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; *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

1. 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:

- a. Attending behavior

- b. Client observation skills
- c. Open and closed questions
- d. Encourage, paraphrase, summarize
- e. Reflection of feeling
- f. Reflection of meaning
- g. Focusing
- h. Influencing skills
- i. Confrontation
- j. Skill sequencing and structuring the interview
- k. 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.

2. 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:

- a. Facilitating communication—learning skills of effective counselors
 - 1. Respond to clients with exploratory questions and behave so as to encourage the client to explore further.
 - 2. Listen intently and compassionately to the client.
 - 3. Focus on client's affect, dealing with client themes that are subtly communicated.
 - 4. Be frank, honest, and gentle.
- b. Affect Simulation—overcome fears of interpersonal involvement
- c. Counselor recall—video, stop tape where you recall feelings and thoughts, then elaborate
- d. Inquirer training—student learns inquirer role of respectful probing

- e. Client recall—client views tape and responds to inquirer regarding interview
- f. Mutual recall—both counselor and client participate with inquirer
- g. Transfer of learning

Applications: mental health workers, teachers, physicians, nurses, prison guards, military personnel

3. 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 1 and 2 while immediacy, self-disclosure, and confrontation were most effective in stages 3 and 4.

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 later 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 196:

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. - are distraught with how he views you in the negative.
- c. cannot figure out how he can be so down on you.

Answer: c. 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.

5.8 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.

A. Models of therapy:

- Moral Model:
 1. Reality therapy
 2. Rational-emotive therapy
 3. Existential therapy
 4. Person-Centered therapy
 5. Gestalt therapy
- Compensatory model:
 1. Adlerian therapy
 2. Behavior therapy
 3. Transactional analysis
- Transpersonal model:
 1. Spiritual
 2. Wholistic
- Medical model:
 1. Psychoanalytic therapy
- Constructivist therapies:
 1. Solution-focused
 2. Narrative therapy
- Integrative and eclectic therapies:
 1. Technical and theoretical integration
 2. Psychodynamic behavior
 3. Multimodal therapy
- Enlightenment model:
 1. Alcoholics
 2. Daytop Village

3. Overeaters Anonymous
 4. Weight Watchers
- B. 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.)

Therapist:

- a. Behavioral
- b. Rational-emotive
- c. Psychoanalytical

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

5.9 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) 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)

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 be assured that 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, kinesics, 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. Kinesics 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 197:

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. kinesics.
- c. proxemics.
- d. synergetic.

Answer: c.

5.9.1 STAGES OF THE COUNSELING PROCESS

I. 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 is when tests or inventories are utilized 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).

II. 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.

III. 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 198:

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. working alliance of trust, expertness, and bonding

5.9.2 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

5.10 COUNSELING THEORIES

1. 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.

- d. Conscience-model standard
- e. 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)

- **Oral Stage** (1st year): Oral erotic and oral sadistic. Sucking reflex. Adjustment to weaning. Gratification- feeding.
- **Anal Stage** (1-3): Anal expulsive and anal retentive.
- **Phallic Stage** (3-6): Self-manipulation of genitals a pleasure source. Oedipal and Electra complex.
- **Latency Stage** (7-13): Sexual motivations recede (dormant) and emphasis is on socialization, skill development, activities.
- **Genital Stage** (12+): Heterosexual relations are source of pleasure.

Techniques: Catharsis, Free Association, Interpretation of Dreams, Parapraxis (Freudian slips), Analysis of Transference, Analysis of Resistance

Question 199:

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.

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

- | | |
|-------------------------|--------------|
| 200. Displacement | Letter: ____ |
| 201. Sublimation | Letter: ____ |
| 202. Introjection | Letter: ____ |
| 203. Reaction Formation | Letter: ____ |
| 204. Projection | Letter: ____ |
| 205. Repression | Letter: ____ |
| 206. Compensation | Letter: ____ |
| 207. Denial | Letter: ____ |
| 208. Regression | Letter: ____ |

209. Rationalization

Letter: _____

Answers:

200. f. Displacement-taking out impulses on a less threatening target.

201. j. acting out unacceptable impulses in a socially acceptable way such as a career. Sublimating aggressive impulses

202. 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.

203. a. Reaction formation is taking the opposite belief because the true belief causes anxiety.

204. d. Projection is placing unacceptable behavior in oneself onto another.

205. b. Repression is to pull the threat into the unconscious such as to forget something traumatic which took place in childhood.

206. i. Compensation or substitution to attempt to make up for some feeling of inadequacy by excelling.

207. e. Denial is to argue against the anxiety by denying that the anxiety exists.

208. c. Regression is returning to a previous stage of development.

209. g. Rationalization is to give excuses for a shortcoming and to avoid a disappointment or criticism.

2. 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)

3. 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

4. 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):

- a. all behavior occurs in social context
- b. rejects reductionism in favor of holism
- c. is interpersonal psychology
- d. consciousness and unconsciousness are used to further goals
- e. cognitive reorganization and life style is important to understand the individual
- f. change occurs in the context of immediate change and long range goals
- g. people are not pushed by causes rather by hereditary and genetics
- h. striving is for perfection, completion, superiority, competence, and mastery

- i. individual is confronted with alternatives
- j. the freedom to choose involves value and meaning
- k. 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. They are considered lessons of life the client hangs on to guide or influence 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

5. 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 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.

6. 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:

A. The first part in the process is structural analysis, the analysis of the person's ego states.

- **Structural Analysis** (Personality): The client examines the content and functioning of the following ego states:
- **Parent Ego State:** Instructions, attitudes, and behavior handed down mostly by parents and authority figures.
- **Nurturing Parent State**-supportive, caring, encourager
- **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 aspects:

Adapted child	controlled, product of demands, whines, cries, rebels
Natural child	spontaneous, impulsive, untrained, self-loving, pleasure-seeking, expressive
Little Professor	intuitive wisdom
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

B. The second step 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.

C. 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.

- **Game Analysis:** Ulterior transactions. Games often result in a bad feeling that serves as “pay off.” (Example: Karpman Drama Triangle: Persecutor, Victim, Rescuer).

D. 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).

- **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:

- a. I’m okay, you’re okay: optimal position (evolutionary)
- b. I’m okay, you’re not okay: paranoid (revolutionary)
- c. I’m not okay, you’re okay: depressive (devolutionary)
- d. I’m not okay, you’re not okay: helpless (obvolutionary)

Question 210:

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 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.

7. 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:

1. 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.).
2. Five layers of neuroses (similar to onion layers). Keep energy up in the service of pretenses (Corey, 1986):
 - a. Phony layer: Stereotypical, inauthentic, roles, games.
 - b. 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.
 - c. Impasse layer: Sense of deadness, feeling stuck, and lack of trust of inner resources.
 - d. Implosive layer: Fully experience deadness, expose defenses, and begin to make contact with the genuine self.
 - e. 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. Retroflexion: 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

8. 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.

9. 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.

- A. Activating event
- B. Beliefs (thoughts or perceptions about that event which can be rational or irrational)
- C. Consequences (feelings that result from beliefs)
- D. Disputation that is directed at an irrational belief
- E. 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, DiGiuseppe, 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

10. REALITY THERAPY (CONTROL THEORY-CHOICE 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 main premise in control theory is that all behavior is generated from within the person. 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). The theory is present-oriented.

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 four psychological needs. These needs are belonging, power, enjoyment, and 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.

11. 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)

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.

12. 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
 - 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.

A. 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

B. 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.

C. 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).

13. 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" (Mahler, 2004).

- Personality offers the potential for experiencing a relationship with another.
- The client constructs his/her own personal world.
- The origins of the infant lie within the parents.

- Personality development offers a deeper potential for re-experiencing a relationship with another.
- Pain, unhappiness, and suffering are rooted in hateful, negative, antagonistic, and disintegrative relationships.
- 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.

14. 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.

15. Eye Movement Desentization 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.

SUMMARY: TEN THEORIES

Basic assumptions of 10 theories

I. Psychoanalytical

- A. Medical model (biological bases)
- B. Deterministic view of human nature
- C. Personality is determined by
 - 1. Unconscious motivation
 - 2. Irrational forces
 - 3. Sexual and aggressive impulses
 - 4. Early childhood experiences
- D. Treatment is a lengthy process of analyzing inner conflicts that are rooted in the past.
- E. Therapy is the process of the therapist's direction in restructuring the personality.
- F. Development of ego and differentiation and individuation of the self

II. Adlerian

- A. People are social beings, shaped and motivated by social forces.
- B. Human nature is creative, active, and decisional.
- C. People are pushed by a need to overcome inherent feelings of inferiority and pulled by striving for superiority.
- D. We develop a style of life aimed at compensating for inferiority feelings and becoming the master of our fate.
- E. Lifestyle consists of views about ourselves and the world, and the behaviors we adopt in pursuit of our life goals.
- F. Clients are discouraged, and need encouragement to correct mistaken beliefs.
- G. Counseling is a collaborative effort, working on mutually agreed-upon goals.

III. Existential

- A. We define our lives by our choices and are authors of our lives.
- B. Clients lead a "restricted existence" using limited ways of dealing with life situations.
- C. Therapists must help clients become aware of their restricted life and their part in creating it.

IV. Person-centered

- A. We have the capacity to understand our problems, and we have the resources within us to resolve them.
- B. Emphasis is on the basic trustworthiness of human beings.
- C. Therapist gives little structure or direction.
- D. Clients need understanding, acceptance, support, and positive regard from the therapist.

V. Gestalt

- A. People must find their own way in life and accept personal responsibility if they are to hope to achieve maturity.
- B. Therapists should provide a climate in which the clients can experience their "here and now" awareness.
- C. Clients do experiments aimed at change and at finding their own meanings.
- D. They expand their own level of awareness and integrate the fragmented and unknown aspects of themselves.

VI. Transactional Analysis

- A. We are influenced by the expectations and demands (injunctions) of significant others.
- B. Certain early decisions we made may be nonfunctional, so that we must make new decisions that are more appropriate.
- C. Therapists play an active, directive role, and therapy is a collaborative effort.
- D. Clients carry out contracts to change and make new decisions.

VII. Behavior Therapy

- A. People are shaped by learning and social or cultural conditioning, interaction between person and environment.
- B. Client has ability to eliminate maladaptive behavior and acquire constructive behavior.
- C. Comprehensive assessment, then setting of specific goals.
- D. Therapist teaches client how to recognize and alter maladaptive behavioral patterns.
- E. Client must practice new behaviors in real-life situations.

VIII. Rational-Emotive Behavior Therapy

- A. 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.
- B. It is our responsibility to change distorted thinking that leads to emotional and behavioral disorders.
- C. Therapists use active, directional procedures to help clients change their faulty thinking.
- D. The goal of therapy is to substitute a rational belief system for an irrational one.

- E. Cognitive restructuring occurs through the use of homework, suggestions, and teaching.

IX. Reality Therapy

- A. Identity forms by age five or six through interaction between environment, self, and others.
- B. Humans have a growth potential. (an anti-deterministic and positive view of human nature).
- C. Behavior is goal-oriented toward achieving basic needs for self-worth, love, belonging, etc.
- D. People are responsible for their behavior, thoughts, and feelings.

X. Cognitive Therapies

- A. Primary motive for humans is search for patterns (Mahoney).
- B. There are two types of meaning: tacit and explicit.
- C. Emotions are very powerful, knowing processes.
- D. Behavior is neither good nor bad.
- E. Problems are defective learning patterns.
- F. Maladaptive thoughts and beliefs are unconscious, automatic, and individual.

GOALS OF THE TEN APPROACHES

I. Psychoanalytical

- A. Make unconscious conscious.
- B. Assist client to relive earlier experiences and work through repressed conflicts.
- C. End goal of restructuring personality.
- D. Analysis of resistance and transference.

II. Adlerian

- A. Help client develop social interest.
- B. Provide encouragement.
- C. Facilitate insight into mistaken beliefs.

III. Existential

- A. Increased self-awareness and more authentic existence.
- B. Acceptance of responsibility for making choices.

IV. Person-centered

- A. Provide climate of understanding and acceptance.
- B. Enable clients to move toward greater openness, increased self-trust, increased spontaneity.

V. Gestalt

- A. Increased awareness in the "here and now."

- B. Reintegration of all aspects of the self.

VI. Transactional Analysis

- A. Help client become more autonomous through increased awareness and insight.
- B. Help client make new decisions based on awareness.

VII. Behavior Therapy

- A. Eliminate maladaptive behavior.
- B. Learn adaptive behavior.

VIII. Rational-Emotive Behavior Therapy

- A. Change irrational beliefs into rational beliefs that lead to more effective functioning.
- B. Teach client how to use scientific method to solve his or her problems.

IX. Reality Therapy

- A. Teach client to take responsibility for his or her life and for getting his or her needs met.
- B. Help client develop a success identity through responsible behavior, which leads to feelings of self-worth and love.

X. Cognitive Therapies

- A. Separate rational from irrational thoughts.
- B. Demonstrate self-maintaining pathology.
- C. Cognitive restructuring.

BASIC HEALTH AND A STATE OF BEING HEALTHY: POSITIVE AND NEGATIVE CONDITIONS

I. Psychoanalytical

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.

II. Adlerian

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.

III. Existential

Positive: To accept aloneness and create meaning in life.

Negative: Not living with authenticity; avoiding responsibility.

IV. Person-centered

Positive: Actualize potential for growth, wholeness, spontaneity, and inner directedness.

Negative: Divergence of real self and ideal self.

V. Gestalt

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.

VI. Transactional Analysis

Positive: "Writing one's own script" and living autonomously.

Negative: Enslavement to early decisions, games, and scripts.

VII. Behavior Therapy

Positive: Using adaptive behaviors for problem solving.

Negative: Faulty learning and unadaptive behavior.

VIII. Rational-Emotive Behavior Therapy

Positive: Rational thinking.

Negative: Inaccurate and dysfunctional thinking. The uncritical acceptance of irrational beliefs.

IV. Reality Therapy

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.

X. Cognitive Therapies

Positive: Distorted thinking.

Negative: Irrational thinking. Blaming self and others.

5.11 FAMILY COUNSELING

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 (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.

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).

5.11.1 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: 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

Major family theorists and practitioners who work from the psychodynamic perspective are: Ackerman, Framo, and Boszormenyi-Nagy.

Experiential: 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 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, and therapy occurs in stages. His therapy is often referred to as the Leaning Tower of Pisa because it is unconventional.

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

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 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. These 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 raising. 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.

Strategic Family Therapy is a communication theory for problem solving. 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.

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. 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." 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.

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 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). This therapy focuses on the process of **feedback** between circumstances and the person involved. The therapist joins the family with the idea of changing the family organization so that family members experience change.

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, accommodation, mimeris, marking boundaries, and blocking.

5.11.2 KEY TERMS IN FAMILY COUNSELING

(Overview of Terminology)

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)

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.*

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.*

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.*

5.12 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 211:

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. 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 212:

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 s/he would raise his or her hand to speak and then begin to swallow, finding it difficult to speak. One day it became so unbearable she/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/her parents are desiring 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 records and in light of the fact this is an adolescent this refers to parent rights as well. Informing the client is to convey respect and allows the counselor to prepare the client for any concerns s/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 213:

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.

