DR. ARTHUR'S STUDY GUIDE

for the

NCE

NATIONAL COUNSELOR EXAMINATION

CACREP 2016 STANDARDS UPDATED

30+ YEARS

GARY L. ARTHUR, Ed.D.

Providing NCE Preparation Program Since 1985

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

To secure the

National Counselors Certification (NCC)

and

Licensed Professional Counselor (LPC)

Gary L. Arthur, Ed.D.

Gary L. Arthur, Ed.D. retired as a Professor Emeritus in the Counseling and Psychological Services Department at Georgia State University. He has taught counseling courses at the graduate level for forty-two years. He served as the past Coordinator for the Professional Counseling Program and as clinical coordinator for the internship program. He has conducted over 158 two-day training workshops for participants taking the NCE. He has taught all of the courses in the content areas being tested for the NCE. His research interests include clinical supervision, therapist safety, spirituality and health, geriatrics, and assessment.

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Introduction to the NCE Study Guide

Be sure this is the preparation guide for the examination for which you have made an 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 for Certified Counselors (NBCC) administers the NCE for certifying counselors as a National Certified Counselor (NCC). Frequently the NCE is the same examination many states use for their state license. These licensed counselors are frequently called Licensed Professional Counselors (LPC) however some states may use a different title. Be sure you check with your license board for your state. A ready source to begin your search will be the NBCC (www.nbcc.org) website for the state board directory and state licensure home.

Presently those seeking to take the National Counselor Examination may 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. Many students take the NCE during the last semester of an accredited master level program in counseling. 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

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counseling. The 2002 spring issue of the Journal of Counseling and Development (Archival Features: 2001-2002, 2003) listed those states that have contacts for a 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, same examination questions (in the past), and scoring procedures. It is possible that results may be received at different times for the two groups. An independent company frequently administers the NCE.

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 about 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 passing score has ranged from 87-107 of the 160 scored items and has varied for different times of testing. According to Loesch and Vacc (1994), the NBCC pass score (minimum criterion score) for some states issuing a license may be set higher than the NBCC national cutoff score.

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

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

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

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

A sixth change appeared when NBCC announced during 2012 a change in categories for the Work Behavior area as a result of a completed survey. The work behavior areas are: Fundamental Counseling Issues (32), Counseling Process (45), Diagnostic and Assessment Services (25), Professional Practice (38) and Professional Development, Supervision and Consultation (20).

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

The most recent change has been the adoption of the 2016 CACREP Standards implemented July 1, 2016. Three content areas contain new 2016 standards. New content objectives include knowledge areas of technology, disaster, inflicted self-harm, outcome evidence for treatment, specialty areas, community outreach and emergency teams, self-care, counselor evaluation, diagnosis, conceptualizing clients, and biological, neurological, and physiological facts.

Please note that the organization of the material in this manual for the 2016 standards, at times, overlap from one unit to another. To illustrate this overlap, note that in:

Unit 1: Professional Counseling Orientation and Ethical Practice

Objective 1j: technology's impact on the counseling profession

Unit 5: Counseling and Helping Relationships

Objective 5e: the impact of technology on the counseling process

Objective 5d: ethical and culturally relevant strategies for establishing and maintaining in-person and technology on the counseling process

For a more overall approach and understanding of the implication and impact of technology for the field of counseling, it will be important to utilize content from all units of study. The reader will observe some degree of overlap for other constructs related to prevention, evidence-based strategies, techniques for prevention and intervention and ethics.

Numerous research studies and literature support with limited information will be evident in all units of study. Often the number of participants in the study, procedures, and analyses will not be delineated. The findings add to the knowledge and support the context of the CACREP objective. The references will be included for retrieval if the reader desires the complete coverage.

An eighth observation has to do with family, a change from the CACREP 2009 to the new 2016 standards. Read the objectives carefully to decide the amount of time and the depth of study required for this preparation. The wording is as follows:

CACREP 2009 Standard Unit 2: Social and Cultural Diversity

2c. individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies

CACREP 2016 Standards Unit 2: Social and Cultural Diversity

The word family does not exist

CACREP 2009 Standard Unit 3: Human Growth and Development

3d: theories and models of individual, cultural, couple, family, and community resilience

CACREP 2016 Standard Unit 3: Human Growth and Development

3a. theories of individual and family development across the lifespan

CACREP 2009 Standard: Unit 4: Career Development

4d. interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career

CACREP 2016 Standard: Unit 4: Career Development

The word family does not exist

CACREP 2009 Standard Unit 5: Helping Relationships

5 e. A systems perspective that provides an understanding of family and other system theories and major models of family and related interventions

CACREP 2016 Standard Unit 5: Counseling and Helping Relationships

The word family does not exist. CACREP programs require a family course thus terms associated with family theories could be in the test.

NCE Score Reporting

The National Board for Certifying Counselors did not grant permission to reproduce a sample of the format for the standard score report. The number of questions for each of the eight content areas is subject to change. If you should desire the exact number, you should contact the National Board for Certifying Counselors for this release of information.

The following test item information should be considered but not taken as an exact figure. The number of test questions for each study does not appear to be equal. Human Growth and Development, Social and Cultural Diversity, Counseling and Helping Relationships, Group Counseling and Group Work, Career Development, Assessment and Testing, Research and Program Evaluation, and Professional Counseling and Orientation and Ethical Practice are the eight chapters for study. From recent score reports the percentage or number of questions for each content area often changes 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 Diversity, 20.5% (41) Counseling and Helping Relationships, 10.5% (21) Group Counseling and Group Work, 13% (25) Career Development, 12.5% (25) Assessment and Testing, 10.5% (21) Research and Program Evaluation, and 17% (34) Professional Orientation and Ethical Practice. Therefore, in prioritizing study time, it is advisable to rank the percentages. Also, 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. The five work behaviors scores will be included in the final score report. Those areas include Counseling Process, Professional Practice, Fundamental Counseling issues, Diagnostic and assessment services, and Professional development, supervision and consultation (NBCC, 2014; www.nbcc.org/nce).

In 2001 NBCC included work behaviors to the scoring format to represent counselor work areas. Job analysis surveys are conducted periodically to determine if job tasks are different from past data. The same 200 questions designated for the eight content areas are grouped or sorted into the counselor work

behaviors and yield percentages of 16%, 22.5%, 12.5%, 19%, and 10% respectively in the 2012 reported survey.

The National Board for Certifying Counselors releases for publication only past testing results in range scores. Although this is not very helpful for the 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 NBCC application packet secured from the NBCC's website includes the curriculum and degree requirements for NBCC approval to take the NCE. The following address and telephone number will assist you in securing this information.

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

Information about the NCE Examination and Testing

NBCC schedules the NCE, and it is administered in every state, many university programs, 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 taking the examination.

1. Data are being gathered regarding success from individuals who have purchased this manual. Also, a questionnaire has been designed to request information from users of this manual. Information that would be helpful will focus on how many years exist between one's graduate degree and taking the examination, whether the individual used a study guide, studied alone or with someone, attended a seminar, used a study guide plus a seminar, and whether the study guide was helpful and in what way.

2. I have made the following suggestions based upon 43 years teaching counseling courses and 30 years teaching in a CACREP program and experiences in conducting in excess of 158 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 workshop 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 workshop are usually helpful. In all cases, many participants recommend a study partner.

3. The examination is composed of 200 multiple-choice questions each with four options. The exact numbers of items for each of the eight content areas and five counselor work behavior areas are not equal. There is no penalty for guessing, so do not leave any questions unanswered. Remember, you do not have to pass each subtest area but must receive a total correct number to pass. The particular group under testing and the NBCC board establish the "pass" score number. Reviewing past testing, this score has varied from 83 (1985) to as high as 107 of the 160 items scored. It is not known how many forms of the NCE exist and the passing score may be different for each form. However, they are to be equal in difficulty.

4. NBCC indicates that some items on the test are being reviewed as future test items. This number is stated as 40 or possibly five from each of the eight areas. Therefore, your score will be based upon 160 rather than 200.

5. The individual total score (raw) may be a part of the 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. Taking the NCE through NBCC, information will be provided along with your newly acquired credential, the National Certified Counselor (NCC).

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

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

8. The examination rules allow for three hours and 45 minutes to complete the examination (Center for Credentialing & Education, 2016-2017), 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 an examinee who is a rapid test taker; the rest will be like you. Take your time but do not linger on the more difficult items too long. If you are nervous or tense use some of your stress-coping strategies such as breath inhalation or muscle relaxation. Previous test takers comment that they did not use their test time wisely. The questions are longer than in earlier examinations, therefore it takes more time to read and reread questions. If you are unable to determine an answer in a couple of minutes and you find a need to reread, mark it as one of those questions to return. Make it easy to locate those items so mark the number on the piece of paper provided at the test site. The question may look different when you return, plus you may read a future question that will assist your memory and recall. For those program students taking the NCE at a university or a large group of examinees the paper form has been the procedure. Writing on the test booklet has been allowed but troublesome turning pages to find those left unanswered. So, for those left undone, at the time, write the number down on the piece of paper so that it is easier to locate it on return. For the computer application of the NCE use the electronic scratch pad. Some states do not contract with NBCC for the NCE. When this is the situation individuals in those states contract with NBCC directly to take the NCE and likely will be administered the paper form of the NCE.

9. There will be an established procedure for taking leave of the examination for necessary breaks. You are not likely to have time for going over each question a second time. Before the examination, consider a method to return to those items you want to review a second time. A special type of marking is recommended, as you will be able to write on the examination. Pressure mounts when there are five or six items you want to revisit but are unable to locate them. If computer testing is the test format it is possible NBCC has established for the examinee a bubble next to the question as a reminder for those items where the examinee did not submit an answer.

10. It is advisable to know how you take examinations. Take a practice examination of four hours and determine fatigue points. Four on-line 200-item practice exams are available through Career Training Concepts, and two are a part of the purchase. Three of the 200-item practice tests are similar in construction to the NCE. First, take the pre-assessment exam to assess strengths and determine areas where the study will be helpful. The pre-assessment examination is more difficult than the NCE according to past users of the on-line practice exams.

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

12. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) has implemented the 2016 Standards as of July 1, 2016 (CACREP, 2015). In each of the eight units of study some of the 2009 CACREP standards were separated and developed into two or more standards, and some objectives were added. These changes and new standards will be highlighted in each of the study units.

Style and Format of Questions

This examination covers a broad area of study. It has not been steeped in psychoanalytic material or heavy in the specifics of the DSM-5™. That does not mean one should not know the structure of those theories or the framework for the diagnostic process. Training at this difficulty level for this examination is not testing for detailed diagnostic information. New terms or changes from the DSM-IV-TR to the DSM-5 should be noted. CACREP presently stipulates all CACREP programs to require at the master level programs a course in psychopathology (e.g., DSM-5™) and in addictions. New material for both areas will appear in this revision of the NCE Manual.

1. This examination covers material across the life span. It appears that the test writers and developers are interested in testing an awareness of the many concepts across the eight content areas of this examination. Also, the application of these constructs in the form of scenarios will test a working knowledge of field experiences (counselor work behaviors). Changes in the lifespan of an individual for any of the human growth theories require knowing the stages, functions, and definitions.

2. You may come across questions for which you have not had content exposure in your program of study or a study course guide. Do not allow that to affect you, as this is a broad examination. It is even possible that the question may be one under review and will not affect your score. It is only one question. The pre-assessment exam online has a few questions for which the content is not covered in the manual. When you take these questions, attend to your personal reactions and recognize how best not to allow this to affect your overall performance.