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 214:

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. 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.

5.13 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 new 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 patriarchal and inequalities through radical social change. Androgyny was an early formation of feminist therapies. Liberal feminism became an offshoot of or evolutionary 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.

REFERENCES

- Adkins, W. (1984). Life skills education: A video-based counseling/learning delivery system. In E. Larson (Ed.), *Teaching psychological skills* (pp. 44-68). Monterey: Brooks/Cole.
- Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin*, 82, 738-783.
- Becvar, D. S., & Becvar, R. J. (1988). *Family therapy: A systematic integration*. Boston: Allyn & Bacon.
- Beels, C.C. (2001). *A different story... the rise of narrative in psychotherapy*. Phoenix, AZ: Seig, Tucker & Theisen.
- Berne, E. (1964). *Games people play*. New York: Grove.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research and practice*, 16, 252-260.
- Brammer, L. M., & Shostrom, L. (1977). *Therapeutic psychology*. (3rd ed.). Englewoods, NJ: Prentice-Hall.
- Brown, D., & Srebalus, D. J. (2003). *Introduction to the counseling profession* (3rd ed.). Boston: Allyn & Bacon.
- Brown, J. H., & Christensen, D. N. (1999). *Family therapy: Theory and practice* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Brown, L.S. (1994). *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books.
- Capuzzi, D., & Gross, D. R. (2003). *Counseling and psychotherapy: Theories and interventions* (3rd ed.). Upper Saddle Creek, NY: Merrill Prentice Hall.
- Carkhuff, R. (1987). *The art of helping VI*. (6th ed.). Amherst, MA: Human Resource Development Press.
- Coleman, J. C. (1959). *Abnormal psychology and modern life*. Chicago: Scott Foresman.
- Corey, G. (1986). *Theory and practice of counseling and psychotherapy* (3rd ed.). Monterey: Brooks/Cole.
- Corrigan, J. D., Del, D. M., Lewis, K. N., & Schmidt, L. D. (1980). Counseling as a social influence process: A review. *Journal of Counseling Psychology*, 27, 395-441.
- Corsini, R. J., & Wedding, D. (2005). *Current psychotherapies* (7th. ed.). Upper Saddle River, NJ: Brooks/Cole, Thompson.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Cullari, S. (2001). *Counseling and psychotherapy: A practical guidebook for students, trainees, and new professionals*. Needham Heights, MA: Allyn & Bacon.
- Day, S.X. (2004). *Theory and design in counseling and psychotherapy*. Boston: Lahaska Press.
- Dreikurs, R. R. (1967). *Psychodynamics, psychotherapy, and counseling*. Chicago: Alfred Alder Institute.
- Dreikurs, R. R. (1968). *Psychology in the classroom*. New York: Harper & Row.
- Edgerton, J. E., & Campbell, R. J. (Eds.). (1944). *American psychiatric glossary* (7th ed.). Washington, DC: American Psychiatric Press.
- Egan, G. (1994). *The skilled helper* (5th ed.). Pacific Grove, CA: Brooks Cole.
- Eisenberg, S., & Patterson, L. E. (1979). *Helping clients with special concerns*. Boston: Houghton Mifflin.
- Ellis, A. (1999). Early theories and practices of rational-emotive behavior therapy and how they have been augmented and revised during the last three decades. *Journal of Rational-Emotive & Cognitive Behavior Therapy*, 17(2), 69-93
- Epperson, D., Bushway, D., & Warman, R. (1983). Client self-termination after one counseling session: Effects of problem recognition, counselor gender, and counselor experience. *Journal of Counseling Psychology*, 30, 307-315.

- Eysenck, H. J. (1966). *The effects of psychotherapy*. New York: International Science Press.
- Frankl, V. (1962). *Man's search for meaning: An introduction to logotherapy*. New York: Washington Square Press.
- Garfield, S. L., & Bergin, A. E. (1986). *Handbook of psychotherapy and behavior change: An empirical analysis*. New York: Wiley & Sons.
- Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy. *The Counseling Psychologist*, 13, 155-244.
- Gendlin, E. T. (1984). The politics of giving therapy away: Listening and focusing. In D. Larsen (Ed.), *Teaching psychological skills* (pp. 288-305). Monterey: Brooks/Cole.
- George, R. L., & Cristiani, T. S. (1990). *Counseling theory and practice* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.
- Gladding, S. T. (1988). *Counseling: A comprehensive profession*. Columbus, Ohio: Merrill.
- Gladding, S. T. (1996). *Counseling: A comprehensive profession* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Glasser, W. (1969). *Schools without failure*. New York: Harper and Row.
- Glasser, W. (1998). *Choice theory: A new psychology of personal freedom*. New York: Harper Collins.
- Goldenberg, L., & Goldenberg, H. (1991). *Family therapy: An overview* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- Goldstein, A. P. (1981). *Applying structured learning therapy*. New York: Pergamon.
- Greenson, R. R. (1967). *Technique and practice of psychoanalysis*. New York: International Universities Press.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factor? *Professional Psychology: Research and Practice*, 21, 72-378.
- Gurman, A. S., & Kriskern, D. P. (1991). *Handbook of family therapy*. New York: Bruner/Mazel.
- Hackney, H. L., & Cormier, L. S. (1996). *The professional counselor: A process guide to helping* (3rd ed.). Boston: Allyn & Bacon.
- Hall, C. S., & Lindzey, G. (1970). *Theories of personality* (3rd ed.). New York: Wiley & Sons.
- Hansen, J. C., Stevic, R., & Warner, R. W. (1986). *Counseling theory and process*. Boston: Allyn & Bacon.
- Hazel, R. J. (2003). Person-centered theory. In D. Capuzzi & D. R. Gross, *Counseling and psychotherapy: Theories and interventions* (3rd ed., pp. 157-180.). Upper Saddle River, NJ: Prentice-Hall.
- Held, B. S. (1995). *Back to reality: A critique of postmodern theory in psychotherapy*. New York: Norton.
- Ivey, A. (1994). *Intentional interviewing and counseling: Facilitating client development, psychotherapy psychoeducation* (2nd ed.). Springfield, IL: Charles C. Thomas.
- Ivey, A., & Galvin, M. (1984). Microcounseling: A metamodel for counseling, therapy, business, and medical interviews. In D. Larson (Ed.), *Teaching psychological skills* (pp. 207-228). Monterey: Brooks/Cole.
- Johnson, D. W. (1997). *Reaching out: Interpersonal effectiveness and self-actualization* (6th ed.). Boston: Brooks/Cole.
- Kagan, N. (1984). Interpersonal process recall: Basic methods and recent research. In D. Larsen (Ed.), *Teaching psychological skills* (pp. 230- 243). Monterey: Brooks/Cole.
- Kelly, K. (1991). Theoretical integration is the future for mental health counseling. *Journal of Mental Health Counseling*, 13, 106-111.
- Kitanishi, K., & Mori, A. (1995). Morita therapy: 1919 to 1995. *Psychiatry and Clinical Neurosciences*, 49, 245-254.
- Kokotovic, A. M., & Tracey, T. J. (1987). Premature termination at a university counseling center. *Journal of Counseling Psychology*, 34, 80-82.

- Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology*, 37, 16-21.
- Kottler, J. A., & Brown, R. W. (2000). Introduction to therapeutic counseling: Voices from the field (4th ed.). Belmont, CA: Wadsworth/Thompson Learning.
- Krumboltz, J. D. (1966). Behavioral goals of counseling. *Journal of Counseling Psychology*, 13, 153-159.
- Lambert, M. J., & Cattani-Thompson, K. (1996). Current findings regarding the effectiveness of counseling: Implications for practice. *Journal of Counseling and Psychotherapy*, 74, 601-608.
- Landis, J. T., & Landis, M. (1948). *Building a successful marriage*. New York: Prentice Hall.
- Larson, D. (1984). Teaching psychological skills: Models for giving psychology away. Monterey: Brooks/Cole.
- Lazarus, A. A., & Beutler, L. E. (1993). On technical eclecticism. *Journal of Counseling and Development*, 71, 381-385.
- Leathers, D. G. (1976). Nonverbal communication systems. Boston: Allyn & Bacon.
- Levi-Straus, C. (1966). The family. In: Shapiro, H. L. *Man, culture, and society*. New York: Oxford Press.
- Linehan, M. M. (1993). Cognitive behavioral treatment of borderline personality disorder. New York: The Guilford Press.
- Mahrer, A. R. (2004). Theories of truth, models of usefulness: Toward a revolution in the field of psychotherapy. London: Whurr.
- Maslow, A. (1973). The further reaches of human nature. New York: Viking.
- McBride, M. C., & Martin, G. E. (1990). A framework for eclecticism: The importance of theory to mental health counseling. *Journal of Mental Health Counseling*, 12, 495-505.
- McNeil, B. W., May, R. J., & Lee, V. E. (1987). Perceptions of counselor source characteristics by premature and successful terminators. *Journal of Counseling Psychology*, 34, 86-89.
- Meier, S. T., & Davis, S. R. (2001). *The elements of counseling* (4th ed.). Belmont, CA: Wadsworth.
- Mennicke, S. A., Lent, R. W., & Burgoyne, K. L. (1988). Premature termination from university counseling center: A review. *Journal of Counseling and Development*, 66, 458-465.
- Milliren, A. P., Evans, T., & Newbauer, J. F. (2003). Adlerian counseling and psychotherapy. In D. Capuzzi & D. R. Gross, *Counseling and psychotherapy: Theories and interventions* (3rd ed., pp. 91-130). Upper Saddle River, NJ: Prentice-Hall.
- Mosak, H. (1989). Adlerian psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (4th ed., pp. 65-116). Itasca, IL: Peacock.
- Moursund, J. (1985). The process of counseling and therapy. Saddle River, NJ: Prentice-Hall.
- Moursund, J. (1990). The process of counseling and therapy (2nd ed.). New York: Pergamon.
- Moursund, J., & Kenny, M. C. (2002). *The process of counseling and therapy* (4th ed.). Upper Saddle River, NJ: Prentice-Hall.
- Murdock, N.L. (2009). *Theories of counseling and psychotherapy: A case approach* (2nd ed.). Upper Saddle River, NJ: Pearson Education, Inc.
- Najavits, L. M., & Strupp, H. H. (1994). Differences in the effectiveness of psychodynamic therapists: A process outcome study. *Psychotherapy*, 31, 114-123.
- Najavits, L. M., & Weiss, R. D. (1994). Variations in therapist effectiveness in treatment of patients with substance use disorders: An empirical review. *Addiction*, 89, 679-688.
- Norcross, J. C. (2004). Tailoring the therapy relationship to the individual patient: Evidence-based practices. *Clinician's Research Digest, Supplemental Bulletin* 30, 1-2.

- Novice, G. J. (2003). Psychoanalytic theory. In D. Capuzzi, & D. R. Gross, *Counseling and psychotherapy: Theories and interventions* (3rd ed., pp. 47-67). Upper Saddle River, NJ: Prentice-Hall.
- Nugent, F. A. (1994). *An introduction to the counseling profession* (2nd ed.). New York: Macmillan College Publishing.
- Peterson, J. V., & Nisenholz, B. (1995). *Orientation to counseling* (3rd ed.). Boston: Allyn & Bacon.
- Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis*. Homewood, IL: Dorsey Press.
- Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Schulz, D. A. (1976). *The changing family: Its function and future*, (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.
- Seligman, L. (2001). *Systems, strategies, and skills of counseling and psychotherapy*. Upper Saddle River, NJ: Prentice-Hall.
- Sexton, T. L. (1999). Evidence-based counseling: Implications for counseling practice, preparation, and professionalism. *ERIC Digest*. www.ed.gov/databases/ERIC
- Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: Guilford Press.
- Sharf, R.S. (2008). *Theories of psychotherapy and counseling: Concepts and cases* (4th ed.). Belmont, CA: Thomas Higher Education
- Srebalus, D. J., & Brown, D. (2001). *A guide to the helping professions*. Boston: Allyn & Bacon.
- St. Clair, M. (1986). *Object relations and self-psychology: An introduction*. Monterey: Brooks/ Cole.
- Steffler, B., & Matheny, K. (1968). *The function of counseling theory*. Boston: Houghton Mifflin.
- Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, 15, 215-224.
- Truax, C., & Carkhuff, R. (1967). *Toward effective counseling and psychotherapy*. Chicago: Aldine.
- Vaillant, G. E. (1977). *Adaptation to life*. Boston: Little, Brown, and Company.
- Walen, S. R., DiGiuseppe, R., & Wessler, R. L. (1980). *A practitioner's guide to RET*. New York: Oxford University Press.
- Weitz, S. (1979). *Nonverbal communication: Readings with commentary* (2nd ed.). New York: Oxford University Press.
- Wellins, R. S., Byham, W. C., & Wilson, J. M. (1991). Empowered teams: Creating self-direct work groups that improve quality, productivity, and participation (p. 50). San Francisco: Jossey-Bass.
- Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. [Special issue: Wellness through the life span]. *Journal of Counseling & Development*, 71 (2), 140-148.



Group Work

6.1 INTRODUCTION

The content of Chapter Six primarily focuses on the dynamics and process of group work. The latter part of this chapter 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 in 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.

6.2 CACREP OBJECTIVES

CACREP objectives for group work are not presented in full. Therefore, those preparing for the NCE may want to visit their website for the full standard objectives.

The group objectives are:

- a. principles of group dynamics
- b. leadership styles
- c. group theory
- d. counseling methods
- e. types of groups and approaches
- f. preparation standards
- g. ethical and legal considerations

Question 215: 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

Question 216: 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

Question 217: Objective c.

The group theory that encourages spontaneity, creativity, present, encounter, and 'tele' is:

- a. Person-centered.
- b. Psychodrama.
- c. dlerian.

- d. Psychoanalytic.

Question 218: Objective d.

The ethical code for growth group formation recommends a pre-interview. One reason why 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.

Question 219: Objective e.

One type of group that can exceed 20 members and still function as a group is:

- a. task.
- b. encounter.
- c. growth.
- d. Balint

Question 220: Objective f.

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

Question 221: Objective g.

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. Members should be careful to not use:

- 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.
-

Question 222:

Self-disclosure is more frequent at which stage of group development?

- a. initiating
 - b. transition
 - c. working
 - d. termination
-

Question 223:

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
-

Question 224:

The most important issue in developing a group is which of the following?

- a. interviewing all group members before beginning 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
-

Question 225:

"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
-

Answers: 215 a. 216. b. 217 b. (tele-action at a distance) 218 d. 219. a.
220. c. (Conye & Wilson, 1998) 221. b. 222. c. 223. d. 224. a. 225. d.

6.3 Terms

Definitions for the following terms can be found at the end of this chapter.

Autocratic Leadership	Group Mind
Balint	Group
Blocking	Here and Now
Boston Model	Icebreaker
Capping	Leveling
Charismatic Leader	Lewin, Kurt
Co-leadership	Mandate Phenomenon
Conformity	Mindlessness
Contagion	Norms
Critical Incidents	Power
Dynamics	Premature Termination
Emergent Norm Theory	Primary Group
Empowerment	Reingelmann Effect
Encounter	Self-help group
Entitativity (group	Sociometry
Farewell Party Syndrome	T-group
FIRO	Task group
Fishbowl	University

6.4 Group

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.”