3. Study terms, definitions, purposes, functions and 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 in the examination.

4. Some questions may confuse the examinee to what is being requested. Do the very best to break the question down into parts and re-link the meanings. Search for clue words such as initial, ending, concluding, or significant for an approach to the question. If it becomes a struggle, do not spend too much time and become frustrated; leave it and return later during the examination. It may look different the second time you read it.

5. For ethical questions in the form of a scenario that requires a counselor action or decision, adhere to the basics. The overriding principle of do no harm should be foremost in your mind. In addition, do not act in isolation or take the dilemma to supervision are good choices. Keep in mind a decision should be based upon the greater good and basic fundamentals. It is difficult to write a question for intervention or midway into a dilemma as all of us could add or interject conditions such as "but also," "if it were this way I would," etc. Sometimes field experiences do not fit nicely into a multiple-choice format. Some practice examples will be provided in the next few pages.

6. Answer only the question as it is worded. Do not read into the question or assume what is behind the question.

7. These are straightforward questions. When answering questions, first think of the basics, how one should begin counseling and proceed from there.

8. Questions may also reflect the cognitive domain, thus becoming increasingly more difficult. Some questions will require more than simple recall, and two or more chunks of facts or inferences will be necessary.

9. The questions that follow (1-10) are intended to reflect spiraling omnibus in difficulty in applying the cognitive taxonomy and are phrased in a variety of depth levels. The difficulty level will begin with recall.

Recall:

Recall questions can be in the form of straightforward identification. Who is considered the father of vocational guidance (Frank Parsons)? Also, arranging certain theories and stages in order, such as the GAS syndrome (Hans Selye), and the purpose or function of theory (career, counseling, group, learning, family, and consultation, developmental theories.) Recall can be names of authors, founders, and matching author with theory, authors who share similar theoretical formulations, definitions, concepts, and constructs. Memorization is important because facts will be important to solve the more difficult questions. Recall questions within the NCE may be few. However, the recall of facts and process will be necessary for advanced levels of the cognitive domain.

Question I-1:
Transference is:

    a. the attributes of unwanted emotions.

    b. returning to an earlier phase of development.

    c. incorporating the qualities of another.

    d. a client's projection of past feelings and attitudes onto the counselor.

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

Question I-2:

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

    a. projection.

    b. catharsis.

    c. quoid and mavis.

    d. countertransference.

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

Option a. projection is a psychoanalytical defense mechanism

Option b. catharsis is the emotional release

Option c. quoid and mavis refer to (quiet, ugly, old, indigent, and dissimilar) (young, attractive, vivacious, intelligent, and single)

Option d. countertransference is the counselor's emotional reaction toward the client

Question I-3:

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

    a. nonmaleficence.

    b. fidelity.

    c. beneficence.

    d. honesty.

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

Information and Analysis

The application of information and the analysis questions require the selection of one or more facts. Application and analysis may require several steps such as a four-step procedure. An assessment question may contain more information than required to answer the question. Creating the confidence band in question four (1-4) will require the selection of appropriate facts to establish the predicted score range for a client. This question requires a four-step procedure. Step one is to recognize the term to be applied such as standard error of measurement. Step 2 is to recognize what data or information contained in the question is necessary such as the student's score (950) and the standard error of measurement is equal to 25. Step 3 is to perform the arithmetical procedure (see Unit 7). Step 4 is to interpret the result or answer.

Question I-4:

A student requests assistance in understanding his SAT score that was 950. The data sheet indicated that the group mean was 1000, median of 1050, standard deviation of 100, standard error of measurement equal to 25, and test-retest reliability equal to .94. The student wanted to know if it was feasible to retake

the examination, as a score of 1000 was required to enter the school of his choice. The counselor could make one of the following statements:

    a.   two out of three times the score is likely to fall between 950-1000.

    b.   19 out of 20 times the score is likely to fall between 900-1000.

    c.   1 out of 100 times the score is likely to fall between 900-1000.

    d.   2 out of 3 times the score is likely to fall between 850-1050.

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

Theory Questions

      Theory questions require a recognition of terms, how to process or progress from one stage or phase to the next stage, understanding the meaning or definition of terms at various 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 philosophy, technique or process associated with that theory or what does the author consider a healthy person. Finally, the question may be formatted to appear as though the counselor is working in a field setting with a client (work behavior questions). Be mindful the question is still requesting content.

Question I-5:
Arrange in order Erikson's stages:

    1.   industry vs. inferiority

    2.   initiative vs. guilt

    3.   generativity vs. stagnation

    4.   autonomy vs. shame

    a.   1, 2, 3, 4

    b.   4, 3, 2, 1

    c.   3, 4, 1, 2

    d.   4, 2, 1, 3

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

Question I-6:
An adolescent counselor is counseling a 15-year-old youth who is experiencing difficulty in peer relationships, both male and female. In addition, this student vacillates between wanting to do well in

school and not caring about grades. Using the Erikson psychosocial model, the counselor would expect this person to be experiencing conflict at which stage of development?

    a.   industry vs. inferiority

    b.   autonomy vs. shame

    c.   initiative vs. guilt

    d.   identity vs. role confusion

Answer: d. identity vs. role confusion. This stage usually encompasses those individuals in the age range of 12-18 who, in the process of finding out who one is, can experience the failure side of a false sense of self. The name of the theory will not be in the body of the question rather the examinee will need to recognize the approach by the terms contained in the question or from the four answers.

Question I-7:

Successful progression through Erikson's stages requires:

    a.   resolution of the conflict at each stage.

    b.   meeting the tasks presented by society at each stage.

    c.   completing differentiation and integration of one's ego.

    d.   displaying age-appropriate cognitive learning per stage.

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

Question I-8:

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

    a.   acquire and implement a skill.

    b.   integrate self-concept into an occupation.

    c.   complete tasks society presents at each stage.

    d.   continue the sequence of ego differentiation.

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

Question 1-9:

The double bind theory is:

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

    b.   the fear of approaching a goal.

    c.   a series of anxious, repetitive thoughts.

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

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

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

Synthesis-Inference

These appear to be more 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 it is not difficult. If not, attempt to break this type of question down and work from the answers to the terms.

Question I-10:
Criterion-related validity described as empirical validity and assumed to be separate will differ in:

    a.   size of a group of examinees.

    b.   distribution of scores.

    c.   statistics used to derive meaning.

    d.   time sequence.

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

CACREP Objectives

The 200 questions will also reflect the CACREP 2016 standards. Since the NCE is a cognitive examination sponsored and developed by NBCC, it is reasonable to expect the NCE will represent the CACREP objectives. The curriculum objectives for one unit will be illustrated in the introduction chapter and the rest will be illustrated in the study units. For this example, unit seven-assessment and testing will serve as an example. Unit 7 assessment and testing objectives will be abbreviated (CACREP, 2015).

    a.   historical perspective and meaning of assessment and testing

    b.   methods for conducting initial assessment

    c.   assessing the risk of aggression or danger to others, suicide or harm to self

    d.   identifying trauma and abuse (reporting abuse)

    e.   diagnostic assessment and intervention planning

    f.   standardized and non-standardized testing, norm-referenced and criterion-referenced assessment, individual and group

    g.   statistical concepts, scales of measurement, central tendency, variability, shapes and types of distributions (skew), correlations

h. reliability and validity

i. academic, career, personal, and social development assessment

j. environmental assessments and behavioral observations

k. symptom checklists, personality and psychological testing

l. diagnosing developmental, behavioral, and mental disorders

m. ethical and culturally strategies in interpreting results

Appraisal and Testing

Question I-11: (Objective A.)

Early forms of test development in Europe and the United States focused on which human behavior?

a. personality

b. interest

c. intelligence

d. achievement

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

Question I-12: (Objective B.)

The most frequent type of data gathering to form a case conceptualization is a (an):

a. interview.

b. test administration and interpretation.

c. sociometric.

d. computer program.

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

Question 1-13: (Objective C.)

All of the following suicide theories include suicide factors except the:

a. Three-element Model

b. Suicide Trajectory Model

c. Cubic Model

d. Motivational Model

Answer: d. (Motivational Model) Overlap theory-greater the overlap in domains the greater risk, three-element-predisposing factors, family history, social environment, personality, life situation and availability

of means, Suicide Trajectory Model-interactive influences of risk factors, and Cubic–person has reached stage of hopelessness and suicide is considered the only exit.

Question 1-14 (Objective D.)

Survey results report that professionals who conduct sexual abuse assessments lack validity and accuracy and make judgment errors because assessors:

    a.   have not experienced sexual abuse

    b. lack research knowledge

    c. fear reporting abuse

    d. too sensitive to request direct questions about the abuse

Answer: b. lack research knowledge

Question 1-15: (Objective E.)

Which of the following is essential and most helpful in developing a treatment protocol for a client diagnosed with an eating disorder:

    a. medical history

    b. case conceptualization

    c. client input

    d. psychiatric history

Answer: b. case conceptualization. A case conceptualization includes all aspects of probing information from categories in a clinical interview, direct interview observations, mental status (if needed) and collateral services.

Question I-16: (Objective F.)

When a counselor is considering how well a client performed in a test area, this concept is:

    a. qualitative.

    b. quantitative.

    c. evaluation.

    d. measurement.

Answer: a. qualitative.

Question I-17: (Objective G.)

When a score on a teacher-made math test is used to provide information to a client, it is often transformed into a standard score. All are standard scores except?

    a. T-score

    b. z-score

    c. stanine

    d. raw score

Answer: d. raw score

Question I-18: (Objective G.)

A counselor is determining the relationship between grade point average and a graduate record examination score. A statistical technique to reflect this relationship is:

    a. mean.

    b. variability.

    c. student t test.

    d. correlation.

Answer: d. correlation.

Question I-19: (Objective H.)

Which reliability's correlation is derived when there are two administrations using two different but equal tests that measure the same construct?

    a. test-retest

    b. alternate forms

    c. coefficient alpha

    d. Kuder-Richardson 20

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

Question I-20: (Objective H.)

Standard error of measurement is to reliability as what is to validity?

    a. standard equivalence

    b. standard deviation

    c. standard error of estimate

    d. standard error of validity

Answer: c. standard error of estimate

Question I-21: (Objective J.)

When using a standard achievement test for elementary and middle school children and for the test to be fair, the sample when established should represent what type of sampling procedure?

    a. random

    b. cluster

    c. systematic

    d. stratified

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

Question 1-22: (Objective K.)

A counselor assessed a 9-year-old child using the DSM-5 diagnostic symptom criteria. One way to validate the diagnosis for a conduct disorder might be to administer the:

    a. Achenbach Child Behavior Checklist

b. Beck Depression Inventory

c. Hamilton Rating Scale for Children

d. The Connors 3

Answer: a. Achenbach Child Behavior Checklist. Achenbach Child Behavior Checklist measures for conduct disorder, oppositional defiant disorder, ADHD, somatic, and anxiety problems.

Question I-23: (Objective L.)

When a counselor is using an instrument to diagnosis for a DSM-5™ disorder it is important to be mindful of the:

a. qualifications of the examiner.

b. level of licensure the counselor holds.

c. years of work experience the counselor has with the dysfunction area.

d. supervisory capacity of the counselor.

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

Question I-24: (Objective M.)

When interpreting test results to a client, the ACA 2014 Code of Ethics recommends that the counselor:

a. is of the same gender.

b. review the results with a supervisor.

c. rescores the test answers for accuracy.

d. has a manual present.

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

The Profession: American Counseling Association (ACA)

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

ACA Formation

Standard Development and Associations

1. U.S. OFFICE OF EDUCATION: The U.S. Office of Education and programs such as NCATE administered early accreditation of counselor training. Accreditation focused on curriculum and instructor credentials.

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

3. NBCC (National Board for Certifying Counselors) was established in 1982 to create and monitor a national certification system, identify professionals and public counselors seeking certification, and to maintain a registry (Gibson & Mitchell, 2008).

4. 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.

5. CACREP sought membership in NCATE and COPA (Commission on Postsecondary Accreditation)

6. In 1987, CACREP applied for and received Category A membership on the National Commission for Health Certifying Agencies. CACREP is recognized as an accrediting agency by the Council for Higher Education Accreditation (CHEA) with full membership status with the Association of Specialized and Professional Accreditors (ASPA) and the International Network of Quality Assurance Agencies in Higher Education (INQAAHE).

NBCC: National Board for Certifying Counselors

NCE Examination: All counselors who meet the graduate degree and curriculum requirements are eligible to sit for the NCE. Those who successfully pass the NCE and graduates of CACREP programs may place after their name, NCC (Nationally Certified Counselor). Those graduating from non-CACREP programs are to acquire work experience of 3000 hours under supervision. For exact requirements and changes contact NBCC. Those who are approved to take the examination but under different circumstances place after their name, Board Certified until additional criteria are completed.

Entry-level specialty areas include career, clinical mental health, clinical rehabilitation, college counseling and student affairs, marriage, couple, and family, and school counseling (CACREP, 2015). After becoming an NCC and having met specific criteria, one can apply for one of the special examinations now offered through NBCC (C.2.b., ACA, 2014). Very often an examination is required. A few include: The Masters Certified Addiction Counselor (MCAC), National Certified School Counselor (NCSC), and Certified Clinical Mental Health Counselor (CCMHC). The applicant must be an NCC and meet specific course work to qualify to take one of the special examinations.

Continuing Education: To remain in good standing and to retain your NCC, each holder is required to update his/her expertise (C.2.f., ACA, 2014). Specific methods and required hours are provided to each NCC. Similar requirements are to be found for those holding state licenses to upgrade, remain current, and in some form continue to develop their professional expertise. These requirements are also reinforced within the ACA and NBCC Code of Ethics. Two terms common to continuing education are

"core" and "elective." Institutions that offer workshops, readings, supervision, and other experiences qualifying for continuing education credits are called Providers. NBCC will issue them a provider number. The provider reviews programs before they are conducted ensuring the content falls within the curriculum requirements for credit and that the presenters are experts. The ACA Code of Ethics construct for this review is informed consent (prior approval and knowledge).

Counselor Work Behaviors

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

FUNDAMENTALS OF COUNSELING ISSUES

Counseling practice includes content questions as well as scenarios. This section will cover several of the content areas. The following questions are examples for the unit chapters: Counseling and Helping Relationships, Human Growth and Development, Social and Cultural Diversity, Assessment and Testing, and Professional Counseling Orientation and Ethical Practice.

Question I-25:
CONTENT: The counselor is utilizing the Erikson Psychosocial Stages to understand what the client is experiencing. The client indicates he is an isolate among his friends, and often verbally assaults them for their lack of involving him. He further elaborates that he has no personal feel for himself and frequently is unsure of whom he is or what he wants to do. The counselor might surmise the person is conflicted at which stage?

    a. industry vs. inferiority

    b. identity vs. role confusion

    c. intimacy vs. isolation

    d. trust vs. mistrust

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

Question I-26:
PRACTICE: A client in therapy with a person-centered counselor makes the following statement,

"I am a lousy parent." A person-centered counselor would respond:

    a. I know what you mean when you say, "lousy parent."

b. It must feel bad to think you are a bad parent.

c. In what ways do you see yourself as a lousy parent?

d. I am sure you are not a lousy parent but may have, at times, neglected to do the right thing.

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

Question I-27:

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

a. empathy.

b. immediacy.

c. concreteness.

d. confrontation.

Answer: c. concreteness

Question I-28:

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

a. parent.

b. adult.

c. child.

d. little professor.

Answer: b. adult

Question I-29:

PRACTICE: When a transactional therapist recognizes that the client is utilizing an ulterior transaction, the counselor will 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 later.

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

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

Question I-30:

CONTENT: A counselor is counseling a client who represents a culture different from 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 will recognize or stand up for her rights. She is confused and has thoughts that she should return to her country of origin. The counselor using the Minority Identity Model surmises the client is at which stage of this model:

    a. dissonance

    b. resistance

    c. immersion

    d. introspection

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

Question I-31:

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

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

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

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

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

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

COUNSELING PROCESS

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

Question I-32:

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

    a. uncertainty about his/her choice

    b. no choice

    c. discrepancy between interest and aptitudes

    d. unwise choice

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

Question I-33:

PRACTICE: In the above example, the counselor would:

a. attempt to point out other occupations that 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. explores with the student the requirements for training in the health sciences as well as his/her depth of interest in the field. Keep the options open to the student and counsel for exploratory measures.

Question I-34:

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

a. congruence.

b. consistency.

c. transition.

d. realism.

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

Question I-35:

PRACTICE: A cyclical counselor would consider the first step in assisting a client with career direction and reaching a level of satisfaction would be to:

a. assess vocational maturity

b. assess the person's self-concept

c. teach decision-making skills

d. appraise the life stage in which the individual is presently residing

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

Question I-36:

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 is confused about why the jobs end so abruptly. He has not, at any of the jobs, been delinquent regarding equipment, late to work, or disrespectful. During counseling, the client expresses that he has no real feelings or reasons for these frequent job losses, in fact, he offers many reasons why the companies benefit. His initial request is for the counselor to help him find a job. The action of the counselor may be to:

a. administer a battery of tests to include an interest and personality.

b. refer him for a psychological evaluation to rule out any diagnoses.

c. indicate to him he should seek personal counseling with another counselor while this counselor works with him on a vocational plan.

d.   assess whether his work history has a similar pattern to a parent's work history.

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

Question I-37:

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

a.   recommend he begin with at least a few cold calls.
b.   begin his search with Career InfoNet.
c.   suggest he start with a temporary agency.
d.   recommend the daily newspaper want ads.

Answer: b. begin his search with Career InfoNet. Career InfoNet is a key word search (Internet access) for more than a thousand occupations that includes descriptions, detailed data, employment outlook, and salary range, state by state. It also includes the fastest growing occupations, largest employment, those occupations declining, and includes links to Web sites that provide assessment, occupational information, resume-writing instruction, job-seeking instruction, and general career planning support (Niles & Harris-Bowlsbey, 2013)

DIAGNOSTIC AND ASSESSMENT SERVICES

Question I-38:

All are interview protocols when gathering client data to formulate a case conceptualization except?

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

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

Question I-39:

PRACTICE: In a theme-oriented group for alcoholics, one member dominates the interaction. The group is in the cohesion stage, and 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 much of the talking.

c.   take the person aside and ask him to allow others to talk.

d.   break into dyads and provide them a task, thus everyone gets to talk.

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

PROFESSIONAL PRACTICE

Professional development questions will sample counselor knowledge and practice for skill application.

Question I-40:
CONTENT: A school counselor referred a family for counseling because of suspected verbal abuse. The intake application indicates that there is a communication problem within the family, especially evident with the teenage daughter. During the first session, this teenager refuses to speak or look at the father. Some therapies or parents might refer to the daughter as the:

a.   scape goat.

b.   identified client.

c.   client.

d.   all the above.

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

Question I-41:
PRACTICE: In example 40 the counselor would best:

a.   refer the daughter for individual counseling.

b.   conduct a genogram.

c.   conduct informed consent and begin to elicit trust.

d.   teach communication skills to the family members.

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

PROFESSIONAL DEVELOPMENT, SUPERVISION, AND CONSULTATION

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

Question I-42:
The ACA 2014 Code of Ethics regarding professional responsibility charges the counselor to do all except?

a.   monitor effectiveness.

b. maintain supervision with professionals and refrain from peer supervision.

c. practice in new specialty areas with training and supervised experience.

d. be alert for self-impairment.

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

Question I-43:

The principle goal in consultation when utilizing a consultant is to:

a. produce a change in client behavior.

b. advance the skill of the counselor.

c. maintain client adherence to the continued pursuit of the goal.

d. alter the counselor's treatment plan.

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

Question I-44:

A consultant in working with a consultee (counselor) attempts to provide all except:

a. defining problems.

b. techniques for evaluating whether problem solutions have been attained.

c. create definitions of terms provided by the counselor or client.

d. strategies for solving problems.

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

Question I-45:

CONTENT: This is the first session with a 29-year-old male who has listed on the 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 romantically 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 on his behalf. This statement is an example of:

a. an inappropriate act on the part of the counselor.

b. informed consent.

c. duty to warn.

d. malpractice.

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

Question I-46:

A counselor takes public transportation to the therapy center on this 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 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.   suggest 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. suggest to the client she or he should discuss this matter with her/his counselor. Maintain a line of positive regard and respect but politely indicate this material should be shared in therapy.

Additional Practice Questions:

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

Question I-47:

In a population of clinical clients and documented research findings, all are true except?

    a.   A small number of clients (15%) will show measurable improvement before attending the first session.

    b.   Three out of four clients 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 client benefit.

    d.   Research evidence reports that psychotherapies are not equal in effectiveness.

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

Question I-48:

The most common therapy response mode used by clients in the traditional therapies and by the majority culture is:

    a.   disclosure.

    b.   impulse response.

    c.   control.

d. silence.

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

Question I-49:

All therapies *h*ave a common goal that is:

    a. responsibility assumption.

    b. hope.

    c. emotional bonding.

    d. self-efficacy.

Answer: d. self-efficacy. Self-efficacy is one component for mental health direction regarding effectiveness.

Question I-50:

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

    a. paranoia

    b. agoraphobia

    c. panic disorder

    d. obsessive-compulsive

Answer: a. paranoia

Question I-51:

A new employee in the secretarial pool who is typing psychiatric evaluations consults a supervisor because he became confused with the procedures for the DSM-5™. He had overheard that the DSM-5™ was different than the DSM-IV-TR. The psychiatrist made the following notation 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 correct term for this notation is?

    a. disorder

    b. z-code

    c. axis I and II

    d. specifier

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

Question I-52:

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 the above.

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

Question I-53:

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 selection of friends and career preference because of parental differences.

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

Question I-54:

Proponents of the Social Influence Model suggest that clients are influenced toward change by 'high' counselor levels except:

    a. expertness.

    b. resources.

    c. attractiveness.

    d. trustworthiness.

Answer: b. resources.

Question I-55:

According to Strong (1968) the best predictor of client outcome as perceived by the clients is:

    a. expertness.

    b. attractiveness.

    c. trustworthiness.

    d. resources.

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

Question I-56:

Strong (1968) believed the greatest influencing factor for client change took place when the client is convinced of the counselor's:

    a. experience level.

    b. competence.

    c.   reality base.

    d.   involvement in personal counseling.

Answer: b.   competence (cited in Ardito & Rebellino, 2011)

Question I-57:

The therapeutic bond is composed of three variables. Which one is not considered to be one of those therapeutic variables?

    a.   client energy invested in the process

    b.   empathic resonance

    c.   mutual affirmation

    d.   experience level

Answer: d. experience level

Question I-58:

How genuine or self-congruent the client and the therapist perceive their individual role behavior is known as:

    a.   therapy socialization.

    b.   counseling attitude.

    c.   self-concept.

    d.   working alliance.