6.4.1 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).

6.4.2 GROUP DEFINITIONS AND TYPES OF GROUPS

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). "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" (Shaw, 1976, 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 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

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 group psychotherapy (1), therapeutic groups (2), human development and training groups (3), and self-help groups (4). 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 Groups (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:

Groups: Other Types (5)

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 Groups: A 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 Groups: 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 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.

6.4.3 CHARACTERISTICS OF A GROUP

(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.

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. Fuhrman 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.

6.4.4 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.

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.

6.4.5 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.

6.4.6 THE PROCESS OF GROUP FORMATION

1. 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:

Elderly, six to eight;

Substance abusers, 12 to 20;

Alcohol abusers and adolescents, eight to 12;

Alcohol and adult inpatients, five to six; Psychotherapy theme, six to eight;

Psychoeducational theme, ten to 14;

Insight and personal change, eight to 12; Self-help, ten to 20;

Preschool, five or less;

Preadolescent, five to seven;

Adolescent, short duration five to seven, longer duration seven to ten;

Existential, problem solving eight to 12; Under medical care three to four;

Person-centered, eight to 12;

Adlerian, ten to 12;

Multimodal, four to 10;

Gestalt, eight;

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:

- A. more rapid, mutual identification
- B. more rapid development of insight
- C. shorter duration of psychotherapy
- D. more regular attendance
- E. decreased resistance and destructive behavior
- F. less cliquing and subgrouping
- G. more rapid symptom removal
- H. 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)

- A. therapy is deeper
- B. reality testing is more thorough
- C. intragroup transferences are more readily formed
- D. groups are more easily put together
- E. 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.

2. 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:

- A. 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.
- B. 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).
- C. Other reasons:
 - 1. a sense of something missing in life
 - 2. feelings of meaninglessness
 - 3. to diffuse anxiety
 - 4. anhedonia
 - 5. identity confusion
 - 6. mild depression
 - 7. self-derogation/self-destruction
 - 8. compulsive work aholism
 - 9. fear of success
 - 10. critical incidents

Forsyth (1990), in reviewing group 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:

- A. Survival: feeding, defense, nurturing, reproduction
- B. Psychological: affiliation, power, affection
- C. Interpersonal: emotional and social support
- D. 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:

- A. Similarity/attraction effect. Newcomb (1960) said there are four forces acting to cause a similar attraction effect.
- B. 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.
- C. Interaction at a future time is more likely and will be free of conflict.
- D. People feel unity with those like them.

- E. To dislike someone similar is distressing.
- F. Complementarily-of-needs hypothesis. People are attracted to those who are dissimilar in that they fulfill or complement their needs.
- G. 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.
- H. Self-evaluation maintenance model. Tesser 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.
- I. 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.
- J. 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.
- K. 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.

3. 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:

- A. External Factors: These are factors outside of the group.
 - 1. physical, such as moving, scheduling, illness, etc.
 - 2. external stress, such as disruption of significant member of his/her life.
- C. 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:
 - 1. lacks psychological sophistication
 - 2. lacks interpersonal sensitivity
 - 3. lacks personal psychological insight
 - 4. remains on the symptom level
 - 5. is unable to participate in the group task

6. finds that his/her contributions fail to match high group standards
 7. does not value or desire personal change
- C. Intimacy: A member who has difficulty with self-disclosure usually has:
1. maladaptive self-disclosure (too much/little)
 2. unrealistic demands for instant intimacy
 3. 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.

- D. Fear of Emotional Contagion: Examples of a contagion are:
1. fear of hearing the problems of other members. A sign of permeable (penetrate) ego boundaries and inability to differentiate oneself from significant others.
 2. intolerable fear of being alone and an irrational sense that one does not exist unless one is being observed and attended by others.
 3. 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
- E. Inability to share the therapist: A selfish need often indicative of a strong dependency need.
- F. Concurrent Individual and Group Therapy: Some members learn to play one form of therapy off the other, thereby delaying improvement and commitment.
- G. 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.
- H. 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.
- I. Complications arising from subgrouping: Sometimes when the group is a size larger than desired, subgrouping occurs.
- J. 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.

4. Socialization

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:

A. Investigation:

A cautious search for information. Members engage in a reconnaissance. The group estimates the value of each member.

B. Socialization:

Group's view is accepted in place of old perceptions and views. Members accept (assimilates) group's norms, values, and perspectives.

C. 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).

D. 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).

E. 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.

5. 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 difficulty 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 226:

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. The following listing of authors (next page) 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 Phase 1	Stage 2 Phase 2	Phase 3 Stage 3	Phase 4 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	Preaffiliation	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	Forming
Bales & Strodtbeck	Orientation
Bennis & Shepard	Dependence
Schultz	Inclusion
Tuckman	Forming
Boston Model	Pre-affiliation
Kaplan	Dependency
Fisher	Orientation
Trotzer	Security
Levine	Parallel

Middle Sessions:

Thelen & Dickerman	Conflict-Harmony
Bales & Strodtbeck	Evaluation
Bennis & Shepard	Interdependence, Focused Work
Schutz	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
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Bales & Strodtbeck	Control
Benis & Shepard	Productivity
Schultz	Affection
Tuckman	Adjourning
Boston Model	Differentiation
Kaplan	Intimacy
Fisher	Reinforcement
Trotzer	Closing
Levine	Termination

Sequential Stages and Phases Developed

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

- a. Discomfort of ego
- b. Caution
- c. **ISSUE:** In or out of group
- d. Usually a time of primary tension

2. Storming

- 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

- a. Rules of behavior are appropriate and necessary
- b. Greater degree of order
- c. **ISSUE:** For or against

4. Performing

- 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

A. INTERPERSONAL RELATIONSHIPS

1. Forming: Testing and dependency
2. Storming: Tension and conflict
3. Norming: Cohesion
4. Performing: Functional role relationship

B. TASK

1. Forming: Task definition, boundaries, exchange of functional information
2. Storming: Natural emotional response to task
3. Norming: Shared interpretations and perspectives
4. 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.

- a. self-disclosure
- b. confrontation
- c. feedback

Tasks A. working stage for behavior change
 B. conflict and struggle for control

Leader A. reinforcement, caring, confrontation

Member A. interacts openly and directly
 B. expresses some amount of risk with knowledge; respect will be forthcoming
 C. resolves difficulties with sensitivity, not judgment
 D. 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 A. cohesion development
 B. risk-sharing

Leader A. reinforcement
 B. search for common themes
 C. interpretation, modeling
 D. aware of therapeutic factors

Members A. shares issues
 B. provides feedback to others
 C. challenges and support members

Stage 4: FINAL - CONSOLIDATION AND TERMINATION

Characterized: Transferring what they learned in the group to their outside environment, consolidation of learning, summarizing, integrating, and interpreting the group experience.

Tasks A. separation anxiety
 B. unfinished business

Leader A. termination issues unresolved
 B. reinforce changes
 C. feedback to others
 D. applied learning

Members A. feelings of separation
 B. generalize new learning
 C. provide 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 ONE: ORIENTATION

- A. establish common basis for functioning
- B. communication oriented to each other
- C. task dimension approached

PHASE TWO: CONFLICT

- A. form opinions about their own position in group
- B. compete for status within group
- C. assert individuality
- D. persuasive attempts at changing other's opinions

PHASE THREE: EMERGENCE

- A. group settles on norms
- B. moves toward consensus via ambiguity
- C. conflict continues

PHASE FOUR: REINFORCEMENT

- A. sense of direction
- B. consensus of opinion
- C. group identity
- D. genuine sense of accomplishment
- E. reinforcement of group decisions

Levine's Recurring Phases

Baruch 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.
 - 1a. 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 Strodbeck (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.

6.4.7 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.

6.4.8 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:

- The degree to which members of the group desire to remain in the group (Cartwright, 1968, p. 91).
- "The total field of forces acting on members to remain in the group" (Festinger, Schachter, & Bach, 1950, p. 164).
- "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.
- "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).
- "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. 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). (See Chapter 5). 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 in 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.
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:

- A. **Directness:** Overt methods such as threats, demands, and indirect methods such as evasion
- B. **Rationality:** Tactics which employ bargaining, reasoning and persuasion, while the nonrational ones utilize misinformation and emotional responses
- C. **Bilaterality:** Tactics whereby both parties are involved in negotiation. Unilateral tactics are one way, such as demands or disengagement.

6.4.9 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

6.4.10 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.

Question 227:

It is through group _____ that members learn to regulate, evaluate, and coordinate their actions:

- a. dynamics
- b. norms
- c. feedback
- d. roles

Answer: b.

6.4.11 GROUP LEADERSHIP:

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.

6.4.12 GROUP LEADERSHIP STANDARDS

In 1992, ASGW published standards for leader qualifications. These standards 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 standards specify two levels. The first level is core knowledge and skill competencies. 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 is to specialize in one of four types of groups- facilitative, task, counseling, and psychotherapy.

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 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) summarizes 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. Summary disadvantages were lack of coordinated efforts, too leader-focused, competition, and collusion.

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).

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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 228:

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 style of leadership tends to be highest in satisfaction in small, interaction groups.

6.4.13 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 229:

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.

Question 230:

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. Answer d. is a viable option, however without more information this behavior may be premature.

Question 231:

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: b. Consensus is the core behavior of 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 232:

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. 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

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:

1. 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.

2. 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

3. 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.

4. 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.

5. 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.

6. 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.

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, naivete, 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:

A. Emotionally Debilitated:

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.

B. 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.

C. 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: Smooths 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 behavior. It is usually an error to confront the negative member about his/her negativistic 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 not make direct eye contact with a negative person. Sometimes this behavior will intensify the feelings and behavior.
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 is a helpful technique. 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 233:

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 allow the family-of-origin sharing to continue
- b. suggest to the person to take a break for some water and return when he/she is ready
- c. create a break in 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: d. It is recommended crying behavior this early in a group formation is not to focus on the individual. Creating dyads will allow this person to feel a bit more in control and less intensity of group pressures. If the member is able to speak to one person about what one is feeling at the moment, to regroup may be sufficient. No doubt you could develop a better alternative.

6.5 SPECIFIC TECHNIQUES

1. 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:

- a. rambling
- b. sharing comments which conflict with the group's purpose
- c. saying something hurtful
- d. saying inaccuracies
- e. rescuing
- f. arguing

- g. session is nearing the end (2002, p. 161)

Timing is crucial for intervention. 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 234:

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.

Question 235:

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 best ways for the leader to know 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. 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.

2. 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.

3. 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.

4. 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. The leader or another member has to be insightful and synthesize a common bridge of understanding. Jacobs, et al. (2002) refer to this behavior as tying together.

Question 236:

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. How should this be done?

- 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
- 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. 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 in as others have perhaps a different answer would be suggested.

5. 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:

- a. 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.

- b. 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).
- c. 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.
- d. 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).

Question 237:

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. 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 it will:

- a. diminish sharing by all members.
- b. not clarify why the interruption has occurred.
- c. shift the focus away from the topic.
- d. shift the focus away from the person to a topic.

6. 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" (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 one another. 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 238:

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: d. There is limited time remaining. If more time is available, the leader may respond.

7. 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.

6.6 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 those of 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

Individuals 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.

6.7 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. Rather, it is an evolution in development, which reflects more of a sequencing of events and process. 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):

- a. milling around
- b. resistance to personal expressions/ explorations
- c. descriptions of past feelings
- d. expression of negative feelings
- e. expression/exploration of personally meaningful material
- f. expression of immediate interpersonal feelings in the group
- g. development of healing capacity
- h. self-acceptance and beginning of change
- i. cracking of facades
- j. feedback
- k. confrontation
- l. helping relationships outside group
- m. basic encounter
- n. expression of positive feelings/closeness
- o. 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 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. This includes guidelines in selecting members. Ground rules are made up by the membership. Goals: Self-awareness and awareness of others.

2. 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, retrofect, 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, 1988).

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. Be 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).

3. 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 as individuals goal-oriented 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 (1988) and Gladding (1995) view the process as developing in the following four phases:

- a. Phase 1: Developing a relationship
- b. Phase 2: Analysis and assessment
- c. Phase 3: Insight
- d. 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.

4. 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. The individual attempts to meet his/her psychological and physiological needs. Control 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 four 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 in a rational process. It is a 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 control theory is a process and does not 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.

5. 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.

Phases: Three phases:

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.
2. **Action Phase** - when reenactment takes place. The members and group work through focusing on the exploration. Interpersonal issues are worked through.
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.

6. RATIONAL-EMOTIVE BEHAVIOR THERAPY:

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 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.

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 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: Directive, confronting, active. Serves as a teacher, illustrating how a person connects emotions and behavior. Many people have conditioned themselves into "musts." 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 RET 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 RET and personal understanding of the change process (Gladding, 1995).

7. EXISTENTIAL:

Victor Frankl, Ludwig Binswanger An example of existential thought is Victor Frankl’s logotherapy (Corey, 1995).

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.

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 is often 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. 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.

8. 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 the 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 he calls 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. Participant-observer.

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.

9. PSYCHOANALYTIC:

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, who 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.

10. TRANSACTIONAL ANALYSIS:

Eric Berne, 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 RET 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.

Question 239:

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.

Question 240:

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.

Question 241:

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

Question 242

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.

Question 243:

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. System for the Multiple Level Observation of Groups. NGT is a nominal-group technique, a six-step procedure to help nonworking groups become productive.

6.8 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 (FIRO). 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 Crowd*; 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.

REFERENCES

- Allen, R. D. (1931). A group guidance curriculum in the senior high school. *Education*, 52, 189-194.
- Asch, S. E. (1952). *Social psychology*. Englewood Cliffs, NJ: Prentice-Hall.
- ASGW. (1990). ASGW ethical guidelines for counselors. *Journal for Specialist in Group Work*, 15 (12), 119-126.
- Bales, R. F. (1955). How people interact in conferences. *Scientific American*, 192(3), 31-35.
- Bales, R. F., & Strodtbeck, F. L. (1951). Phases in group problem solving. *Journal of Abnormal and Social Psychology*, 46, 485-495.