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

Question I-59:

Research data suggests the counselor has all power bases except:

    a.   coercive

    b.   referent

    c.   expert

    d.   legitimate

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

Question I-60:

Engagement in counseling refers to:

    a.   counseling delays regarding the length of wait for ongoing counseling beyond the intake session.

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

    c.   the client prematurely terminating.

d. the formation of bonding and development regarding transference.

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

Question I-61:

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

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

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

Question I-62:

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

    a. random
    b. systematic
    c. unsystematic
    d. uncharacteristic

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

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UNIT 1 - Professional Counseling Orientation and Ethical Practice

Introduction

The units in this study manual are arranged according to the 2016 CACREP curriculum standards numerical and alphabetical order (1-8, a. b., etc.) describing the curriculum objectives with the first unit Professional Counseling Orientation and Ethical Practice and the last unit Research and Program Evaluation. The same procedure exists within each unit study with material appearing first in line with the order of the objectives for that unit such as 1a, 1b, 1c, 2a, and 2b throughout the eight units. An effort has been made to integrate the ACA 2014 Code of Ethics (ACA, 2014) into the CACREP curriculum objectives where possible. ACA released the 2014 Code of Ethics March 25, 2014.

There is considerable content overlap in several units of study such as lifespan, consultation, multicultural society, diversity, wellness, crises, and family. Sometimes this may appear as though there is a certain amount of redundancy from unit to unit. The reason for the overlap has to do with the number of CACREP objectives that require material for more than one unit of preparation. An effort has been made to limit this as much as possible without detracting from the specifics for that objective in that unit. What may be important in preparation for this examination is to examine each objective for the keyword to study the details of the material. Keywords appear in the objectives such as framework, effects, strategies, methods, importance, history, roles, responsibilities, advocating, trends, styles, basic concepts

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

The professional counseling orientation and ethical practices subtest covers material relevant to the historical development of the profession, professional preparation, professional organizations, roles and functions of counselors, professional credentialing, labor market information, self-care, role of supervision, professional organizations, advocating for the profession and client, advocating for institutional and social barriers, technology, self-evaluation, and the ethical standards and practice.

The 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 for specialty areas. The ACA 2014 Code of Ethics can be found in most introductory counseling textbooks and on-line (www.counseling.org). Examine your understanding of this code by developing an ethical dilemma pertinent to each section of this study guide. Also, if you have not had a recent course in ethics, it would be helpful to select a current textbook in ethics and become familiar with the legal and ethical practices in counseling. Since one chapter of a preparation guide cannot provide comprehensive coverage of such a broad area of counseling, be sure to understand the terms and concepts in the remaining chapters of the manual by interpreting the content about the ethical code, best client care and implications of counselor behaviors. To aid in this endeavor, questions in this chapter span the broad area of the field to include integrating information from all eight units of study (chapters) and content areas for ethical decision-making. The most recent NCE examinations have included 34 content questions for the professional counseling orientation and ethical practices section, of which 29 counts toward your total score. These numbers are subject to change as NBCC conducts surveys and makes changes.

The CACREP 2016 standard objectives are identified by a numbering system (1-8). Unit 1 is Professional Counseling Orientation and Ethical Practice.

CACREP Objectives

Each unit of the eight NCE content areas and chapters of this manual will begin with the CACREP curriculum objectives. These objectives are outlined in the CACREP 2016 standards manual Section III, Professional Identity (pp. 9-14). The full text of the 2016 CACREP standards is available at www.cacrep.org. Each unit of study will include the identifying Section of the 2014 Code of Ethics that pertains to that CACREP objective. An effort has been made to integrate the 2016 CACREP standards and the 2014 ACA Code of Ethics. Example questions follow the listed objectives.

These objectives are abbreviated in this manual but are fully developed in the CACREP 2016 standards for Professional Counseling Orientation and Ethical Practice (CACREP, 2015, p. 9-10).

A. History and philosophy of the profession and specialty areas

B. Professional roles, functions, across specialty areas, human service, behavioral health, and interagency and interorganizational collaboration

C. Counselor roles, responsibilities, and emergency management response teams

D. Advocating role and process on behalf of profession

E. Advocating addressing institutional and social barriers

F. Professional organizations

G. Professional credentialing, including certification, licensure, and accreditation standards and practice

H. Labor market for opportunities and practice

I. Ethical standards

J. Technology impact

K. Strategies for personal and professional self-evaluation

L. Self-care strategies appropriate to the counselor role

M. Supervision roles

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

Question 1-1: (Objective A.)

The professional counselor educator who was charged to create a code of ethics for the American Personnel and Guidance Association later named the American Counseling Association was:

a. Frank Parsons.

b. Victor Frankl.

c. Carl Rogers.

d. Donald Super.

Answer: d. Donald Super.

Question 1-2: (Objective B.)

A counselor and counselor-trainee are to begin the process to establish a professional identity with other mental health disciplines (psychologist, social workers, etc.) by:

a. respecting other discipline's code of ethics

b. joining ACA membership.

c. acquiring knowledge of human behavior.

d. reviewing professional and personal characteristics of a counselor.

Answer: a. respecting other specialty areas practice and code of ethics.

Question 1-3: (Objective C.)

First responders such as safety officers, fire personnel, mental health professionals, and volunteers often encounter repeated stressful situations during disasters and are themselves affected emotionally, psychologically, and physically. First responders should recognize personal burnout signals and current level of resiliency to cope. All actions or techniques are considered helpful to those responders affected by the disaster except for?

a. mindfulness technique

b. resiliency training

c. stress reduction

d. separate self from the crisis activities

Answer: d. Separate self from the crisis activities. First responders need to develop self-care when confronted with disasters. Debriefing activities encourage the first responder to recognize their coping skills (resiliency) and honor their feelings regarding the impact a crisis has on the person.

Question 1-4: (Objective D.)

To advocate for the profession philosophically, counselors share in the belief of helping others with their emotional and mental health. Typically, four tenets make up this philosophy. Which one represents one of the tenets?

    a. An intervention is the most successful approach to solving emotional and psychological 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 problems independently of mental health workers.

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

Question 1-5: (Objective D.)

Professionals can begin to advocate for the profession by:

    a. writing a paper on professionalism.

    b. securing liability insurance.

    c. joining a local professional association.

    d. including a lawyer on your counseling board.

Answer: c. join a local professional association.

Question 1-6: (Objective E.)

To advocate against a social barrier that limits clients or a service institution can be through all except:

    a. policymakers.

    b. media.

    c. group activities serving a particular social barrier.

    d. achieving an advanced degree or license for greater recognition.

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

Question 1-7: (Objective F.)

The ACA sub-division that was responsible for spearheading the development of CACREP:

    a. ASGW

    b. ACES

    c. AMHCA

d. AAC

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

Question 1-8: (Objective G.)

The designation that a professional has met certain predetermined qualifications is a non-statutory process by which an agency or association grants recognition:

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

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

Question 1-9: (Objective G.)

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

a. licensure
b. business license
c. standard of care
d. certification

Answer: d. certification. Licensure subscribes to following an ethical code but requires additional requirements such as an examination, required years of work experience and supervision.

Question 1-10: (Objective H.)

The U.S. Bureau of Labor Statistics (BLS, 2016) predicted that for the 21st century what occupation was a high priority?

a. computer related
b. surveying
c. restaurant
d. oceanography

Answer: a. computer related

Question 1-11: (Objective I)

Most standards of care or practice in the mental health field recommend that counselors adhere to all except:

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

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

Question 1-12: (Objective I.)

When a counselor decides to accept a client for services, the counselor considers which of the following to be a primary consideration?

  a.   client's ability to pay

  b.   client welfare

  c.   years of clinical experience in counseling

  d.   other professionals who have more experience and may be the better provider for the client

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

Question 1-13: (Objective J.)

The ACA 2014 Code of Ethics stipulates that a counselor is to be knowledgeable about the correct procedure when a client requests technology transmission of records to another therapist. The legal requirements are in which document?

  a.   Health Insurance Portability and Accountability Act (HIPAA)

  b.   Public Law 142-192

  c.   Federal Educational Rights and Privacy Act (FERPA; USD Education, 2008)

  d.   McNaughton Rule

Answer: a. HIPAA

Question 1-14: (Objective K.) Self-evaluation

Internet and technology counseling are on the increase. All are considered advantages for the use of technology except:

  a.   a greater freedom in scheduling.

  b.   a better choice of written words.

  c.   anonymity decreases anxiety.

  d.   stronger client-counselor relationship.

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

Question 1-15: (Objective L.)

The Wheel of Wellness bases self-care upon the:

  a.   disease and illness model.

  b.   Adlerian model of leisure.

  c.   mental and physical disorders.

  d.   human growth and behavior.

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

Question 1-16 (Objective M.)

The supervisory role includes all except:

 a. monitoring client welfare.
 b. encouraging compliance with legal, ethical, and professional standards.
 c. monitoring counselor clinical performance.
 d. pursuing an advanced academic degree equal to or beyond that of others.

Answer: d. pursuing an advanced academic degree equal to or beyond that of others

Question 1-17: (Objective M.)

The model of supervision that does not rely on being didactic but rather helps the supervisee draw on his or her resources, learn to behave independently, make changes and attend to the positive in both the counselor and the client is:

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

Answer: b. solution-focused.

Question 1-18: (Objective M.)

Solution-focused supervisors adhere to all assumptions except:

 a. resistance resides outside the supervisory relationship.
 b. focus on supervisee's strengths and successes.
 c. work to achieve what is possible.
 d. accept that there is no one correct way to intervene.

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

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.

Adaptive Functioning	MCKAS
Alliance Focused Training	NCC
Beers, Clifford	NDEA
Binge Eating Disorder	NVGA
Buros, Oscar	OARS
Casual Leisure	Parsons, Frank
Certification	Portability
Chi Sigma Iota	Privileged Communication
Covered Entity	Professionalism
Davis, Jesse	Public Law 94-142
Duty to Warn	ROM
Eclectic	Specialty Areas
Exception to Privilege	Specifier (DSM-5™)
Expert Witness	Super, Donald
Galton, Francis	Supervision
HIPAA	Tiered Licensing
ICM-10	Tripartite
Licensure	Unspecified
Malpractice	Z-code
Mental Status Examination	Wellness
Merrill, George	20/20 Vision

ACA Guideline Sections

As you prepare for the NCE examination and ethical practice, note the relationship between the core requirements in each unit of study and the 2014 ACA ethical code sections A-I.

Section A: The Counseling Relationship
Section B: Confidentiality and Privacy
Section C: Professional Responsibility
Section D: Relationships with Other Professionals
Section E: Evaluation, Assessment, and Interpretation
Section F: Supervision, Training, and Teaching
Section G: Research and Publication

OBJECTIVE A1: History of the Profession

CACREP curriculum core objective 1.a. provides an understanding of the history and philosophy of the counseling profession and its specialty areas. (CACREP, 2015, p. 9)

Entry-level specialty areas were first adopted along with the first set of CACREP standards and included the Association for Counselor Education and Supervision, the American School Counselor Association, and American College Personnel Association (Bobby, 2013). Presently the six specialty areas include career; clinical mental health; clinical rehabilitation; college counseling and student affairs; marriage, couple, and family, and school counseling. Specialty area examinations and certifications are available upon meeting specific requirements.

The counseling profession originated and formed around the term guidance. Brown and Srebalus (2003) indicated 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 closely associated with the curriculum in the schools and occupational work with immigration during the early 1900s. Gibson and Mitchell (2008) 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 individuals making contributions emerged during the years 1900-1940. These contributions emphasized the importance of testing, philosophy, and education. Social counseling was first applied around 1930 with Trait and Factor Theory.

The establishment of the American Personnel and Guidance Association (APGA) was in 1952. 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).

Wade Silverman (2013) in the past 20 years has offered his thoughts about the future of psychotherapy. His first prognostication in 1994 identified six trends, the second in 2000 with six more

(two repeats), and in 2012, four. The most notable of these predictions in 1994 was gender and psychotherapy, in 2000 integration of psychotherapy, specialty areas, and prescribing privileges. For 2012 the four areas of growth and change include new diversity along levels of technological sophistication, expanding the use of technology, a new economy of health care, and emerging markets for consumers for the quality of life. Attention is devoted to Silverman's predictions in the 2016 standards and this manual.

Future Trends

1. Demographic trends (aging population excess of 39 million over 65, 6 million over 85)
2. Information access (technology, website quality, Internet counseling, privacy of information, advise, assist, provide, arrange data)
3. Science and health (neuroscience, wellness, managed care, efficacy studies)
4. Disaster/trauma, violence (acute stress, PTSD, first responders, psychological first aid, school shootings, environmental, terrorism) (debriefing questionable results such as Critical Incident Stress Debriefing (CISD)
5. Bias or social stigma (immigration, negative stereotypes, labels, courtesy stigma-fear of contamination of mental illness by family members (Angermeyer, Schulze, & Dietrich, 2003)
6. Wounded warriors (access to parity in providing services)-PTSD/TBI
7. Advocacy for communities, self and others
8. Managed Care
9. Identity (unity-counselor first, specialist second)
10. Portability

Question 1-19:

The individual given credit for the founding of psychology is:

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

Answer: b. Wilhelm Wundt.

Profession-Professionalism

CACREP objective core curriculum standards for Professional Counseling Orientation and Ethical Practices includes an understanding of counselor roles, functions, and relationships with other human service providers, including strategies for interagency/organizational collaboration and communications standards (CACREP, 2015). Section C of the 2014 ACA Code of Ethics regarding knowledge of and compliance with standards include: knowledge of standards (C.1.), professional competence (C.2.), professional qualifications (C.4.), public responsibility (C.6.), and responsibility to other professionals (C.8.)

apply to this objective. The ACA Standards of Practice have been integrated into the Code of Ethics and represent the aspirational guidelines found at the beginning of each section (Introduction).

A profession gains status and maturity through professionalism, 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 standards within the U. S. Office of Education for ACA began during the reform movements. 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). CACREP adopted ACES standards at the first board meeting and by 1987 formatted standards for all entry-level programs (Bobby, 2013). The primary 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) a national oversight organization that accredited the accreditors (Bobby, 2013; 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 advantage of acquiring this membership is for the promotion of excellence in counselor behaviors in competency and research. Also, 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" (cited in Sweeney,1995, p. 99). The process involves and includes a clear statement of educational objectives, a directed self-study focused on the objectives, on-site evaluation by a peer group, and a decision by an independent commission as to the worthiness of the requested program.

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

    a.   Council for Mental Health Programs.

    b.   American Psychological Association.

    c.   Council for Accrediting Counseling and Related Education Programs (CACREP).

    d.   American Association for Counseling and Development.

Answer: c. CACREP

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

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

1. a specialized body of knowledge based on theory-driven research.
2. an established professional society or association.
3. control of training programs.
4. a code of ethics to guide professional behavior.
5. standards for admitting and policing practitioners.

VanZandt (1990) described professionalism as an attitude that 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 profession's willingness to enforce standards and monitor competencies with well-established ethics and certification programs.

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

1. the way in which a worker relies on a personal standard of excellence in competency
2. the way in which the worker promotes the image of the profession
3. improvement of skills is observed through professional development
4. ongoing striving for quality and ideals
5. way 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, 2007). Political involvement is the action step in promoting, maintaining, and acquiring the elements of a profession.

The future of the profession was crafted and guided toward the 1990s starting in 1982 by Gary Waltz, George Gazda, and Bruce Shertzer who presented addresses to the membership of the Association for Counselor Education and Supervision (ACES; Kaplan & Gladding, 2011). Eventually, an oversight committee was formed in 2006 and was identified as 20/20: A Vision for the Future of Counseling. Waltz, Gazda, and Shertzer highlighted the initial focus and attention for the direction of the profession. The priority areas included the aging population, insurance companies and evidence-based therapy, family counseling skills, diversity and recruitment, peer counseling and networking, national marketing, technology, new skills, ethical and legal boundaries, self-help techniques, and special interest groups requiring advocacy skills.

Chi Sigma Iota's contribution for the profession's future direction was a call for establishing a clear identity as a professional counselor. They also called for promoting an advocacy agenda, establishing an adequate compensation, partnering with sister professions, promoting rigorous research in client outcomes, preparation for employment, public awareness, and promoting prevention and wellness.

The oversight committee planned for the development of 20/20: A Vision for the Future of Counseling and in 2007, 31 major organizational stakeholders composed the guiding group. This group in 2007 focused on seven strategic areas for future attention. The seven areas included:

1. strengthening identity
2. presenting ourselves as one profession
3. improving public perceptions/recognition and advocating for professional issues
4. creating licensure portability
5. expanding and promoting the research base of professional counseling
6. focusing on student and prospective students and
7. promoting client welfare and advocacy (Kaplan & Gladding, 2011, p. 369, 371; Locke, 2011).

The seven core areas included a total of 22 subgoals. In addition, Mascari and Webber (2013) from interviews with 22 leaders, primarily former ACA presidents, noted the most important licensure issues included:

a. counselor identity.
b. portability.
c. variance in state licensing requirements.
d. psychologists' attempts to restrict diagnosis and testing in counselor practice.
e. use of certified clinical supervisors.

In 2005 the American Association of State Counseling Boards (ASSCB; 2005), a member of 20/20 Vision created the National Credential Registry (NCR; Tarvydas & Hartley, 2009).

As a result of the 20/20 initiatives a new definition of counseling emerged.

Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals (Kaplan, Tarvydas, & Gladding, 2014).

Life Span Stress and Problem Areas for Clients and Counselors

Depending on the level and specialty of training, a counselor will encounter and treat a variety of stressors and levels of functioning regarding personality, learning, emotions, social skills, moral development, 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 life-stress-related symptoms of anxiety, depression, mood swings, isolation, and psychological incapacitation. Prospective clients experience a multitude of events that are stressful and lack the coping skills to resolve the issue. The stressors stem from 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 normal and abnormal behaviors before applying treatment modalities and strategies for change. He or she should be knowledgeable about the 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 an appropriate referral, and initiate therapy.

It is important to become acquainted with many of the psychological abnormalities found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5™), information that is essential for the diagnostic and treatment process.

OBJECTIVE 1B: Counselor Roles, Functions, Responsibilities

Objective 1b. the multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation (CACREP, 2015, p. 9).

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

The elementary school counselors' roles include individual counseling, group guidance and counseling, working with parents, consultation with teachers and administration, classroom guidance instruction, assessment activity and coordination with community agencies (Gibson & Mitchell, 2008). Also, their roles are goal directed for health prevention as the three Cs, counseling, consulting, and coordinating. The counselor forms relationships with other helping professionals and often is called upon to work in interdisciplinary roles with first responders. Some interagency relationships are shared with psychologists, social workers, medical specialists, family practitioners, health personnel, psychiatrists, neurologists, rehabilitation counselors and employee assistance counselors.

Counselors perform a multitude of roles and functions. They are to be trained to perform individual and group guidance and counseling interventions, techniques and skills, and to be vigilant in a gatekeeper role for the profession. Counselor activities, job roles, and commitments are the focus in the broad areas of guidance, counseling, and psychotherapy.

Guidance-Counseling-Psychotherapy

The definitions of guidance, counseling, and psychotherapy, often used interchangeably, are best understood by reviewing the evolution of the field of guidance and counseling. 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. 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, & Niles, 2004). Recently the focus has been a lifestyle concept combining vocational and career guidance emphasizing sex role, sex bias, a holistic approach, decision-making, self-concept, lifestyle, free choice, individual differences, diversity, and coping skills (Herr, Cramer & Niles, 2004). Herr, Cramer, and Niles. (2004) defined 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 (2012), is "relatively a short (time-limited), interpersonal, theory-based, professional activity guided by ethical and legal standards that focus on helping persons who are psychologically healthy to resolve developmental and situational problems" (p. 8). 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. 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 (tripartite).

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 values, morals, biases, and belief system regarding the concern or client complaint

PSYCHOTHERAPY: Psychotherapy is a re-educative process aimed at aiding the individual in perceptual reorganization, integration of insight, and to cope with feelings of hurtful events from the past (Brammer & Shostrom, 1977). Psychotherapy focuses on serious problems, emphasizing the past, insight more than change, and is long-term. Psychotherapy typically is long-term for chronic and severe problems.

Question 1-21:

Which one of the following was not one of the reasons vocational guidance evolved into a comprehensive career guidance definition?

    a. awareness of personality dynamics in vocational choice and work adjustment
    b. the lack of a psychological approach to vocational guidance
    c. knowledge of individual differences
    d. developmental view of the individual

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

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

Question 1-22:

A newspaper reported on a specialty technique and skill regarding a counselor. When the article appeared in print, the writer had included an additional area of expertise as part of the counselor's credentials, but 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. try to acquire some expertise in the area since it was mentioned in the article and could provide additional clients.
    d. write a statement to the paper addressed to the editor for a reprinting of the article with the stated corrections or a statement to that effect.

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

Question 1-23:

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

   a.   that the treatment is grounded in theory.
   b.   there is empirical support.
   c.   to document the treatment protocol in the chart.
   d.   the treatment is to have had at least two literature supported effectiveness studies.

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

OBJECTIVE 1C: Roles, Responsibilities, Emergency Teams

Objective 1c: counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams (CACREP, 2015, p. 9).

Disaster responses demand an emergency preparedness plan for organizations, professionals, and volunteers to promptly coordinate activities during and after a crisis. Emergency services are necessary to reduce the consequences of disasters (Kim, 2014). The development of response management in the United States emerged after September 11, 2001, terrorist attack (Jensen, 2014). Emergency management teams in readiness to respond have developed for a variety of reasons. The roles and responsibilities shift according to the amount of preparedness that is necessary for the type of disaster. Counselors are involved in emergency situations in the form of crises and disasters that occur with individuals (clients), community citizens, and on a global basis. Individual crises such as domestic violence, suicide and harm to self, shootings, and unexpected death are usually a one-to-one counselor crisis response. Large groups of citizens experience hurricanes, floods, tornadoes, fires, school shootings, landslides, tidal waves, and terrorism on a county, state, country, and global basis regarding risk and threat of life.

The Centre for Research on the Epidemiology of Disasters (CRED) disaster definition is "a situation or event which overwhelms local capacity, necessitating a request to a national or international level for external assistance; an unforeseen and often sudden event that causes great damage, destruction and human suffering" (Guha-Sapir, Below, & Ponsere, 2011, p. 7).