- Balint, M. (1957). *The doctor, his patient, and the illness*. New York: International Universities Press.
- Beck, A. P., Dugo, J. M., Eng, A. M., Lewis, C. M., & Peters, L. N. (1983). The participation of leaders in the structural development of therapy groups. In R. R. Dies & K. R. MacKenzie (Eds.). *Advances in group psychotherapy: Integrating research and practice*. New York: International Universities Press.
- Benne, K. D., & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues*, 4(2), 41-49.
- Bennis, W. G., & Shepard, H. A. (1956). A theory of group development. *Human Relations*, 9, 415-437.
- Berg, R. C., Landreth, G. J., & Fall, K. A. (1998). *Group counseling: concepts and procedures* (3rd ed.). Philadelphia, PA: Accelerated Development.
- Berzon, B., Pious, C., & Farson, R. (1963). The therapeutic event in group psychotherapy: A study of subjective reports by group members. *Journal of Individual Psychology*, 19, 204-212.
- Bion, W. R. (1948). Experience in groups. *Human Relations*, 1, 314-329.
- Bion, W. R. (1985). Experiences in groups and other papers. In I. D. Yalom, *The theory and practice of group psychotherapy* (3rd ed.). New York: Basic Books.
- Blake, R. R., & Mouton, J. S. (1964). *The managerial grid*. Houston, TX: Gulf.
- Bloch, S. (1986). Therapeutic factors in group. In A. J. Frances & R. E. Hales (Eds.), *Annual review* (Vol. 5, pp. 678-698). Washington, DC: American Psychiatric Press.
- Bonner, H. (1959). *Group dynamics*. New York: Ronald Press.
- Braaten, L. J. (1991). Group cohesion: A new multidimensional model. *Group*, 15, 39-53.
- Brammer, L. M., & Shostrom, E. L. (1960). *Therapeutic psychology*. Englewood Cliffs, NJ: Prentice-Hall.
- Brilhart, J. K. (1982). *Effective group discussion* (4th ed.). Dubuque, IA: Wm C. Brown.
- Brodbeck, M. (1958). Methodological individualism: Definition and reduction. In D. Cartwright & A. Zander, *Group Dynamics*. New York: Harper & Row.
- Brown, N. W. (1992). *Teaching group dynamics: Process and practice*. Westport, CT: Praeger.
- Burke, J. F. (1989). Contemporary approaches to psychotherapy and counseling: The self regulation and maturity model. Pacific Grove, CA: Brooks/Cole.
- Capuzzi, D. & Gross, D. R. (1992). *Introduction to group counseling*. Denver: Love Publishing.
- Carroll, M. R., & Wiggins, J. (1990). *Elements of group counseling: Back to the basics*. Denver: Love Publishing.
- Cartwright, D. (1968). The nature of group cohesiveness. In D. Cartwright & A. Zander, *Group dynamics: Research and theory*. New York: Harper & Row.
- Cartwright, D., & Zander, A. (1968). *Group dynamics: Research and theory* (3rd ed.). New York: Harper & Row.
- Chaplin, J. P. (1968). *Dictionary of psychology*. New York: Dell Publishing.
- Clark, R. D., III, & Sechrest, L. B. (1976). The mandate phenomenon. *Journal of Personality and Social Psychology*, 34, 1057-1061.
- Cohen, A. M., & Smith, R. D. (1976). Critical incidents in growth groups: Theory and techniques. In R. W. Napier & M. K. Gershenfeld, *Groups: Theory and experience* (3rd ed.). Boston: Houghton Mifflin.
- Conway, J. A. (1967). Problem-solving in small groups as a function of open and closed individual belief systems. *Organizational Behavior and Human Performance*, 2, 394-405.

- Conye, R. K. & Wilson, F. R. (1998). Toward a standards-based classification of group work offering. *Journal for Specialist in Group Work*, 23 (2), 117-184.
- Corey, G. (1990). *Theory and practice of group counseling* (3rd ed.). Pacific Grove, CA: Brooks/Cole.
- Corey, G. (1995). *Theory and practice of group counseling* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Corey, G. (2000). *Theory and practice of group counseling* (7 th ed.). Pacific Grove, CA: Brooks/ Cole.
- Corsini, R. J. (1957). *Methods of group psychotherapy*. Chicago: James.
- Corsini, R. J. (1989). Method of group psychotherapy. In G. M. Gazda, *Group counseling: A developmental approach* (4th ed., p. 23). Boston: Allyn & Bacon.
- Corsini, R., & Rosenberg, B. (1955). Mechanisms of group psychotherapy: Processes and dynamics. *Journal of Abnormal & Social Psychology*, 51, 406-411.
- Couch, R. R., & Childers, J. H. (1987). Leadership strategies for instilling and maintaining hope in group counseling. *Journal of Specialist in Group Work*, 138-143.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Donigian, J., & Hulse-Killacky, D. (1999). *Critical incidents in groups* (2nd ed.). Belmont, CA: Brooks/ Cole.
- Drum, D. J., & Knott, J. E. (1989). Structured groups for facilitating development: Acquiring life skills, resolving life themes, and making life transitions. In G. M. Gazda, *Group counseling: A developmental approach* (4th ed., p. 123). Boston: Allyn & Bacon.
- Eddy, W. B., & Lubin, B. (1989). Laboratory training and encounter groups. In G. M. Gazda, *Group counseling: A developmental approach* (4th ed.). Boston: Allyn & Bacon.
- Edelwich, J., & Brodsky, A. (1992). *Group counseling for the resistant client*. New York: Lexington Press.
- Elizabeth, P. (1983). Comparison of a psychoanalytic and a client centered group treatment model on measures of anxiety and self-actualization. *Journal of Counseling Psychology*, 30, 425-428.
- Elmes, M. B., & Gemmill, G. (1990). T psychodynamics of mindlessness and dissent in small groups. *Small Group Behavior*, 21(1), 28-44.
- Falbo, T. (1977). The multidimensional scaling of power strategies. *Journal of Personality and Social Psychology*, 35, 537-548.
- Festinger, L. (1950). Informal social communication. *Psychological Review*, 57, 271-282.
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117-140.
- Festinger, L., Schachter, S., & Back, K. (1950). *Social pressures in informal groups: A study of human factors in housing*. New York: Harper & Brothers.
- Fiedler, F. E. (1978). The contingency model and the dynamics of the leadership process. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 12, pp. 59-112). New York: Academic Press.
- Fisher, B. A. (1970). *The counselor and the group Integrating theory, training, and practice*. Monterey, CA: Brooks/Cole.
- Forsyth, D. R. (1990). *Group dynamics* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- French, J. R. P., & Raven, B. (1968). The bases of social power. In D. Cartwright & A. Zander (Eds.), *Group dynamics: Research and theory* (3rd ed.). New York: Harper & Row.
- French, J. R. P., & Raven, B. (1959). The bases of social power. In D. Cartwright (Ed.), *Studies in social power*. Ann Arbor: Institute on Social Research.

- Fuhrman, A., & Burlingame, G. M. (1990). Consistency of matter: A comparative analysis of individual and group variables. *The Counseling Psychologist*, 18, 6-63.
- Furst, W. (1963). Homogeneous versus heterogeneous groups. In M. Rosenbaum & M. Berger (Eds.), *Group psychotherapy and group functions*. New York: Basic Books.
- Gazda, G. M. (1989). *Group counseling: A developmental approach* (4th ed.). Boston: Allyn & Bacon.
- Gazda, G. M., Duncan, J. A., & Meadows, M. E. (1969). Group counseling and group procedures-Report of a survey. In G. M. Gazda, *Group counseling: A developmental approach* (4th ed.). Boston: Allyn & Bacon.
- Gibbs, J. (1981). Norms: The problem of definition and clarification. In J. E. Baird, Jr., & S. B. Weinberg, *Group communication: The essence of synergy* (2nd ed.). Dubuque, IA: Wm C. Brown.
- Gladding, S. T. (1991). *Group work: A counseling specialty*. New York: Macmillan Publishing Company.
- Gladding, S. T. (1995). *Group work: A counseling specialty* (2nd ed.). Upper Saddle River, NJ: Merrill.
- Gladding, S. T. (2003). *Group work: A counseling specialty* (4th ed.). Upper Saddle River, NJ: Merrill.
- Glasser, S. T. (1984). Reality therapy. In R. J. Corsini (Ed.), *Current psychotherapies* (3rd ed., pp. 320-353). Itasca, IL: F. E. Peacock.
- Golembiewski, R. T. (1962). *The small group: An analysis of research concepts and operations*. Chicago: The University of Chicago Press.
- Halpin, A. W., & Winer, B. J. (1952). *The leadership behavior of the airplane commander*. Columbus: Ohio State University Research Foundation.
- Hare, A. P. (1976). Handbook of small group research (2nd ed.). In R. W. Napier & M. K. Gershenfeld, *Groups: Theory and experience* (3rd ed.). Boston: Houghton Mifflin.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York: Wiley.
- Hersey, P., & Blanchard, K. H. (1969). Life-cycle theory of leadership. In R. W. Napier & M. K. Gershenfeld, *Groups: Theory and experience* (3rd ed.). Boston: Houghton Mifflin.
- Hill, W. F. (1957). Analysis of interviews of group therapists' papers. *Provo Papers*, 1, 1.
- Hollander, E. P. (1985). Leadership and power. In G. Lindzey & E. Aronson (Eds.), *Handbook of Social Psychology* (Vol 2, 3rd ed., pp. 485- 537). New York: Random House.
- Jacobs, A. (1974). Affect in groups. In A. Jacobs & W. Spradlin (Eds.), *The group as agent of change*. New York: Behavioral.
- Jacobs, E. E., Harvill, R. L., & Masson, R. L. (1988). *Group counseling: Strategies and skills*. Pacific Grove, CA: Brooks/Cole.
- Jacobs, E. E., Harvill, R. L., & Masson, R. L. (1994). *Group counseling: Strategies and skills* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Jacobs, E. E., Masson, R. L., & Harvill, R. L. (2002). *Group counseling: Strategies and skills* (4th ed.). Pacific Grove, CA: Brooks/Cole.
- Janis, I. L. (1982). *Groupthink: Psychological studies of policy decisions and fiascos* (2nd ed.). Boston: Houghton Mifflin.
- Johnson, D. W., & Johnson, F. P. (1997). *Joining together: Group theory and group skills* (6th ed.). Boston: Allyn & Bacon.
- Kaplan, S. R. (1967). Therapy groups and training groups: Similarities and differences. *International Journal of Group Psychotherapy*, 17, 473-504.
- Kellerman, H. (1979). *Group psychotherapy and personality: Intersecting structures*. New York: Grune & Stratton.
- Kipnis, D. (1984). The use of power in organizations and in interpersonal settings. In S. Oskamp (Ed.), *Applied social psychology annual* (Vol. 5, pp. 179-210). Newbury Park, CA: Sage.

- Kottler, J. A. (1994). *Advanced group leadership*. Pacific Grove: Brooks/Cole.
- Lakin, M. (1972). *Interpersonal encounter: Theory and practice of sensitivity training*. New York: McGraw-Hill.
- LeBon, G. (1895/1960). *The crowd* (translation of *Psychologie des foules*). New York: The Viking Press.
- Levine, F. (1979). *Group psychotherapy: Practice and development*. Englewood Cliffs, NJ: Prentice-Hall.
- Levine, F. (1991). *Group psychotherapy: Practice and development* (2nd ed.). Prospect Heights, NJ: Waveland Press, Inc.
- Lewin, K. (1944). The dynamics of group action. *Educational Leadership*, 1, 195-200.
- Lewin, K. (1951). *Field theory in social science*. New York: Harper.
- Lewin, K., Lippitt, R., & White, R. (1939). Patterns of aggressive behavior in experimentally created "social climates." *Journal of Social Psychology*, 10, 271-299.
- Lieberman, M., Yalom, I., & Miles, M. (1973). *Encounter groups: First facts*. New York: Basic Books.
- Lifton, W. M. (1967). *Working with groups*. New York: John Wiley & Sons.
- Luft, J. (1969). *Human interaction*. Palo Alto, CA: Mayfield.
- Moreland, R. L., & Levine, J. M. (1982). Socialization in small groups: Temporal changes in individual-group relations. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 15, 137-192). New York: Academic Press.
- Moursund, J., & Kenny, M. C. (2002). *The process of counseling and group therapy* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- Nelson-Jones, R. (1992). *Group leadership: A training approach*. In B. W. Posthuma, *Small groups in counseling and therapy* (2nd ed.). Boston: Allyn & Bacon.
- Newcomb, T. M. (1960). Varieties of interpersonal attraction. In D. Cartwright & A. Zander (Eds.), *Group dynamics: Research and theory* (2nd ed., pp. 104-119). Evanston, IL: Row, Peterson.
- Nugent, F. A. (2003). *Introduction to the profession of counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.
- Ohlsen, M. M., Horne, A. M., & Lawe, C. F. (1988). *Group counseling* (3rd ed.). New York: Holt, Rinehart & Winston.
- Pierce, K. A., & Baldwin, C. (1990). Participation versus privacy in the training of group counselors. *The Journal of Specialists in Group Work*, 15(3), 149-158.
- Posthuma, B. W. (1996). *Small groups in counseling and therapy: Process and leadership* (2nd ed.). Boston: Allyn & Bacon.
- Pruitt, D. G., & Rubin, J. Z. (1986). *Social conflict: Escalation, stalemate, and settlement*. New York: Random House.
- Redl, F. (1949). The phenomenon of contagion and shock effect in group therapy. In W. Healy & A. Bronner (Eds.), *Searchlights on delinquency*. New York: International University Press.
- Rogers, C. R. (1967). The process of basic encounter groups. In J. F. T. Bugenthal (Ed.), *Challenges of humanistic psychology*. New York: McGraw-Hill.
- Rose, S. D. (1989). Working with adults in groups. In J. A. Kottler, *Advanced group leadership*. Pacific Grove, CA: Brooks/Cole.
- Rossi, P. H., & Berk, R. A. (1985). Varieties of normative consequences. *American Sociological Review*, 50, 333-347.
- Schachter, S. (1951). Deviation, rejection, and communication. In D. Cartwright & A. Zander, *Group dynamics*, New York: Harper & Row.
- Schein, E. (1981). *Organizational psychology* (2nd ed.). In J. E. Baird, Jr., & S. B. Weinberg, *Group communication: The essence of synergy* (2nd ed.). Dubuque, IA: Wm. C. Brown.
- Schneider-Corey, M., & Corey, G. (1997). *Groups: Process and practice* (5th ed.). Pacific Grove, CA: Brooks/Cole.

- Schutz, W. C. (1958). A three-dimensional theory of interpersonal behavior. Palo Alto, CA: Science and Behavior.
- Schutz, W. C. (1973). Encounter. In R. Corsini (Ed.), *Current psychotherapies*. Itasca, IL: F. E. Peacock.
- Shapiro, J. L. (1978). *Methods of group psychotherapy: A tradition of innovations*. Itasca, IL: Prentice-Hall. psychotherapy: A tradition of innovation. Itasca, IL: Prentice-Hall.
- Shaw, M. E. (1976). Group dynamics: The psychology of small group behavior (2nd ed.). New York: McGraw Hill.
- Shepherd, C. R. (1964). Small groups: Some sociological perspectives. Scranton, PA: Chandler.
- Sherif, M. (1936). The psychology of social norms. New York: Harper & Row.
- Simpson, D. (1977). Handling group and organizational conflict. In T. Jones & J. W. Pfeiffer (Eds.), *1977 Annual handbook for group facilitators* (pp. 120-122). LaJolla, CA: University Associates.
- Sklare, G., Keener, R., & Mas, C. (1990). Working with groups: Preparing members for "Here-and-Now" group counseling. *The Journal of Specialist in Group Work*, 15(3), 141-148.
- Slavin, R. L. (1993). The significance of here-and-now disclosure in promoting cohesion in group psychotherapy. *Group*, 17, 143-149.
- Snyder, L. M. (1978). Effects of mutuality of control orientation between leaders and group members. *Journal of Educational Research*, 71, 231-234.
- Sorrels, J. P., & Kelley, J. (1984). Conformity by omission. *Personality and Social Psychology Bulletin*, 10, 302-305.
- Stein, A., & Kibel, H. D. (1984). A group dynamic-peer interaction approach to group psychotherapy. *International Journal of Group Psychotherapy*, 34(3), 315-333.
- Steiner, I. D. (1972). Group process and productivity. New York: Academic Press.
- Stogdill, R. M. (1974). *Handbook of leadership*. New York: Free Press.
- Thelen, H. A., & Dickerman, W. (1949). Stereotypes and the growth group. *Educational Leadership*, 6, 309-316.
- Trotzer, J. P. (1989). *The counselor and the group* (2nd ed.). Muncie, IN: Accelerated Development.
- Tuckman, B. W. (1965). Developmental sequences in small groups. *Psychological Bulletin*, 63, 384-399.
- Tuckman, B. W., & Jensen, M. A. (1977). Stages of small group development revisited. *Group and Organizational Studies*, 2(4), 419-427.
- Vander Kolb, C. J. (1985). Introduction to group counseling and psychotherapy. Columbus, OH: Merrill.
- Yalom, I. D. (1985). The theory and practice of group psychotherapy (3rd ed.). New York: Basic Books.
- Zimpfer, D. & Waltman, D (1982). Correlates of effectiveness in group counseling. *Small Group Behavior*, 13(3), 275-288.