The preparedness of health providers and their response capabilities include knowledge, skills, and abilities for different phases of an emergency event. A response plan will include training content. Slepski

(2007, 2016) defined emergency preparedness as "the comprehensive knowledge, skills, abilities and actions needed to prepare for and respond to threatened, actual or suspected chemical, biological, radiological, nuclear or explosive incidents, man-made incidents, natural disasters or other related events" (p. 426). Sixty-six percent of Americans feel they are personally unprepared for a disaster. Thirty-one percent of Americans have a basic emergency preparedness kit that includes a three-day supply of food and water for each family member, a portable radio, batteries, telephone numbers and pertinent information in how to proceed and where to meet (FEMA, 2009).

Meredith et al. (2010) reported that behavioral health services could range from 4 to 50 times higher than the surge for medical care. Behavioral health facilities that work with community planners develop a set of structures and processes that will support adaptive and appropriate responses for a disaster (Meredith et al., 2011).

The National Incident Management System (NIMS) identifies the terms, protocols, procedures, and standards for effective coordination of local, regional, state, and federal levels for emergency preparedness and response (U.S. DHHS, 2008). Disasters are managed at the local level for the first line of emergency management. Behavioral health response teams are called upon by NIMS and credentialed in and operate under NIMS structure. Local communities working in behavioral services are encouraged to develop a hazard identification and risk assessment based on the kind of threat. Behavioral teams are organized to meet the type of disaster. A team is composed of counselors who are on call to respond to a site should a youth die from a school shooting, automobile accident, or an athletic event to be available to those affected should they be family members, survivors, student body, close friends, and the community. The preparedness team in risk and impact planning find ways to lessen impending disaster (mitigation, building evacuation, safe rooms, the supply of food, and water, housing, flashlights, etc.).

Mental health professionals participating in emergency services alongside first responders, law enforcement personnel, nurses, public health workers, clinicians, and citizens perform necessary work to save life and stabilize help during events of a disaster. Crisis management in context means to work simultaneously with other responders and in a hurry sharing modes of involving resources and information (Lauras, 2015). Since no two crises are the same mental health workers are to be prepared for changing role requirements based on different types of emergencies. For those crises when information is forthcoming, Lauras (2015) and Alexander (2002) suggested a reusable four phase system model (meta-model) that includes a crisis, treatment, collaboration, and global crisis management:

a. the first phase is before the beginning of a crisis (example hurricane warning) to decrease the probability of risks (evacuation) and consequences
b. the second phase is before the impact to establish new processes to future crises
c. the third phase is to integrate all the actions to be carried out as rapidly as possible after the impact
d. the fourth phase is when the crisis is under control to return to a normal functioning as quickly as possible and to repair infrastructure to a stable and manageable state

When a crisis occurs on a local level, the responsibility for identifying the risks and managing the vulnerabilities associated with the occurrence of a disaster falls on the local emergency manager. Because most crises are somewhat of an unpredictable nature, the manager is to exercise cognitive critical thinking practices in decision-making (Peerbolte, 2013).

A protective action decision model (PADM) is a comprehensive model designed to identify key factors that influence people to make decisions related to disaster preparedness. This protective model identifies risks, evaluates based on environmental cues and how one may respond (Lindell & Perry, 2004). Miller, Adame, and Moore (2013) to better understand the preparedness of individuals for impending disasters integrated critical components of the vested interest theory (VIE) and the extended parallel process model of fear (EPPM) to isolate the social aspects of attitude for preparedness and a disconnect between belief and action. Five dimensions were separated for consistent measures and included stake, salience, immediacy, certainty, and self-efficacy. Self-efficacy is a fundamental element in predicting motivating and coping ability as a protective factor after a disaster. Mulilis, Duval, and Rombach (2001) reported depending on the severity of a catastrophe that problem-focused, as opposed to emotion-focused coping activities, were central to personal responsibility.

Communication is at the heart of an emergency plan, response, and recovery (Houston et al., 2014). Social disaster media provides immediate information to assist in the changing roles of mental health providers. Risk management to decrease risk is to warn ahead of the impending disaster such as the National Weather Service (NWS) with broad-based alerts and updates. Web-based platforms, social media, and free networking allow for a system to connect with other members within or outside the crisis event. The use of computing devices such as cell phones, laptops, smartphones, blogs, Twitter, Facebook, Google, and LinkedIn is available to disaster communicators as the tragedy unfolds. Social media provides information that includes:

a. warnings, signals, and monitoring.

b. sending and receiving requests for assistance.

c. informing others of one's condition and location.

d. learning what is happening during and after a disaster.

e. how to assist in the emergency.

f. providing and receiving mental and behavioral health support.

g. expressing emotions, concerns, well-wishes.

h. recovery efforts.

i. connecting with family members.

j. discussing socio-political causes and responsibility for the event (Houston et al., 2014).

Geospatial technology is an outgrowth of several earthquake disasters (Kawasaki, 2013).

Preparedness is to know how to what. Broadly defined preparedness may include:

a. describing the public health role in emergency situations including communication equipment.

b. developing a chain of command and a management system (global or state/local large scale) that will include the American College of Emergency Physicians (ACEP), Centers for Disease Control and Prevention (CDC), International Nursing Coalition for Mass Casualty Education (INCME), Office of Emergency Preparedness (OEP), US Department of Homeland Security (DHS), and the Department of Health and Human Services (Slepski, 2005, 2007).

c. being flexible about roles, needs, schedules, and expectations, missions will change

d. It is okay not to know what to do especially for first time responders thus be patient, adaptable, and be prepared to work without direction.

e. Role changes will involve the responder as a person (needs of the individual), the responder in the physical environment (characteristics of the setting), and the responder as part of a social environment (social and legal norms and cultures that had an influence on the event). Also, changes include those representing the chain of command system, mental health issues, keeping families from being separated, and speaking with grieving families.

Wisner (2004) and Wisner, Blaikie, Cannon, and Davis (2004) reported that vulnerability is a key casual factor in disasters. Vulnerability refers to "the characteristics of a person or group and their situation that influence their capacity to anticipate, cope with, resist, and recover from the impact of a natural hazard" (International Federation of Red Cross, 2006, p. 11). Disabled people are vulnerable to disasters because of social marginalization as well as individual impairments. Counselors in preparation for and responding to disaster participants are to stand ready to identify these needs.

Miller, Adame, and Moore (2013) utilized Witte's Risk Behavior Diagnosis (RBD) to measure the preparedness risk assessment in two tornadoes and one earthquake study (after the disasters). Witte's instrument assesses for risk and readiness preparation for an impending disaster. The Risk Behavior Diagnosis scales include: (a) perceived susceptibility, (b) perceived response efficacy, and (c) perceived self-efficacy with subscales consisting of perceived certainty, perceived immediacy, and perceived salience (Witte, Cameron, McKeon, & Berkowitz, 1996).

The first responders and mental health services use the in-structure psychological first aid recommendations. These recommendations include promoting:

a. safety (find medical assistance, food/shelter, straightforward and accurate information)

b. calm (listen: how they feel, stories, etc.)

c. connectedness (contact friends and loved ones)

d. self-efficacy (practical suggestions)

e. help locate government and nongovernment services and support services. (Substance Abuse and Mental Health Services Administration, 2013, p. 36).

OBJECTIVE 1D, IE: Profession and System Advocating

Objective 1D: the role and process of the professional counselor advocating on behalf of the profession and Objective 1E: advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients (CACREP, 2015, p. 9)

Counselors are encouraged to advocate and to promote change at the individual, group, institutional, and societal levels (Introduction C, ACA, 2014). Ethical responsibilities for advocacy are further identified in the 2014 Code of Ethics and defined in terms of the counselor role (A.7.a.) confidentiality (A.7.b.), public responsibility (C.6.), testimonials (C.3.b), statements by others (C.3.c.), accurate representations (C.4.a.), media presentations (C.6.c.) and personal public statements (C.8.a.). Success in becoming a change agent and taking action and addressing oppression that impedes access, equity, and opportunities for client

success is through training and individual and societal commitment at the institutional level within the educational and political world. Oppression refers to the "systematic disadvantage of one group by other groups who hold more power in society" (Lopez-Baez & Paylo, 2009, p. 277). Neighborhoods, schools, media, culture and religious, political and social institutions are avenues for social justice advocacy efforts by mental health organizations and mental health individuals. Processes to promote advocacy on behalf of a client, community, systems, public, and social/political levels consist of the ACA advocacy competencies (Lewis, Arnold, House, & Toporek, 2002).

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

Advocating requires competencies in six domains extending from the micro level to macro level and acting with and acting on behalf of the client (Toporek, Lewis, & Crethar, 2009, p. 267).

Tracing the history of social justice and advocacy to the time of Frank Parsons' and Clifford Beers' writings regarding mental illnesses and mental hygiene sheds light on this movement. Smith, Reynolds, and Rovnak (2009) maintain that the "major focus of advocacy is related to power, privilege, allocations of resources, and various forms of prejudicial discrimination and violence toward the underrepresented individuals or groups" (p. 483). The elimination of social ills caused by forms of oppression and inequality is the fundamental goal of advocacy.

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

Competencies:

The ACA Code of Ethics (2014) for competence (A.11.a., C.2.), limits (E.2.a.), and supervision (F.2.).

Lewis, Lewis, Daniels, and D'Andrea (1998) identified two goals of advocacy: (1) to increase a client's sense of person power and (2) to foster environmental change. In addition to developing knowledge and skills for advocacy, it is important to implement those competencies with client issues and barriers effectively. Lewis and Lewis (1983) described two types of advocacies, those that involve clients (case advocacy) and those that include policies and institutions. The framework of social action is a continuum

of empowerment. Empowerment is an intervention taken by the counselor regarding the environment for a client or group and recognizing sociopolitical barriers. The social action occurs when the counselor's actions are to advocate for change in the public arena (Lee & Rodgers, 2009; Lewis et al., 1998). Three different levels for acting with or on behalf for intervention are client/student, school and community, and the public arena (ACA Governing Council, March 2003).

The client/student response is through empowerment and direct intervention within the system for clients. School and community intervention is addressed by a systems advocacy, a systemic approach with information and insight. The public arena intervention is a broader scale social/political advocacy (Ratts, Manivong, & Hutchins, 2009). This framework suggested a macro level to a micro level involving recruitment, sociopolitical education, diversity management, and self-care of the counselor-advocate.

Level of Intervention

Empowering the client to identify external barriers and the development of client self-advocacy skills, strategies, and resources is critical to counter the obstacles. A second power intervention helps the client to identify strengths, resources, and expertise and helps the client develop the confidence and ability to be proactive (Toporek et al., 2009). An additional level involves a direct intervention in which the client identifies allies and carries out an action plan.

Community Advocacy:

Eight competencies for community advocacy intervention include:

1. identifying environmental factors impinging upon students and clients' development.
2. alerting community or school groups with common concerns related to the issue.
3. developing alliances with groups working for change.
4. using active listening skills to gain an understanding of the group's goals.
5. identifying the strengths and resources that the group members bring to the process of systemic change.
6. communicating recognition of and respect for these strengths and resources.
7. identifying and offering the skills that the counselor can bring to the collaboration.
8. assessing the effect of the counselor's interaction with the community (Lewis et al., 2002, p. 2).

Level of Intervention (community)

Advocacy takes place at different levels of the community intervention and involves supporting efforts of some groups with similar barriers. This level of response is for a systematic change focused on injustice and oppression.

System Advocacy:

A systems advocacy according to Lewis et al. (2002) consisted of eight competencies to address barriers at the community level. The intervention steps include:

a. identifying environmental factors impinging on students' or clients' development.

b. providing and interpret data to show urgency for change.

c. in collaboration with other stakeholders, developing a vision to guide change.

d. analyzing the sources of political power and social influence within the system.

e. developing a step-by-step plan for implementing the change process.

f. developing a plan to deal with probable responses to change.

g. recognizing and dealing with resistance.

h. assessing the effect of counselor's advocacy efforts on the system and constituents (p.1).

Lewis et al. (2002) reported that when community collaboration becomes a need for policy advocacy the counselor assumes a leadership role to implement a plan of change.

Level of Intervention (System)

System interventions target organizations and recognizable patterns that affect communities as well as client groups. The interventions can focus on public information through the media, (editorials), legislation, public demonstrations (marches/rallies), and social/political action for a community-wide issue (Lee & Rodgers, 2009). Interventions can promote change through media communication, establishing allies and supporting existing ones, lobbying legislators, and policy makers.

In summary, the counselor is first to determine self-care through self-reflection. The personhood of the counselor is ultimately important when involved with client, community, and system advocacy and small steps are often effective. These acts of change make a difference between repression and liberation (Roysircar, 2009). As mentioned in the self-care section the well-being of the counselor is critical to becoming aware of warning signals and in avoiding burnout, compassion fatigue, secondary trauma, affecting resiliency, and multicultural adaptation (Roysircar).

The Congressional Management Foundation surveyed influencing factors that have a positive impact with senators to support advocacy legislation (CMG, 2008). The following factors in order had the most influence:

1. In-person issue visit from constituents   46%
2. Contact a representative who represents other constituents   36%
3. Individualized postal letters   20%
4. Personalized emails   19%
5. Comments during a telephone town hall   17%
6. Phone calls   14%
7. News editorial endorsement of an Issue   10%
8. Visit from a lobbyist   8%
9. Individualized faxes   8%
10. Send postal letters   1%

11.	Email messages	1%
12.	Comments on social media sites	1%
13.	Send faxes	1%

Question 1-24:

A counselor desires to advocate for the passage of a bill that will allow for admitting clients to a hospital for treatment. The influence of most importance regarding this advocacy action is:

  a. asking a friend to contact the lobbyist for support

  b. an in-person issue visit

  c. an individualized email

  d. a phone call

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

Volunteering with advocacy groups and organizations work towards building a social movement for peace, justice, equity, access, racial equality, internationalism and disaster recovery (Roysircar, 2009)

OBJECTIVE 1E. Advocating: Institutional and Social Barriers

Objective 1e: advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients (CACREP, 2015, p. 9). Counselors are encouraged to advocate and to promote change at the individual, group, institutional, and society levels (Introduction C, ACA, 2014). Ethical responsibilities are outlined in the code of ethics to ensure confidentiality when speaking on behalf of a client or a group of clients regarding barriers (ACA, 2014, A.7.a. b.).

Wherever possible the counselor works toward improving and alleviating systematic barriers or obstacles that inhibit access, growth, and development (A. 7.b.). Structural racism is a barrier in numerous institutional settings such as the workplace, health services, education, neighborhoods, recreation, criminal justice system, political process, unemployment, school dropouts, and poverty. Denied or repressed access, equity, and freedom involving racial tension and stress affect the negative impact on mental and physical disparities. Nuru-Jeter et al. (2009) reported that effects of institutional and societal barriers oppression experiences are stressful at the time but last throughout the lifetime. The lack of access and social support results in social isolation.

Neighborhoods, schools, media, culture and religious, political and social institutions are fertile grounds for social justice advocacy efforts by mental health organizations and mental health individuals. Processes to do advocacy are identified in the ACA advocacy competencies appendix (Lewis et al., 2002). This document elaborates competencies at the community, systems, public, and social/political levels.

Community level advocacy is a collaboration to:

  1. identify environmental facts that impinge upon students' and clients' development.
  2. alert community or school groups with common concerns related to the issue.
  3. develop alliances with groups working for change.
  4. use active listening skills to gain an understanding of the group's goals.

5. identify strengths and resources that the team members bring to the process of systemic change.

6. communicate recognition of and respect for these strengths and resources.

7. detect and offer the skills that the counselor can make to the collaboration.

8. assess the effect of the counselor's interaction with the community (Lewis et al. 2002, p.2).

Systems advocacy occurs when there is recognition of barriers that:

1. identify environmental factors impinging on students' or clients' development.

2. provide and interpret data to show the urgency for change.

3. are in collaboration with other stakeholders, develop a vision to guide change.

4. analyze the sources of political power and social influence within the system.

5. develop a step-by-step plan for implementing the change process.

6. develop a plan for dealing with probable responses to change.

7. recognize and deal with resistance.

8. assess the effect of counselor's advocacy on the system and constituents (p. 2).

Those practitioners using managed care organizations (MCO) to treat clients must be vocal advocates for continuing care beyond the prescribed limitations. Even though MCOs have an appeal system, it is hard to navigate the long amount of time to pursue this pathway and maintain continued therapy.

ACA Office of Public Policy and Legislation (ACA, 2011, pp. 1-11) identified and published statistical data for professional counseling service needs and issues that pose barriers and impede client success or access. The list for adults (1-8), children (9-13), seniors (14-19), and veterans (20-23) includes:

1. adult mental illness and substance use disorder

2. suicide is the 3rd leading cause of death 15-24 and 2nd for 25-34 (ACA), and second-leading cause of death for the Native American and Alaska Native (AI/AN) and young adults aged 10-24 (NCHS, 2011)

3. receiving mental health services.

4. major depression leading cause of disability.

5. disabled workers desiring work and have lower educational attainment.

6. young adults (18-25) the rate of binge drinking was 41.7% and heavy drinking was 13.7%. In 2009 youth 12 and older used an illicit drug for the first time.

7. 64% of adults with major depression received treatment.

8. rural area residents less likely to receive treatment with populations of 2,500 or less.

9. in 2006, 5% of children ages, 4-17 had severe difficulties with emotions, concentration, and behavior or getting along with others, 49% prescribed medication.

10. 5%-9% of children have a serious emotional disturbance.

11. 80% of children in juvenile centers have mental disorders.

12. in 2009 8.1% of the population ages, 2 to 17 had a major depressive episode that year. Of that number 35.7% used illicit drugs.

13. in 2009 34.7% of youths age 12 to 17 received treatment for depression.

14. for 65 and older seniors, 20% had mental illness and expected to double in next 30 years.

15. less than 3% report seeing a mental health professional.

16. depression affects more than 6.4 million seniors.

17. seniors account for 20% of suicides, 75% of those who committed suicide saw a physician within the month before.

18. medicare spending represented 3% of the budget for all mental health services.

19. inadequate training in working with the seniors.

20. 20% of all suicides occur among veterans.

21. in 2010 there were 295,000 veterans from Iraq diagnosed with one mental health disorder and 171,000 with PTSD.

22. 25-30% of veterans of the wars in Iraq and Afghanistan reported symptoms of a mental disorder or cognitive condition.

23. from 2004-2007 99.2% of veterans aged 21 to 39 reported major depressive episodes and impairment.

This list is incomplete, and selections were made to highlight areas for social justice involvement on the part of counselors, clients, community groups, and legislative actions. Social barriers may be economic needs, educational limitations, lack of familial support, gender and ethnic discrimination, prejudice, socioeconomic issues, belief systems, power, authority, and oppression.

Question 1-25:

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

a. family and personal life issues or economic conditions

b. different factors such as genetics or mental constitution in explaining individual or social behavior

c. it is a lack of support from the mental health field

d. a personal view that these changes and client rights are to begin at the federal level

Answer: b. different factors such as genetics or mental constitution in explaining individual or social behavior.

Prilletensky (1994, 1997) stated that there is excessive weight given to different factors such as genetics or mental (psychological) constitution in explaining individual or social behavior. Lerner (1998) believed that the lack of a sense of social causality by counselor perceptions that frustrations of the family and the personal life of clients are failings of the family and the individual client. In using culturally appropriate intervention strategies counselors are to be aware of institutional barriers that prevent minorities from using mental health services and to have knowledge of biases in assessment procedures. The introduction to the ACA 2014 Code of Ethics, Section A stipulates that counselors are to be active in attempts to understand the diverse cultural background of clients as well as their own and how the counselor's values and beliefs may affect the client care. Section A.4.b. personal values, illustrates that the counselor is to be aware of and avoid imposing his/her values, attitudes, beliefs, and behaviors. The counselor is to explore his/her training and clinical areas where imposing values are inconsistent with the client's goals and are discriminatory (APA, 2014, p. 5).

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

OBJECTIVE 1F: Professional Organizations

Objective f. professional counseling organizations, including membership, licensure, accreditation practices, standards, and the effects of public policy on these issues (CACREP, 2015, p. 10).

Membership status (C.4.f.)

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

The American Counseling Association (ACA) was formerly called the American Association for Counseling and Development (AACD). Before that, it was the American Personnel and Guidance Association (APGA). The first organized body of guidance professionals formed in 1910 was called the National Vocational Guidance Association. The major association, ACA, has 20 divisions. These 20 divisions are comprised of a body of professionals who regard their expertise and identity to be within one or more of the divisions. Some of those divisions represent college personnel, counselor education and supervision, career development, school counseling, rehabilitation, assessment, employment, cultures, religion and values, gay and lesbian issues, group work, public offenders, mental health, military, adult and aging, and marriage and family. American Counseling Association (ACA) and divisions are (ACA, 2015-2016):

AARC –Association for Assessment and Research in Counseling

AADA –Association for Adult Development and Aging

ACAC –Association for Child and Adolescent Counseling

ACC –Association for Creativity in Counseling

ACCA - American College Counseling Association

ACES –Association for Counselor Education and Supervision

AHC –The Association for Humanistic Counseling

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

AMCD –Association for Multicultural Counseling and Development

AMHCA –American Mental Health Counselors Association

ARCA –American Rehabilitation Counseling Association

ASCA –American School Counselor Association

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

ASGW –Association for Specialists in Group Work

CSJ –Counselors for Social Justice

IAAOC –International Association of Addiction and Offender Counselors

IAMFC –International Association of Marriage and Family Counselors

MGCA--Military and Governmental Counseling Association

NCDA – National Career Development Association

NECA –National Employment Counseling Association

ACA and all divisions subscribe to the ACA 2014 Code of Ethics. Several divisions, such as ASGW, have developed specific codes about 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 explicitly mentioned in the code for the National Board for Certified Counselors (NBCC). The NBCC Code of Ethics can be secured on-line at NBCC.org. For those applying for a state license, the ACA 2014 Code of Ethics will need to be obtained. The Code of Ethics for ASGW emphasizes counselor behaviors which are unique to that area of counselor skills for group work.

Membership Benefits

Membership benefits include:

a. support through lobbying (access, equity, and unity)

b. media (Journal of Counseling and Development, Counseling Today)

c. continuing education (library and JCD)

d. national, state, and local conventions

e. ACA sub-division access, education, involvement, and on-line updates (substance, lobbying, decisions, and actions)

1. Media: Journal of Counseling and Development (JCD), the flagship journal for ACA includes articles, information membership, and yearly ethical violations. Also, the content page includes articles about:
   a. Practice and Theory
   b. Research
   c. Assessment & Diagnosis
   d. Best Practice
   e. Other

In 2003 the Best Practices section in the JCD was developed to educate the membership about and how to apply the research evidence that undergirds the practice of counseling (Marotta & Watts, 2007). According to Sexton et al. (2011) best practices has come to mean evidence-based or evidence-informed approaches.