Human Growth and Development

7.1 INTRODUCTION

Human growth and development 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. This is a change from previous examinations.

7.2 CACREP OBJECTIVES

CACREP objectives for Human Growth and Development are not presented in full. Those preparing for the NCE may want to visit their website for the full standard objectives. The objectives for Human Growth and Development are:

- a. theories of individual and family development

- b. theories of learning and personality development
 - c. developmental crises, disability, addictive behavior, psychopathology, and factors affecting normal and abnormal behavior
 - d. strategies for optimum development
 - e. ethical and legal
-

Question 244: 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 stage is imaginal

Question 245: 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. Piaget believed the child had precursors to forming concepts

Question 246: 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 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 247: 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.

Question 248: Objective e.

A counselor, who has been counseling a family of four frequently, has received feedback from his/her supervisor to consider 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. The two choices are a and c except naivete includes both social skills and knowledge.

Question 249:

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.

7.3 TERMS AND PEOPLE

Definitions for the following terms are found at the end of the chapter.

Apgar Rating	Lamaze method
Canon-Bard	Learning
Centration	Mainstreaming
Clang Association	Maturation
Cohort Effect	Maturity
Dembers Ideational Addiction	McClelland, David
Developmental Norm	Ontogenesis
Equilibration	Opponent Process
Field Theory	REM
Harlow, Harry	Rites Passage
Hierarchical	Schachter Cognition
Imprinting	Schema
Internal-External	James Lange

7.4 DEVELOPMENTAL RESEARCH

1. 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).
2. 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.
3. 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).
4. 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.

5. 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.

6. 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.

7.5 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.

7.6 THEORIES OF HUMAN DEVELOPMENT

Human growth and development 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

Humanistic

Language

Learning

Moral

Physical

Psychosocial

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.

7.6.1 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.

7.6.1-1 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 Chapters 5 and 6.

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.

7.6.1-2 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 250:

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. During the initiative vs. guilt stage, initiative is developed by trying out new roles. When these attempts fail, the result is guilt.

7.6.1-3 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

(Capuzzi & Gross, 2002)

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).

7.7. 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).

7.7.1-1 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.

7.7.1-2 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.

7.7.1-3 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.

- **Primary** reinforcement satisfies a primary need.
example: food
- **Secondary** reinforcement includes reinforcers that have somehow been associated with primary reinforcers in the past so that they have acquired reinforcing qualities.
example: money
- **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
- **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
- **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.

- **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.
- **Fixed-ratio:** Reinforcement is presented after a set number of correct responses, such as every third correct response.
- **Variable Interval:** Reinforcement is presented so that it averages a particular time interval, such as an average of one reinforcement every seven minutes.
- **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 251:

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.

Question 252:

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.

7.7.1-4 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.

7.7.1-5 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.

7.7.1-6 EDWARD L. THORNDIKE

Thorndike believed that all learning consisted of associative bonds between situations and responses (Byrnes, 2001). 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).

7.7.1-7 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.

7.7.1-8 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

1. Dollard and Miller integrate Hullian behaviorism, psychoanalytic concepts, and contributions of social science in their approach to psychotherapy.

2. The four fundamental factors that are important for all learning are:
 - a. drive or motivation
 - b. cue or stimulus
 - c. response
 - d. 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

1. Therapy is a learning situation in which neurotic responses are extinguished and better, normal responses are learned.
2. The following are elements of therapeutic learning:
 - a. lifting of repression
 - b. transference relationship
 - c. learning to label
 - d. learning to discriminate.
3. 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

1. **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.

2. **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.

3. **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)

1. **Permissiveness** The therapist is warm, friendly, understanding, and not shocked by what he or she hears.
2. **Free Association** The client is encouraged to report everything that comes into his/her mind, immediately and without reservations.
3. **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.
4. **Handling the Transference** The therapist attempts to overcome transference-induced reactions by the following:
 - a. interpretation of silence
 - b. pointing out that avoidance is an escape and urging the client to resume work
 - c. reframing from inferring that the transference reactions are purposely produced by the client
 - d. identifying transference responses and finding out how they arose
 - e. handling these reactions without anger or irritation
5. **Labeling**
 - a. The client may discover or create the new verbal unit, under the compulsion of free association.

- b. The therapist may selectively strengthen the client's responses that he/she thinks are important without contributing his or her own ideas.
- c. The client may rehearse responses provided by the therapist as interpretation.

6. Teaching Discrimination

- a. The therapist calls attention to problem areas in order to evoke new discriminations by failing to understand the client.
- b. The therapist may discourage certain responses by labeling them as false or doubtful.
- c. The therapist points out similarities between similar sets of stimuli.
- d. 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:

Instrumental: these are reinforced behaviors that are repeated while punished behaviors are avoided. The repeated ones become self-reinforcing.

Associative: the individual associates past affective neutral stimulus with an emotional stimulus and the affective stimuli will be strengthened.

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 Chapter Five.

Question 253:

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.

7.7.1-9 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 254:

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 kids all respect
- c. teenager who uses drugs
- d. older teenager who does not use drugs

Answer: d. 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.

7.7.1-10 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. Provide a client into 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.

7.7.2 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.

7.7.2-1 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 not to 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. Child develops 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 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:

1. strong ties to perception, similarity, and spatial relations. That is, the dog is a cat, the dog is duck, etc.
2. unidimensional-think only of one aspect at a time. Example: conservation—centration
3. irreversible—what is done cannot be undone. If you pull the tape out it cannot be retracted.
4. distinguishing between reality and fantasy. The difficulty reveals itself when children talk of their dreams and people as real people.

Question 255:

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 because the child tells others that he has friends, gives them names, and that he sees them at night in his dreams. The counselor queries the couple for more information that appears 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. 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 (Brynes, 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 256:

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. Object permanency is usually obtained just before a child's first birthday.

Question 257:

At which of Piaget's developmental stages does the child understand conservation?

- a. Sensorimotor
- b. Preoperational
- c. Concrete Operational
- d. Formal Operational

Answer: c. Schemata serves four functions. These functions are to categorize, remember, comprehend, and problem solve (Bryne, 2001).

7.7.2-2 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.

Vygotsky's theory is known for five cognitive functions: language, thinking, perception, attention, and memory.

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 difficulty in learning to where, with help (teacher), he/she can eventually achieve the task independently.

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.

7.7.2-3 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:

7.7.2-4 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:

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.

Iconic mode: This mode centers on images and represents objects, an important development toward symbols. The child imagines pictures that represent something.

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:

- Domain specificity-usually not transferable from one expert area to another area.
- Greater knowledge and experience
- Meaningful perceptions-experts see the whole while novice see the parts
- Reflective qualitative problem solving
- Principled problem representation-understand in a deep way
- Effective strategy construction
- 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 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

Set-the tendency to solve new problems the way old ones were solved.

Functional Fixedness-the tendency to see objects for their most obvious function and ignore possible alternatives

Question 258:

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. The problem-solver verifies that the solution he or she has chosen is correct.

7.7.3 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:

- A. Personal Construct Therapy - George Kelly
- B. Logotherapy - Victor Frankl
- C. Multimodal Therapy - Arnold Lazarus
- D. Rational Behavior Training - Maxie Maultsby
- E. Cognitive Behavior Modification - Donald Meichenbaum
- F. Cognitive Developmental Therapy - Michael Mahoney

Problem-solving Therapy (Dobson, 1988)

- A. Interpersonal Cognitive Problem-solving (ICPS) - Spivack and Shure
- B. Self-control Training - T. D'Zurilla and M. Goldfried
- C. Personal Science - Michael Mahoney
- D. Self-control Therapy - L. P. Rehm

Cognitive Restructuring (Dobson, 1988)

- A. Rational Emotive Therapy - Albert Ellis
- B. Cognitive Therapy - Aaron Beck
- C. Self-Instructional Training - Donald Meichenbaum
- D. Rational Behavior Therapy - Maxie Maultsby

Coping Skills (Dobson, 1988)

- A. Anxiety Management Training - R. M. Suinn and B. Richardson
- B. Stress Inoculation Training - Donald Meichenbaum
- C. 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.

Cognitive Modeling Counselor demonstrates to clients a cognitive change procedure in "what to say to themselves while performing a task" (Cormier & Cormier, 1998, p. 344).

Steps

1. Counselor serves as the model and first performs the task while talking aloud to him/herself.
2. Client performs the same task while the counselor instructs the client aloud.
3. Client is instructed to perform the same task again, while instructing himself/ herself.
4. Client whispers instructions while performing the task.
5. Client performs the tasks and instructs himself/herself covertly.

Procedure

1. Provide rationale
2. Cognitive modeling of the task and of self-verbalization.
3. Client practice

4. Overt external guidance
5. Overt self-guidance
6. Faded overt self-guidance
7. Covert self-guidance
8. Homework and follow-up

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

1. Provide rationale
2. Counselor directs thought-stopping:
 - a. Interruption Counselor assumes control of the interruption (LOUD STOP). Client is instructed to verbalize all thoughts and images aloud.
 - b. Second effort. Visual again, but this time does not talk loud. Instead, uses hand signal to inform: STOP.
3. Client directs thought-stopping: Client now assumes responsibility for interruption: LOUD STOP
4. Client-directs thought stopping: Covert Interruption Client stops thoughts covertly.
5. Shift to assertive, positive, or neutral thoughts. Explain reasons for substituting positive thoughts. Different thoughts should be used so that saturation does not occur.

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.

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.

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:

1. Before: anticipate, prepare
2. During (very angry): confront self, lose control (cope)
3. After: encourage yourself
4. Information on Coping Skills
5. Acquisition and Practice

Question 259:

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.

7.7.4 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 shows 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 260:

According to Kohlberg, most adults operate at what moral level?

- a. Preconventional
 - b. Conventional
 - c. Postconventional
 - d. Exconventional
-

Answer: b.

7.7.5 VALUES CLARIFICATION

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
 1. act upon
 2. act with consistency
-

Question 261:

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.

7.8 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. Ethologists do admit that learning can modify these innate behaviors, but these innate behaviors also affect the learning experiences themselves and are therefore worth studying.

Ethologists believe in studying people in a natural setting. They look for evolutionary causes for behaviors.

7.8.1 KONRAD LORENZ

Nobel Prize-winning ethologist Lorenz has shown that there is a short period of time early in the lives of geese 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).

7.8.2 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:

- access the adult and responsiveness to the child
- 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:

secure - explore their environment and protest separation behaviors from the adult

avoidant - explore without their base (adult) and ignore separation, avoid reunion

anxious-ambivalent - refuse to explore and express anxiety during separation

7.8.3 MARY AINSWORTH

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 Horowitz (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 the main source.

Question 262:

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. The two characteristics of the pattern have to do with responses to separation and reunion.

7.9 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 reflect that people can make choices about their lives. They believe that humans are intrinsically good and are more than the sum of their parts.

7.9.1 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:

- Self-actualization
- Esteem needs (confirmation)
- Belongingness needs (love, be loved)
- Safety needs (to feel secure in daily life)
- 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.

7.10 THEORIES OF PHYSICAL GROWTH AND MATURATION

7.10.1 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).

Day Cycle: Growth is an expanding process that occurs every day.

Self-regulatory fluctuations: Instability and growth occur at the same time, moving the person toward maturation.

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.

7.10.1-1 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)

- a. toy age until school year
- b. formal education begins at age 6
- c. after children become sexually mature, they are adolescents
- d. six levels of interaction (Mildred Parten):
 1. **Unoccupied behavior**
 2. **Solitary play**
 3. **Onlooker play** - child observes other children
 4. **Parallel play** - child plays beside other children, but does not interact with other children
 5. **Associated play** - child shares materials and interacts with other children, but does not share the same goal of play
 6. **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 (4) self-help, social-help, school, 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.

7.10.2 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

7.11 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 and development.

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 Femand 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).

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).

7.12 Questions

Question 263:

Larry, a student in the tenth grade, comes to you experiencing 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

Question 264:

Sharon is a law-abiding person who is known to rely on approval from others. According to Kohlberg's Moral Development Theory, Sharon would be operating on what stage?

- a. preconventional
- b. conventional
- c. postconventional
- d. formal operative

Question 265:

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.
-

Question 266:

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.
-

Question 267:

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
-

Question 268:

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.
-

Question 269: Piaget's process of building one step of intellectual growth into another during maturation is called?

- a. schemata.
- b. reification.
- c. equilibration.
- d. conservation.

Answers: 263. a. 264. b. 265. b. 266. d. 267. c. 268. c. 269. c.

REFERENCES

- Ainsworth, M. D. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709-716.
- Ayllon, T., & Azrin, N. (1968). The token economy: A motivational system for therapy and rehabilitation. New York: Appleton-Century-Crofts.
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61, 226-244.
- Bowlby, J. (1982). *Attachment and loss* (Vol. 1) (2nd ed.). New York: Basic Books.
- Bowlby, J. (1988). Clinical applications of attachment: A secure base. London: Routledge.
- Brown, D., & Srebalus, D. J. (2003). Introduction to the counseling profession (3rd ed.). Boston: Allyn & Bacon.
- Bruner, J. (1983). Child's talk. In F. B. McMahan & J. W. McMahan, *Psychology: The hybrid science* (5th ed.). Chicago: Dorsey Press.
- Bryne, J. P. (2001). Cognitive development and learning in instructional context (2nd ed.). Boston: Allyn & Bacon.
- Capuzzi, D., & Gross, D. R. (2003). Counseling and psychotherapy: Theories and interventions (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.
- Chomsky, N. (1968). *Language and mind*. New York: Harcourt, Brace, & World.
- Coleman, E. (1981). Counseling adolescent males. *Personnel and Guidance Journal*, 60, 215-218.
- Cormier, S., & Cormier, B. (1998). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions. Pacific Grove, CA: Brooks/Cole.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Dacey, J., & Travers, J. (1994). *Human development across the lifespan* (2nd ed.). Dubuque, IA: Wm. C. Brown Communications, Inc.
- Dacey, J., & Travers, J. (2002). Human development across the life span (5th ed.). Boston: McGraw-Hill.
- Dobson, K. S. (1988). Handbook of cognitive-behavioral therapies. New York: The Guilford Press.
- Dollard, J., & Miller, N. E. (1950). Personality and psychotherapy: An analysis in terms of learning, thinking, and culture. New York: McGraw-Hill.
- Erikson, E. H. (1968). Identity, youth, and crisis. New York: W. W. Norton.
- Gesell, A. (1949). *Child development*. New York: Harper.
- Havighurst, R. J. (1951). Developmental tasks and education. New York: Longman, Green.
- Kanfer, F. H., & Goldstein, A. P. (1991). Helping people change: A textbook of methods (4th ed.). New York: Pergamon Press.
- LeFrancois, G. R. (1982). Psychological theories and human learning. Monterey, CA: Brooks/Cole.
- Loevinger, J. (1976). *Ego development*. San Francisco: Jossey-Bass Publishers.
- Mahoney, M. J., & Lyddon, W. J. (1988). Recent developments in cognitive approaches to counseling and psychotherapy. *The Counseling Psychologist*, 16(2), 190-234.

- Main, M. (1996, April). Introduction to the special section on attachment and psychopathology: Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, 64(2), 237-242.
- Maslow, A. H. (1954). *Motivation and personality*. New York: Harper and Row.
- Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Boston: Little, Brown.
- McMahon, F. B., & McMahon, J. W. (1986). *Psychology: The hybrid science* (5th ed.). Chicago: The Dorsey Press.
- Meichenbaum, D. H. (1993). Stress inoculation training: A 20-year update. In P. M. Lehrer & R. L. Woolfolk (Eds.), *Principles and practice of stress management* (2nd ed., pp. 373-406). New York: Guilford.
- Patterson, C. H. (1966). *Theories of counseling and psychotherapy*. New York: Evanston & London.
- Rosenthal, H. (1993). *Encyclopedia of counseling*. Muncie, IN: Accelerated Development.
- Shafer, E. (1985). *Developmental psychology: Theory, research, and applications*. Belmont, CA: Brooks/Cole.
- Siegelman, C. K., & Shaffer, D. R. (1995). *Life span human development* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Simon, S., Howe, L. W., & Kirshenbaum, H. (1972). *Values clarification: A handbook of practical strategies for teachers and students*. New York: Hart Publishing Co.
- Valsiner, J. (1998). The development of the concept of development: Historical and epistemological perspectives. In R. M. Lerner (Ed.), *Handbook of child psychology: Volume 1. Theoretical models of human development*. New York: John Wiley.
- Vygotsky, L. S. (1978). *Mind in society*. Cambridge, MA: Harvard University Press.



Social, Cultural, and Family Foundations

This chapter stresses issues related to individual and family functioning within society. The chapter 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 chapter. 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 abuse are examined in the context of the helping relationship. The social/ cultural and family foundations area has 12 content questions of which 11 count for your total score.

8.1 CACREP OBJECTIVES

CACREP objectives for helping relationship are not presented in full. Those preparing for the NCE may want to visit the Web address for the full standard objectives: www.counseling.org (The specific objectives related to consultation will be covered in Chapter 8 rather than in Chapter 5 of this manual).

- a. multicultural and pluralistic trends
- b. iattitudes, beliefs, understanding, and acculturation
- c. individual, couple, family, group strategies-diverse
- d. roles in social injustice, advocacy, conflict resolution
- e. Multicultural theories identity development
- f. ethical and legal consideration

Question 270: 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. In a discussion the 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 271: 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. According to Hughes (cited in Remley & Herlihy, 2005)) approximately 12% of the population (income under \$15,000) had access to these resources.

Question 272: Objective c.

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.

Question 273: 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.

Question 274: 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. Pederson, et al. (2002) definition of the World View.

Question 275: Objective f.

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 with 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 the client to the client's religious leader(s) for assistance.

Answer: c. Pro-bono. 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.

8.2 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.

Acculturate	Gender Role Conflict
Agoraphobia	Homophobia
Alloplastic	Life Expectancy
Alzheimer's Disease	Life Span

Androgyny	Minority
Autoplastic	Race
Counterculture	Rip Van Winkle Effect
Cross Culture	Role Conflict
Culture	Role Strain
Deindividuation	Set-point Theory
Dying Trajectory	Sexism
Dysthymic Disorder	Social Class
EMIC	Socialization
Ethnic Group	Stereotyping
ETIC	Strength-based Model
Fetal Alcohol Syndrome	Subculture
Gateway Drugs	Type A Personality

8.3 PREVIEW QUESTIONS

Question 276:

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. (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 277:

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: b.

Question 278:

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.

Question 279:

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.

Question 280:

A mixture of male and female characteristics is known as:

- a. androgyny.
- b. jensenism.
- c. synesthesia.
- d. type C personality.

Answers: a. (a term associated with Sandra Bem)

Question 281:

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.

Question 282:

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.

Question 283:

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.

8.4 THEORIES OF SOCIAL PSYCHOLOGY

Social psychology examines how individuals affect one another's behavior (Lamberth, 1980). It also explores the relationships between social institutions, social groups, and individual behavior. Following are some of the prominent theories encountered in the field.

I. 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).

II. 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).

III. Sociological Theories

A. 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).

B. 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).

IV. 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.

V. 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.

A. Balancing Theory

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).

B. 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. Changing a behavior, changing the environment, or adding new cognitive information that will "outweigh" one of the dissonant cognitions can reduce dissonance.

C. **Congruity Theory:**

Osgood and Tannenbaum (as cited in Albrecht, et al., 1980) 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.

D. **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.

E. **Attribution Theory**

Heider (1967) and Kelly (as cited in Albrecht, et al., 1980) define 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 (Albrecht, et al., 1980).

VI. Theories of Collective Behavior

A. **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.

B. **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.

C. Smelsner's Value-Added Theory

The Value-added Theory understands 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).

1. Structural conduciveness: conditions are right for the particular behavior
2. Structural strain: stress and strain within the system
3. Growth and spread of generalized belief: ideas on what action to be taken spread
4. Precipitating factor: an incident sets off the collective action
5. Mobilization of participants: through leadership and communication
6. Lack of social control: if enough social control is present, the collective episode will be diverted

VII. 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.

VIII. Theories of Aggression

A. Instinct Theories

Middlebrook (1980) defines aggression in terms of primary drives as described by Sigmund Freud and Konrad Lorenz.

1. 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.
2. Lorenz: Aggression is adaptive in survival of the species. It underlies vital functions such as protecting territory from invasion, defending young, etc.

B. 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).

C. 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.

D. 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 personal attack will generally result in more aggressiveness than environmental blocking.
- A justifiable "reason" for the frustration will reduce the aggressive response.
- Expecting to be and experience being unpleasant lessens aggressive responding.
- People take cues from the environment when experiencing frustration. The presence of guns or watching others behave aggressively will likely elicit aggression.
- Expected rewards and punishment will determine how aggression is expressed. If punishment is expected, aggression may be expressed indirectly or displaced.

Question 284:

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. 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.

8.5 SOCIAL CLASS

A brief overview of social class structure will be presented to alert 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).

UPPER CLASS:

Often composed of an upper-upper and lower-upper and constitutes less than two percent of the population.

Upper-upper:

A small proportion of the entire population, probably less than one percent. Usually composed of those who inherited wealth with an emphasis on patriarchal and extended family. Status depends on inherited wealth.

Lower-upper:

Usually recent arrivals and are upwardly mobile. Frequently they are disengaged from extended family.

MIDDLE CLASS:

Largest percentage of the population

Upper middle:

Professional and business careers, mostly college-educated who prefer thinking as opposed to hard labor. They tend to be native-born and white. They represent the American Success Syndrome and are civic leaders, future oriented, and read books.

Lower middle:

Second-generation with a significant percentage of minority families. Patriotism and commitment are important values. They are nuclear families.

LOWER CLASS:**Upper-lower:**

Working-class, semi-skilled to skilled labor, foreign-born, job security is most valued.

Lower-lower:

Impoverished and below poverty level, tend to inherit a low economic status from their parents. Hopelessness and despair are represented; they are not joiners.

8.6 MULTICULTURAL COUNSELING

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.

8.6.1 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.

8.6.2 THEORY AND CROSS-CULTURAL COUNSELING

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:

- I. **Pathological View of Minorities:** Some minorities could never fit into a white society.
- II. **Genetic Deficiency Model:** Cultural minorities are biologically inferior to white society.
- III. **Cultural Deficiency Model:** The environments of minority members are deviant or inferior.
- IV. **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)."

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) definition in 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:

- a. avoiding cultural differences and assume all are alike
- b. too color conscious and a tendency to attribute a problem to cultural background
- c. ignoring or blinded by one's own countertransference
- d. co-dependency relationships with clients out of a need to be needed
- e. misunderstanding defensive reactions to stereotypical thinking
- f. failure to learn a client's cultural way of communicating (as cited in Remley & Herlihy, 2005, p. 53)

8.6.2-1 IDENTITY

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 285:

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. The 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.

- 1. Avoidant
lack of consideration of one's own white identity and avoidance of racial issues

2. Dependent
have not considered alternatives to currently held set of attitudes regarding white racial consciousness
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
4. Dominative
strong ethnocentric perspective that justifies dominance by majority culture
5. Conflictive
opposed to obvious discriminatory practices yet opposed to programs aimed at reducing racism
6. Reactive
recognize racial discrimination as a significant behavior in American society
7. Integrative
an integrated sense of Whiteness with regard to racial/ethnic minorities and do not need to be reactive.

8.6.2-2 WORLDVIEW

Sodowsky and Johnson (1994) define worldview as one's inputs shared by members of one's reference group. The inputs consist of individual experiences, and 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):

Human nature

good, bad, or a combination

Social relationship

lineal-hierarchical, collateral-mutual, individualistic

Nature

subjugate and control, Live in harmony, accept power and control

Time orientation

past-present-future oriented

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):

Human nature

view people as good and bad

Social relationship

group and interpersonal

Nature

live in harmony (oneness)

Time orientation

past and present

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 the assimilation and acculturation.

8.6.3 MULTICULTURAL COUNSELOR PREPARATION:

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" - 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 Counseling

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, autoplasmic and alloplasmic, existentialist, communication (verbal/nonverbal language), life span differences, and intracultural, as well as generational, sexual orientation, disability, geographical, and socioeconomic differences.

8.6.3-1 COUNSELING WITH SELECT MINORITY POPULATIONS

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 you 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.

NATIVE AMERICANS

Note: A Native American is anyone born in America.

I. General information: (Atkinson, Morten, & Sue, 1993)

- A. Approximately 2.3 million Native Americans currently live in the U.S., although at one point the population dropped from 3 million to 600,000 (U.S. Bureau of the Census, 1991).
- B. There are some 200 tribal languages spoken today and around 511 federally recognized Native American entities. Marquis (as cited in Axelson, 1993) indicates there are approximately 263 nations, tribes, bands, and ethnic groups.
- C. 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).

II. Value orientations: (Heinrich, Corbine, & Thomas, 1990)

- A. Holistic philosophy. 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). Bryde (as cited in Axelson, 1993) identifies four valued objects in the universe. These four are: God, self, others, and world.
- B. Deep reverence for nature and life. Live in harmony with nature (as opposed to subjugating it) (Baruth & Manning, 1991).
- C. Often resent demand for self-disclosure in traditional counseling situations. May perceive counselor's questions as intrusive or inappropriate.
- D. 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).
- E. Reliance on extended family. Families work together to solve problems (Sutton & Broken Nose, 1996).
- F. Anonymity, humility valued. Time is not rigidly structured (Thomason, 1991).

III. Social and economic concerns: (Atkinson, et al., 1993)

- A. High unemployment rate, 10 times national average
- B. Median income 25% that of whites
- C. High-school dropout rate 60%
- D. Adolescent suicide rate 100 times more than that of whites
- E. High rates of drug use

- F. Alcoholism double the national average
- G. Arrest rates 10 times those for whites, three times those for African-Americans
- H. High infant-mortality rate

IV. Guidelines for counselors:

- A. Open up issue of Native-American/white relationships early in therapy. Work toward moving beyond stereotypes to the individual relationship. Counselor must depersonalize client's anger toward whites.
- B. 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.
- C. Use silence as a positive act. Speak softly.
- D. Describe options and suggest solutions. Short-term, historical, action-oriented, problem-focused, directive approaches often are more successful.
- E. Seek out exposure to Native American culture.
- F. Recognize that many Native American clients may feel pulled between traditional tribal culture and mainstream culture (Thomason, 1991).
- G. Be familiar with general ideas about healing.
- H. Follow the client's lead in terms of nonverbal behavior (Thomason, 1991).

HISPANIC-AMERICANS

- I. 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).
 - A. 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). This group includes Mexican-Americans, Puerto Ricans, Cubans, and Central and South Americans (Atkinson et al., 1993). Ramirez (1999) indicates that Hispanics represent 11.5% of the population.
 - B. Spanish-speaking. Least "Americanized" of the ethnic groups (Zunker, 1990).
 - C. Have experienced discrimination in the U.S. for many years, thus reducing the group's own sense of self-esteem, self-identity, and hope.
- II. Value orientations:
 - A. 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.
 - B. Often strong ties to Spanish-speaking country of origin.

- C. Religion is usually 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.
- D. Cultural values of family, machismo (honor, loyalty, and a code of ethics), spirituality, and personalismo (personal contact and individual interactions) are important.

III. Guidelines for counselors:

- A. Explain the counseling process. Latinos often lack knowledge of the process, despite a generally high regard for mental-health therapists.
- B. Build trust. Trust issues are paramount, due to long history of discrimination.
- C. Be willing to include the dominant male family member (authority of husband).
- D. Be prepared to deal with psychosomatic complaints caused by the special stresses on Hispanic-Americans.
- E. Language issues (switching/bilingual) and acculturation are important.

ASIAN-AMERICANS

I. General Information:

- A. The Asian-American population was 7 million in 1990 and is expected to double by 2010 (Atkinson, et al., 1993).
- B. 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.
- C. 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.
- D. There are few bilingual counselors to present unique problems to this minority.

II. Values orientation:

- A. 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.
- B. 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.
- C. 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.

- D. Not accustomed to time schedules when reporting for treatment. Often expect "first come, first served."
 - E. 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.
 - F. Value authority. Often passive or submissive to authority. Cultural inhibitions concerning aggressiveness.
- III. Guidelines for counselors (Gladding, 1996, 2000):
- A. Establish a clear-cut structure for counseling process. Explain the process to the client.
 - B. Allow questions about you and the process.
 - C. Refrain from assessment.
 - D. Become educated about cultural values.
 - E. Assume authority figure role for short-term therapy.
 - F. 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.
 - G. Use bilingual counselors.

AFRICAN-AMERICANS

- I. General information:
- A. African-Americans are a diverse group displaying a broad range of beliefs (Gladding, 1996, 2000). Individual differences make stereotyping harmful.
 - B. The majority of white therapists' clients are white; therefore, white therapists have little experience with African-Americans in counseling.
 - C. 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."
 - D. 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.
- II. 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.

III. Guidelines for counselors:

- A. Address the realities of racism and discrimination. Validate the client's experience of social and economic injustice.
- B. Engender trust.
- C. Become aware of personal cultural perspectives.
- D. Avoid stereotyping. In selecting treatment, the primary consideration is the individual client's needs, not ethnicity.
- E. Goals range from survival/coping in dominant culture to becoming an activist for social change.

Question 286:

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.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.

8.7 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). This sexism most often manifests itself through:

- counselors supporting traditional sex-role notions that serve to limit choices and options

- counselors having lowered expectations of female clients
- counselors using psychoanalytic concepts that are sexist (i.e., penis envy)
- counselors 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).

8.7.1 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).

I. 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

II. 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) or 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. They internalized values. They sort through options and develop life plans. They 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: 1) foreclosed diffusion, 2) moratorium diffusion, 3) severe psychopathology, and 4) previous developmental deficits. Spence (as cited in Josselson, 1987) defined a healthy identity as being associated with achievement, individualism, self-determination, mastery, and personal success.

III. 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. Belenky, et al. 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).

- A. **Silence:** Women do not perceive themselves as able to learn.
- B. **Received Knowing:** Listening to authorities, external learning.
- C. **Subjective Knowing:** Intuitive, personal knowledge; quest for self-understanding; acknowledge uncertainty of external authority.
- D. **Procedural Knowing:** Connected or objective reasoning.
- E. **Constructed Knowing:** Integration of internal/external knowing and intuitive/ objective reasoning.

IV. 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.

- A. early emotional attentiveness between mother and daughter
- B. mutual empathy and bonding
- C. expectation that relationships are a major source of growth
- D. mutual empowerment, which encourages maturation within relationships; daughters learn to be both givers and receivers in relationships

V. 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 shows how traditional patterns of socialization can be internalized without conscious, overt "teaching" of conventional values and roles.

- A. Daughter identifies with mother's care-taking role and develops sensitivity to others' needs.
- B. Mother unconsciously rejects daughter's "needy" side and leads daughter to deny her own needs and give up expectations of being nurtured.
- C. 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.
- D. Outcome: self-sacrificing, lack of sense of self.

Strengths of Relationship Models:

- A. Affirm previously devalued relational qualities in women.
- B. Positive view of relationships in identity formation.
- C. Connectedness is seen as a strength. (Traditional models place higher value on separateness/autonomy.)

Weaknesses of Relationship Models:

- A. Emphasis on differences between men and women can create artificial dichotomies that perpetuate inequalities.
- B. 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).
- C. Can result in over-romanticizing women's care-giving roles and fail to recognize women's achievement needs.
- D. Lack of emphasis on promoting social change through political activism.

Question 287:

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.

VI. 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.

A. Conjoint models:

- 1. Modulation or balance—both extremes and when both present each tends to modulate the other
- 2. Additive widest acceptance—high levels of both

3. Interactive—combination of masculinity and femininity

B. Developmental:

1. Kaplan's Hybrid Stage—synthesis and integration of dimensions or qualities such as anger/love, assertiveness/dependency, coexist.
2. Sex-Role Transcendence—sex role standards become irrelevant in determining behavior.

C. 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).

D. Personality trait model:

Internally located responses that are a variant of instrumental agents and are expressive/communal distinction.

Question 288:

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. 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.

VII. Feminist Identity Model:

Downing and Rousch (1985) developed a feminist identity model based upon Cross's (1971) model of Black Identity development.

Stage I: Passive-Acceptance

The female buys into the traditional male-oriented system, accepting all of the traditional sex roles.

Stage II: 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 III: Embeddedness-Emanation

Close emotional ties with other women are developed so that anger can be released in a supportive environment.

Stage IV: Synthesis

A positive feminist identity is created. Personal and feminist values merge to form an autonomous identity.

Stage V: 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 289:

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 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.

8.8 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:
 - 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.

- 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 290:

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. Life-cycle theorists believe life-cycle development is an increasing number of role transitions.

8.9 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.

I. Developmental Issues

- A. **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.

- B. **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.
- C. **Physical Changes** Loss of vital capacities in the body (i.e., diminished reserve capacity, increased vulnerability to infection, increased recovery time).

II. Relationship Issues

- A. **Marital Adjustment**
Widowers and widows must find new supportive relationships. Friendships may have been underdeveloped.
- B. **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).
- C. **Remarriage**
Remarriage raises issues around support or lack of support from family members (McKain, 1969; Vinick, 1979).
- D. **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.
- E. **Sexual Difficulties**
 - 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.
 - Men**
Performance declines with age, yet sexually active males can remain active into their 80s. Some men struggle with impotence.
- F. **Sandwich Generation**
Some consider this time in life individuals experience issues with aging parents, adult children, and grandchildren.

III. Grief/Loss Issues

- A. Physical illness and physical decline
- B. Death of spouse and significant others
- C. One's own death: keen awareness of limited life span

- D. Loss of choice

IV. Age-related mental health issues:

- A. Depression
- B. 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%).
- C. Delirium, dementia and depression are common.

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.

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.

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).

8.9.1 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.

I. **Physical Aspects** (Atchley, 1993)

- 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.

II. **Psychological Aspects** (Atchley, 1993)

- 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

Identity development occurs as an individual interacts with the environment and subsequently organizes and interprets his or her experience and assigns subjective meanings (Atchley, 1993). 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).

III. **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 291:

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. Long-term memory remains much intact, while short term-memory appears to diminish. Creativity remains as long as the mind is able to function.

8.10 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.

8.10.1 COUNSELING THE DYING PERSON

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:

- the initial awareness of loss—shock, confusion, numbness, detachment, disbelief, and disorientation
- 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
- 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

- awareness of the extent of loss—mourning, lonely, helpless, and hopeless
- gaining perspective on the loss—reaching a point of acceptance, discovering balance and realization of the extent and limits of the loss
- resolving the loss—can see and pursue activities unconnected with the loss
- reformulating loss in a context of growth—personal growth of strengths and limits, morality, and finiteness of time.
- 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)

8.10.2 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).

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).

Emotional: confusion, despair, sadness, longing, emptiness, fear, anger, guilt, depression, relief, anxiety, preoccupation with thoughts of the person who died (Matz, 1979).

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.

8.10.2-1 TERMS

Mourning 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 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 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 is when the grief cannot be openly expressed or socially supported (Doka, 1996).

8.11 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.

I. 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.

II. 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.

III. 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 hurrieness 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.

IV. Other Names and Terms Associated with Stress

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).

Martin Seligman (1975) developed the concept of learned helplessness. Distress exists when a person does not have control over his or her environment.

Learned Helplessness

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).

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.

8.12 CRISIS AND TRAUMA INTERVENTION

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. Caplan and Parad (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 Cavaola 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 is 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.

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; and (6) obtain a commitment from the client.

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.

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 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, 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. These will vary from war, hurricane, flood disasters, to an individual teenager's thoughts of being pregnant, to an adult who because of an impending divorce feels they can no longer respond to the situation or continue with life. In each of the situations the following tasks are important.

SUICIDAL CLIENT

Suicide theory may best be understood by studying four theoretical models. These models are:

1. Overlap Model
2. Three-element Model

3. Suicide Trajectory Model

4. Cubic (Laux, 2002)

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:

- a. Those who talk of suicide are not going to commit suicide and desire attention.
- b. Impulsive acts of suicide are rare.
- c. If a person survives suicide, the person will not make a second attempt.
- d. Attempting suicide is genetic.
- e. A person is mentally ill if attempting suicide.
- f. Talking about suicide gives the person the idea.

RISK FACTORS

Some types of risk factors associated with suicide:

- a. past history of gestures or attempts
- b. family history of suicide
- c. involved drug or alcohol use
- d. history of psychiatric disorder
- e. history of severe trauma
- f. isolation from others
- g. radical shifts in behavior or mood
- h. expression of hopelessness or helplessness
- i. chronic medical illness
- j. suicidal ideation or a plan and means
- k. living alone or divorced

Therapist Tasks:

- A. 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
- B. 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
- C. 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
- D. 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
- E. 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.

Question 292:

The General Adaptation Syndrome was developed by:

- a. Seligman.
- b. Selye.
- c. Simpkin.
- d. Holmes and Rahe.

Answer: b. Hans Selye, a Canadian physician first studied and wrote a book on the body's reaction to stress.

8.13 ADDICTION

The study of addiction is extensive but for the purpose of this study manual gambling, eating disorders, sexual, and substance abuse are mentioned. Each of these addictions has a pattern of progression, preoccupation, perceived loss of control, and negative long-term consequences (Walters, 1999).

SUBSTANCE USE AND ABUSE

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-IV for substance-related disorders: Substance-Use Disorders (SUDS) and Substance-Induced Disorders. These disorders include abuse of and dependency on nonprescription or prescription drugs, alcohol, inhalants, chemicals, or toxic substances. They also include disorders caused by using or abusing substances. Contained within the DSM-IV-TR (APA, 2000) are 11 classes of drugs with abuse potential: alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opiates, phencyclidine, and sedatives/hypnotics/ anxiolitics.

Substance-Use Disorders include dependence and abuse. Substance-Induced Disorders include anxiety disorder, delirium, hallucinogen-persisting perception, intoxication, mood disorder, persisting amnesic disorder, persisting dementia, psychotic disorder, sexual dysfunction, sleep disorder, and withdrawal.

Fisher and Harrison (as cited in Hogan, Gabrielson, Luna, & Grothas, 2003, p. 4) define substance abuse 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, eating disorder, 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.

1. Alcoholism

The alcohol abuser 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. Abuse is deadly. 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.

2. Recovery and Relapse

Recovery programs can be divided into two approaches to treatment. Early treatment programs focused on denial as prominent and as negative such as 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:

- a. identity as a human being
- b. need for personal control or choice
- c. need for achievement
- d. need for purpose
- e. need for hope
- f. 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.

Guidelines for Counseling

1. 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.
2. 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.
3. Refer the family to Al-Anon and/or Al-Ateen.
4. 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.
5. 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).
6. 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 1999 survey, the drugs identified in emergency room episodes were in rank order; alcohol; cocaine, marijuana, heroin/morphine and acetaminophen as the top five. The drugs associated with the most deaths were in the order of cocaine, heroine/morphine, alcohol, and codeine. (DAWM. 1998).

The drugs with the highest dependence potential are heroin, crack cocaine, morphine, and opium (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:

- nicotine
- amphetamines or methamphetamines ("uppers" or "speed")
- 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 and abuse. 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 293:

The treatment of choice for substance abuse 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. Most addicts readily respond to treatment programs, which include AA meetings.

8.14 CONSULTATION

8.14.1 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 basis aim is to identify a target, the purpose of an intervention, and a method of intervention.

8.14.2 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

8.14.3 CONSULTATION VS. 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).

8.14.4 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.

8.14.5 TARGET POPULATIONS

1. individuals
2. groups
3. organizations
4. communities

8.14.6 PURPOSES OF CONSULTANT INTERVENTION

1. **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.
2. **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.

3. **Tertiary**

This type of intervention is concerned about reducing the debilitating mental-health problems

8.14.7 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.

8.14.8 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.

8.14.9 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.

8.14.10 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 294:

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. The focus is on those already disabled.

8.15 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). NOVA 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, tsunamis, earthquakes, bombings, and other catastrophic incidents where many individuals are involved in a trauma.

8.16 TERMS

ACCULTURATE: To undergo the process of learning a culture.

AGORAPHOBIA: Fear of leaving a familiar environment. 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.

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).

DYSTHYMIC DISORDER: Moderate non-psychotic depression.

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.

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.

MINORITY: Group whose members share racial or ethnic traits different from the dominant group.

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.

REFERENCES

- Abadinsky, H. (1996). *Drug abuse: An introduction* (3rd ed.). Chicago: Nelson-Hall.
- Adams, J. (1965). Inequity in social exchange. In L. Berkowitz (Ed.), *Advances in experimental social psychology*: Vol. 2 (pp. 267-299). New York: Academic Press.
- Aguilera, D. C., & Messick, J. M. (1982). *Crisis intervention: Theory and methodology* (4th ed.). St. Louis: C. V. Mosby.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, text revised* (4th ed.). Washington, DC: Author.
- Atchley, R. C. (1987). *Aging: continuity and change* (2nd ed.). Belmont, CA: Wadsworth.
- Atkinson, D. R., Morten, G., & Sue, D. W. (1993). *Counseling American minorities: A cross-cultural perspective*. Madison, WI: Brown and Benchmark.
- Axelson, J. A. (1993). *Counseling and development in a multicultural society* (2nd ed.). Monterey, CA: Brooks/Cole.
- Baruth, L. G., & Manning, M. L. (1991). *Multicultural counseling and psychotherapy*. New York: Merrill.
- Baruth, L. G., & Manning, M. L. (2003). *Multicultural counseling and psychotherapy: A lifespan perspective* (3rd ed.). Upper Saddle River, NJ: Merrill Prentice Hall.
- Belkin, G. S. (1988). *Introduction to counseling* (3rd ed.). Dubuque, IA: William C. Brown.
- Blumenthal, S. J., & Kupfer, D. J. (1986). Generalizable treatment strategies for suicidal behavior. In J. Mann & M. Standley (Eds.), *Annals of the New York Academy of Science* (Vol. 487, pp. 327-340). New York: New York Academy of Sciences.
- Brammer, L. M. (1985). *The helping relationship: Process and skills* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.
- Brodsky, A. M., Holyroyd, J., Payton, C. R., Rubinstein, E. A., Rosenkrantz, P., Sherman, J., & Zell, F. (1978). Guidelines for therapy with women: Task force on sex bias and sex role stereotyping in psychotherapeutic practice. *American Psychologist*, 33, 1112-1121.
- Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology*, 34, 1-7.
- Brown, D., Pryzwansky, W. B., & Schulte, A. C. (1991). *Psychological consultation: Introduction to theory and practice* (2nd ed.). Boston: Allyn & Bacon.
- Brown, D., Pryzwansky, W. B., & Schulte, A. C. (1995). *Psychological consultation: Introduction to theory and practice* (3rd ed.). Boston: Allyn & Bacon.
- Burnett, M. (1979). Understanding and overcoming addictions. In S. Eisenberg & L. E. Patterson (Eds.), *Helping clients with special concerns* (pp. 343-362). Boston: Houghton Mifflin.
- Canon, W. B. (1929). *Bodily changes in pain, hunger, fear, and rage*. New York: Appleton.
- Cavaola, A. A., & Colford, J. E. (2006). *A practical guide to crisis intervention*. Boston: LaHaska Press.
- Cole, L., & Hall, I. (1964). *Psychology of adolescence*. New York: Holt, Rinehart, and Winston.
- Collier, H. V. (1982). *Counseling women: A guide for therapists*. New York: The Free Press.
- Collins, B. G., & Collins, T. M. (2005). *Crisis and trauma: Developmental-ecological intervention*. Boston: LaHaska Press.
- Cook, E. P. (1985). *Psychological androgyny*. New York: Pergamon.
- Copeland, E. J. (1983). Cross-cultural counseling and psychotherapy: A historical perspective, implications for research and training. *The Personnel and Guidance Journal*, 62(1), 10-15.

- Cross, W. E., Jr. (1971). The Negro-to Black conversion experience: Towards a psychology of Black liberation. *Black World*, 20, 13-27.
- Council for accreditation of counseling and related educational program (CACREP): The 2001 Standards (2005). Section II: Program objectives and curriculum (pp. 6-13).
- Dacey, J., & Travers, J. (1994). Human development across the lifespan. Dubuque, IA: Brown and Benchmark.
- Dettmer, P., Thurston, L. P., & Dyck, N. (1993). Consultation, collaboration and teamwork: For students with special needs. Needham Heights, MA: Allyn & Bacon
- Dobbins, J. E., & Skillings, J. H. (1991). The utility of race labeling in understanding cultural identity: A conceptual tool for the social science practitioner. *Journal of Counseling and Development*, 10, 37-44.
- Doka, K. J. (1996). Commentary by Kenneth J. Doka. In K. J. Doka (Ed.), *Living with grief after sudden loss: Suicide, homicide, accident, heart attack, stroke* (pp. 11-15). Washington, DC: Hospice Foundation of America.
- Dollard, J., Miller, N. E., Doob, L. W., Mowrer, O. H., & Sears, R. R. (1939). *Frustration and aggression*. New Haven, CT: Yale University Press.
- Downing, N. E., & Rousch, K. L. (1985). From passive-acceptance to active commitment: A model of feminist identity development for women. *The Counseling Psychologist*, 13 (4), 695-709.
- Dustin, D., & Ehly, S. (1984). Skills for effective consultation. *The School Counselor*, 32(1), 23-28.
- Edwards, R. B. (1979). *Pleasures and pain: A theory of qualitative hedonism*. New York: Cornell University.
- Eichenbaum, L., & Orbach, S. (1983). *Understanding women: A feminist psychoanalytic approach*. New York: Basic Books.
- Enns, C. Z. (1991). The "new" relationship models of women's identity: A review and critique for counselors. *Journal of Counseling and Development*, 69, 209-217.
- Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, CA: Stanford University Press.
- Fiske, S. T., & Taylor, S. E. (1994). *Social cognition*. New York: Random House.
- Forsyth, D. R. (1990). *Group dynamics* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Freedman, J. L. (1975). *Crowding and behavior*. New York: Viking.
- Friedman, H. S., & Booth-Kewley, S. (1987). The disease-prone personality: A meta-analysis view of the construct. *American Psychologist*, 42, 539-555.
- Friedman, M., & Rosenman, R. H. (1974). *Type A behavior and your heart*. New York: Knopf.
- Friedman, M., & Rosenman, R. H. (1981). *Type A behavior and your heart* (2nd ed). Greenwich, CT: Fawcett.
- Gilligan, C. (1982). *In a different voice*. Cambridge: Harvard University Press.
- Gilliland, B. E., & James, R. K. (1988). *Crisis intervention strategies*. Pacific Grove, CA: Brooks/Cole.
- Gilliland, B. E., & James, R. K. (1993). *Crisis intervention strategies* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Gilliland, B. E., & James, R. K. (2001). *Crisis intervention strategies* (4th ed.). Pacific Grove: CA: Brooks/Cole.
- Gintner, G. G. (1995). Differential diagnosis in older adults: Dementia, depression, and delirium. *Journal of Counseling and Development*, 73, 346-351.
- Gladding, S. T. (1996). *Counseling: A comprehensive profession* (3rd ed.). Columbus, OH: Merrill.
- Gladding, S. T. (2000). *Counseling: A comprehensive profession* (4th ed.). Columbus, OH: Merrill.

- Gladding, S. T. (2001). *The counseling dictionary: Concise definitions of frequently used terms*. Upper Saddle River, NJ: Merrill Prentice Hall.
- Gorski, T. T. (1989). *Passages to recovery: An action plan for preventing relapse*. Center City, MN: Hazelden.
- Groth, A. N., Burgess, A. W., & Holmstrom, L. L. (1977). Rape: Power, anger, and sexuality. *American Journal of Psychiatry*, 134, 1239-1243.
- Gutheil, T. G., & Applebaum, P. S. (2000). *Clinical handbook of psychiatry and the law* (3rd ed.). New York: Lippincott Williams & Wilkins.
- Heider, F. (1967). *The psychology of interpersonal relations*. New York: Wiley & Sons.
- Heinrich, R. K., Corbine, J. L., & Thomas, K. R. (1990). Counseling Native Americans. *Journal of Counseling and Development*, 69, 128-133.
- Helms, J. E. (1995). An update of Helms' white and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181-191). Thousand Oaks, CA: Sage.
- Helms, J. E., & Carter, R. T. (1990). Development of White Racial Identity Inventory. In J. E. Helms (Ed.), *Black and white racial identity: Theory, research, and practice* (pp. 67-80). Westport, CT: Greenwood Press.
- Hogan, J. A., Gabrielsen, K. R., Luna, N., & Grothaus, D. (2003). Substance abuse prevention: The intersection of science and practice. Boston: Allyn and Bacon.
- Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research*, 11, 213-218.
- Ibrahim, F. A. (1991). Contribution of cultural worldview to generic counseling and development. *Journal of Counseling and Development*, 70, 13-19.
- Ivey, A. E., Bradford-Ivey, M., & Simek-Morgan, L. (1993). *Counseling and psychotherapy: A multicultural perspective* (3rd ed.). Boston: Allyn & Bacon.
- Jackson, A. P., & Sears, S. J. (1992). Implications of an Africentric worldview in reducing stress for African-American women. *Journal of Counseling and Development*, 71, 184-190.
- James, R. K., & Gilliland, B. E. (2001). *Crisis intervention strategies* (4th ed.). Belmont, CA: Wadsworth/Thomson Learning.
- Janosik, E. H. (1984). *Crises counseling: A contemporary approach*. Monterey, CA: Wadsworth Health Science Division.
- Johnson, C. (1985). The impact of illness on late-life marriages. *Journal of Marriage and Family*, 47, 165-172.
- Josselson, R. (1987). *Finding herself: Pathways to identity development in women*. San Francisco: London Press.
- Kalish, R. A. (1976). Death and dying in a social context. In R. Binstock & E. Shanas (Eds.), *Handbook of aging and social science*. New York: Van Nostrand Reinhold.
- Kalish, R. A. (1985). *Death, grief and caring relationships* (2nd ed.). Monterey: Brooks/ Cole.
- Katz, J. H. (1985). The sociopolitical nature of counseling. *The Counseling Psychologist*, 13, 615-624.
- Kipnis, D. (1976). *The powerholders*. Chicago: University of Chicago Press.
- Lambers, J. (1980). *Social psychology*. New York: MacMillan.
- Laux, J. M. (2002). A primer on suicidology: Implications for counselors. *Journal of Counseling & Development*, 80, 380-383.
- Lee, S. D. (1968). Social class bias in the diagnosis of mental illness. *Doctoral dissertation*, Ann Arbor, MI: University Microfilms. No. 68-6959.
- Lee, W. M. L. (1999). *An introduction to multicultural counseling*. Philadelphia, PA: Accelerated Development.

- Levinson, D. J. (1978). *The seasons of a man's life*. New York: Ballantine.
- Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101, 141-148.
- Lindemann, E. (1956). The meaning of crisis in individual and family. *Rec*, 57, 3-10.
- Locke, E. C. (1993). *Multicultural counseling*. ERIC Digest. Ann Arbor, MI: Clearinghouse on Counseling and Personnel Services.
- Marcia, J. E. (1966). Development and construct validation of ego identity status. *Journal of Personality and Social Psychology*, 3, 551-558.
- Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology*. New York: Wiley.
- Marshall, V. W. (1980). *Last chapters: A sociology of aging and dying*. Monterey, CA: Brooks/Cole.
- Matheny, K., & Riordan, R. J. (1992). *Stress and strategies for lifestyle management*. Atlanta, GA: Georgia State University.
- Matz, M. (1979). Helping families cope with grief. In S. Eisenberg & L. E. Patterson (Eds.), *Helping clients with special concerns* (pp. 218-238). Boston: Houghton Mifflin.
- McKain, W. C., Jr. (1969). *Retirement marriages*. Storrs: University of Connecticut Agriculture Experiment Station.
- McMahon, R. B., & McMahon, J. W. (1986). *Psychology: The hybrid science* (5th ed.). Chicago: Dorsey Press.
- McNamara, K., & Rickard, K. M. (1989). Feminist identity development: Implications for feminist therapy with women. *Journal of Counseling and Development*, 68, 184-189.
- Middlebrook, P. N. (1980). *Social psychology and modern life* (2nd ed.). New York: Knopf.
- Milgram, S. (1969). *Obedience to authority*. New York: Harper & Row.
- Moursund, J. (1985). *The process of counseling and therapy*. New Jersey: Prentice-Hall.
- Moursund, J., & Kenny, M. C. (2002). *The process of counseling and therapy* (4th ed.). Upper Saddle River, NJ: Prentice Hall.
- Murdock, G. P. (1965). *Social structure*. New York: Free Press.
- Nadelmann, E., McNeely, J., & Drucker, E. (1997). *International perspectives*. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod (Eds.), *Substance abuse: A comprehensive textbook* (3rd ed., pp. 22-39). Baltimore: Williams & Wilkins.
- Newcomb, T. M. (1961). The acquaintance process. New York: Holt, Rhinehart, & Winston.
- Newman, J. L. (1993). Ethical issues in consultation. *Journal of Counseling and Development*, 72, 148-156.
- Parad, H. J., & Caplan, G. (1960). A framework for studies families in crisis. *Social Work*, 5 (3), 3-15.
- Peele, S., Brosky, A., & Arnold, M. (1992). *The truth about addiction and recovery*. New York: Fireside Press.
- Peterson, J. V., & Nisenholz, B. (1995). *Orientation to counseling* (3rd ed.). Boston: Allyn & Bacon.
- Peterson, J. V., Nisenholz, B., & Robinson, G. (2003). *A nation under the influence: America's addiction to alcohol*. Boston: Allyn & Bacon.
- Pine, G. J. (1972). Counseling minority groups: A review of the literature. *Counseling and Values*, 17, 35-44.
- Priest, R. (1991). Racism and prejudice as negative impacts of African-American clients in therapy. *Journal of Counseling and Development*, 70, 213-215.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.
- Ramirez, R. (1999). *The Hispanic population in the United States* (Current population reports No. P20-527). Washington, DC: U.S. Census Bureau, Population Division, Ethnic and Hispanic Statistics Branch.

- Rando, T. (1984). *Grief, dying, and death*. Champaign, IL: Research Press.
- Rapp, C. A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
- Ray, O., & Ksir, C. (2002). *Drugs, society, and human behavior* (9th. ed.). Boston: McGraw Hill.
- Reber, A. S. (1985). *The Penguin dictionary of psychology*. London: Penguin.
- Ridley, C. R. (1989). *Overcoming unintentional racism in counseling and therapy*. Thousand Oaks, CA: Sage.
- Rotter, J. (1975). Some problems and misconceptions related to the construct of internal versus external control of reinforcement. *Journal of Counseling and Clinical Psychology*, 43, 56-67.
- Rowe, W., Bennett, S. K., & Atkinson, D. R. (1994). White racial identity models: A critique and alternative proposal. *Counseling Psychologist*, 22(1), 129-146.
- Royce, J. E. (1989). *Alcohol problems and alcoholism: A comprehensive survey* (Rev. ed.). New York: Free Press.
- Sanford, N. (1969). Research with students as action and education. *American Psychologist*, 24, 544-546.
- Schneider, J. (1984). *Stress, loss, and grief: Understanding their origins and growth potential*. Baltimore: University Park Press.
- Scully, D. & Marolla, J. (1985). "Riding the bull at Gilley's: Convicted rapist describe the rewards of rape. *Social Problems*, 32 (3), 251-263.
- Seligman, M. E. (1975). *Helplessness: On depression, development, and death*. San Francisco: W. H. Freeman.
- Selye, H. (1956). *The stress of life*. New York: McGraw-Hill.
- Skolnick, A. (1981). Married lives. Longitudinal perspectives on marriage. In D. Eichorn, et al. (Eds.), *Present and past in middle age*. New York, Academic Press.
- Sodowsky, G. R., & Johnson, P. (1994). Worldview: Culturally learned assumptions and values. In P. Pedersen & J. C. Cary (Eds.), *Multicultural counseling in schools: A practical handbook* (pp. 59-79). Boston: Allyn & Bacon.
- Staudacher, C. (1991). *Men and grief*. Oakland, CA: New Harbinger.
- Sue, D. W. (1978a). Counseling across cultures. In V. G. Zunker (Ed.), *Career counseling: Applied concepts of life planning* (3rd ed., p. 419). Pacific Grove, CA: Brooks/Cole.
- Sue, D. W. (1978b). Worldviews and counseling. *The Personnel and Guidance Journal*, 56, 458-462.
- Sue, D. W. (1981). Counseling the culturally different. In V. G. Zunker (Ed.), *Career counseling: Applied concepts of life planning* (3rd ed., p. 432), Pacific Grove, CA: Brooks/Cole.
- Sue, D. W., Bernier, J. E., Duran, A., Feinberg, L., Pedersen, P., Smith, E., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, 10, 45-52.
- Sue, S., McKinney, H., Allen, D., & Hall, J. (1975). Delivery of community health care system. *American Journal of Orthopsychiatry*, 45, 111-118.
- Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice* (2nd ed.). New York: Wiley.
- Sundberg, N. D. (1981). Cross-cultural counseling and psychotherapy: A research overview. In A. J. Marsell & P. B. Pedersen (Eds.), *Cross-Cultural counseling and psychotherapy*. New York: Pergamon Press.
- Sutton, C. T., & Broken Nose, M. A. (1996). American Indian families: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 31-44). New York: Guilford Press.
- Thomason, T. C. (1991). Counseling Native Americans: An introduction for non-Native American counselors. *Journal of Counseling and Development*, 69, 321-327.

- US. Bureau of Census (1991). *Population profile of the United States: 1991* (Current population reports, Series P-23, No. 173). Washington, DC: US. Government Printing Office.
- U. S. Bureau of Census (1992). *The Hispanic population in the United States: March 1991*. Washington, DC: U. S. Government Printing Office.
- van Wormer, K., & Davis, D. R. (2003). *Addiction treatment: A strength perspective*. Pacific Grove, CA: Thomson and Brooks/Cole.
- Vinick, B. H. (1979). Remarriage. In R. H. Jacobs & B. H. Vinick (Eds.), *Reengagement in later life: Re-employment and remarriage*. Stanford, CT: Greylock.
- Walters, G. D. (1999). *The addiction concept: Working hypothesis or self-fulfilling prophecy?* Boston: Allyn & Bacon.
- Washton, A., & Boundy, D. (1989). *Willpower's not enough: Understanding and recovering from addictions of every kind*. New York: Harper & Row.
- Webster's third new international dictionary of the English language, unabridged. (1981). Springfield, MA: Merriam-Webster.
- Weingardt, K. R., & Marlatt, G. A. (1999). Sustaining change: Helping those who are still using. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2nd ed., pp. 337-351). New York: Plenum Press.
- Weisman, A. (1972). *On death and denying*. New York: Behavioral Publications.
- Wrenn, G. (1962). The encapsulated counselor. *Harvard Educational Review*, 32(4), 444-449.
- Zunker, V. G. (1990). *Career counseling: Applied concepts of life planning*. Pacific Grove, CA: Brooks/Cole.