2. Counseling Today informs membership of current events in the profession and includes advertisements for materials, and an assortment of training, etc. The content page includes:
   a. Cover Story
   b. Featured Articles
   c. Reader Viewpoint

Question 1-26:
The latest American Counseling Association sub-division is the:
   a. Counselors for Social Justice
   b. Association for Creativity in Counseling
   c. Association for Child and Adolescent Counseling
   d. Association for Adult Development and Aging

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

OBJECTIVE 1G: Professional Credentials and Public Policy

Objective g: professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues (CACREP, 2015, p 10).

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

CACREP was established in 1981. The Association for Counselor Education and Supervision (ACES) was credited with creating the first set of standards for CACREP. CACREP used ACES standards for the first set of standards, and CACREP's first set of standards was in 1988. This set of standards created structure for all

entry level programs for three specialty groups with separate standards; Mental Health Counseling, School Counseling, and Student Affairs Practice in High Education. A split took place between Community Counseling and Mental Health Counseling regarding standards and the number of credit hours. In 2001 CACREP and ACPA disaffiliated from ACA and became the American College Counseling Association (ACCA). CACREP 2009 specialty standards include Addiction Counseling, Career Counseling, Clinical Mental Health, Marriage, Couple, and Family Counseling, School Counseling, and Student Affairs and College Counseling (Bobby, 2013). A major infusion into the 2009 standards was the disaster preparedness and crisis response criteria. Also, Clinical Mental Health Counseling required 60 semester hours for entry-level graduate degree and 600-clock hour internship, Gerontology Counseling standards were eliminated, therapy was dropped from Marital, Couple and Family Counseling, and a new set of standards for Addiction Counseling (Bobby, 2013, Kaplan & Gladding, 2011, Newsome & Gladding, 2014). In summary, CACREP through all revisions of the standards has maintained a direction for a strong counselor identity. The emphasis in a unified profession has been troubled when standards were approved for the specialty areas. Counselors who have specialty training were expressing that identity first and secondly as a professional counselor. The CACREP standards suggest that every student is to develop a professional counselor identity (Professional Orientation and Ethical Practice, 1).

Question 1-27:
CACREP has approved specialty standards for all except:

    a. Gerontology Counseling

    b. Addiction Counseling

    c. Career Counseling

    d. School Counseling

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

Question 1-28:
The CACREP board and standard development have consistently maintained that specialty areas:

    a. are encouraged to broaden the professional counseling service areas.

    b. will be a political force for the professional counselor.

    c. identify as counselors first and specialty counselors second.

    d. should unite and form one organization of counselors.

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

Licensing

Virginia was the first state to establish a license for counselors in 1976 and California the last. Currently, 50 states have passed licensing laws for counselors. Each state has specific requirements for the degree (hours), curriculum requirements, internship hours, post master's clinical work experience, years and hours of supervision and passing either the NCE or NCMHCE. Added to the confusion regarding

professional unity and counselor identity is the fact that there are nine different licensure titles among the 50 states (Bergman, 2013). Some states have a provisional license that allows for counselors to be working toward a full license. Professionally, from the position of the profession for licensing counselors the standards for Counseling Supervisors (AASCB, 2013), CACREP, NBCC, and the National Credentials Registry (ASSCB) have united to work toward a unified identity for counselors, degree requirements, supervisory experience and portability (Mascari & Webber, 2013). There have been two or more; legal identifications of licensure for states, title or practice. A title license indicates the individuals who are licensed with that title, and if there are several different titles in different states, confusion exists. A practice title specifies what duties and skills the licensed individual may practice.

In 1994 NBCC announced a board of individuals (33), The American Association of State Counseling Boards (AASCB) from 28 states which met to discuss and form direction and portability for the licensing of professional counselors. There have been 13 yearly meetings and one purpose is to advocate for equity in providing paid services for counselors and portability. The most recent meeting was in 2013 with 37 states represented with a focus on licensing examination and emerging issues for counselors. A position statement on licensure portability for professional counselors was adopted in 2013 (AASCB, 2005; CACREP, 2013).

Portability

Portability is one of the seven main trends highlighted by 20/20. Portability is the process in which counselors may transfer their license without repeating the application procedure. Reciprocity and endorsement are terms used to recognize credentials from different states and identify this process of portability. The effort to establish portability calls for common licensing standards. The National Credential Registry (NCR) was created by AASCB to assist in gaining portability (AASCB, 2005; Kaplan, Tarvydas, & Gladding, 2014; Tarvydas & Hartley, 2009). The American Association of State Counseling Boards (AASCB), ACA, NBCC, and CACREP in supporting a unification of the profession are lobbying for license portability. To address uniformity of counselor licensure degree program requirements, the National Board for Certified Counselors, Association for Counselor Education and Supervision, and the American Mental Health Counselors Association established standards for education and training (Wakefield, 2013).

Federal and State Government

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

The federal government's Medicare and Medicaid programs do not recognize professional counselors as Medicare providers. The U.S. Department of Veterans Affairs (VA) has recently added licensed professional mental health counselors as providers (U.S. Department of Veterans Affairs, 2010). TRICARE is

the civilian health care provider which opened benefits to licensed counselors although they are to meet specific standards such as master's or higher in mental health or clinical mental health credited by CACREP, state license in a state with tiered licensing, passing the NCMHCE, and a well-defined scope of practice (IOM, 2010, p. 10).

OBJECTIVE 1H: Labor Market Information and Practice

Objective 1h: current labor market information relevant to opportunities for practice within the counseling profession (CACREP, 2015, p. 10).

Opportunities for practice within the counseling profession are a result of national, state, and local professional and governmental entities responding to the mental health needs of the population. TRICARE recently responded to a need for counselors meeting specific requirements to provide services to governmental employees such as the armed service personnel. Movement within the counseling work settings including school counselors, mental health, rehabilitation, religious, private practice, and social services is based on availability, worker satisfaction, and compensation.

Overall job satisfaction and dissatisfaction surveys have been conducted over the years to determine relevant job facets important to counselors. The Minnesota Job Satisfaction Questionnaire (MSQ) has been used to assess job satisfaction of school counselors, employee assistance counselors, rehabilitation counselors, and substance abuse counselors (Jones, Hohenshil, & Burge, 2009). The MSQ measures satisfaction of job facets that include social service (able to do for others), moral values, achievement, activity, independence, ability, creativity, responsibility, variety, working conditions, security, social status, authority, coworkers, recognition, supervision human relations, supervision technical, policies and procedures, compensation, and advancement (Weiss, Dawis, England, & Lofquist, 1967). The responses were based on a Likert scale of 1-4 very dissatisfied to very satisfied respectively.

Jones, Hohenshil, and Burge (2009) reported job facets as satisfied and dissatisfied based upon other studies conducted for different job roles. The very satisfied and very dissatisfied job facets report included:

a. African American counselors were found to be very satisfied with social service and satisfied for moral values, achievement, activity, and independence. African American counselors reported dissatisfaction with opportunities for advancement, and higher position (Jones et al., 2009).

b. School psychologists were satisfied with job security, social service, coworkers, job duties, compensation, and working conditions (Worrell, Skaggs, & Brown, 2006)

c. Substance abuse counselors were satisfied with social service, moral values, creativity, ability utilization, and achievement. Job advancement was listed as dissatisfied (Evans & Hohenshil, 1997)

d. African American psychologists' ratings for very satisfied were social service, independence, activity, moral values, and achievement (Brown, 1997). The same survey reported for school psychologists for dissatisfied job facets to be policies and procedures of the school and opportunities for advancement.

Question 1-29:

A psychologist job satisfaction survey across several roles for psychologists reported common facets for job satisfaction. A job facet common to dissatisfaction is:

    a.   social service

    b.   moral values

    c.   advancement

    d.   achievement

Answer: c. advancement.

A recent employment opportunity for mental health counselors is the approval of mental health counselors as tri-certified service providers meeting criteria of a master's degree from a mental health counseling program, accrediting by CACREP and passing the National Clinical Mental Health Counseling Examination (NCMHCE) by January 1, 2017. By passing the NCMHCE with an application submitted and approved, the counselor is a TRICARE Certified Mental Health Counselor (TCMHC) and is eligible to treat TRICARE beneficiaries independently. Counselors not meeting the criteria for TCMHC may continue under the supervision of a TRICARE-authorized physician. TRICARE regulations are subject to change.

Private Practice

Master-level graduates are considering private practice once they attain the proper legal qualifications for a state license. Some general questions are likely 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 ACA Code of Ethics (2014) for a business entity includes fees and business practices (A.10.), unacceptable business practices (A.10.b.), establishing fees (A.10.c.), nonpayment of fees (A.10.d.), bartering (A.10.e.), and receiving gifts (A.10.f.). The following material does not pertain solely to private practice but also in other settings such as hospitals, group practices, and agencies providing mental health services. Starting a private practice requires preparation involving the 2014 Code of Ethics, a standard of care, budget concerns and accounting, defining the practice, collecting fees, record keeping, managed care, office personnel, determining organizational and therapist effectiveness, and legal parameters (Remley & Herlihy, 2005).

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

1.   is financially solvent to start a business

2.   can manage others and effectively implement and evaluate all aspects of a business

3.   can satisfactorily provide services and maintain professional standards

What are some characteristics needed to operate a successful business?

1.   self-initiative

2.   business sense

3.   organizational and management abilities

4.   ability and willingness to network

Considerations:

1. where to locate office space: home, office complex, separate building, mobile unit, and telephone, the Internet: does it match the type of service you will provide? Can the office space consider disability requirements, safety, and visibility?

2. partnership, alone (pros/cons), need for consultation, part-time, full-time (e.g., consult on cases/safety issues)

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, the collection agency (develop a policy regarding overdue debts and fees, bad checks, pro-bono, sliding scale)

8. policies (pro bono, bad checks, missed appointments)

9. HIPAA and FERPA forms-contracts: informed consent, client rights, release forms, etc.

10. handicap accessibility (Americans with Disabilities Act)

11. advertising: cards, fliers, telephone directories

12. hospital privileges, medication, insurance panels

13. counselors as employers

14. managed care/health care panels

15. computer technology associated with record keeping and electronic transmission of client information

Managed Care Definition: "a system created to slow down or control rising health-care costs using '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 the 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 promptly. The therapist must be willing to limit the duration of care, use low-cost yet effective levels of care (quality), and cooperate with external screening and review by case managers. Managed care is a system that controls the cost as well as the treatment (U.S. Agency for Healthcare Research and Quality, 2004). Some therapists avoid managed care because they have difficulty with some ethical considerations such as confidentiality; managed care only reinforces certain therapies or techniques and attaining membership on panels. There are many managed-care systems, however. Browning and Browning (1996) refer to four evolving systems: health maintenance organizations (HMOs), preferred provider organizations (PPOs), employee assistance programs (EAPs), and utilization review (UR). Patrick

(2007) added a fifth; individualized practice associations (IPAs). Many counselors claim it is hard to access and receive panel approval for these programs. Counselors who decide upon private practice and do not want to participate in a managed care environment have been creative in setting up a practice. The early decision may be to conduct a small, part-time practice and be skilled at aggressively marketing to upper-middle-class clients.

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

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

Effectiveness studies: Private practices, as well as agency programs, are evaluating therapist effectiveness (C.2.d. monitor effectiveness). This can be conducted in several ways. Surveys and empirical studies (pre-post, and control studies designs) have been the usual methods for conducting effectiveness studies. There are some 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 two-way mirrors, video and audio taping, live supervision, and co-therapy as a means to derive client raw data and counselor interventions or theory applications.

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

Pros and Cons of a Private Practice

1. Pros of a Private Practice

    a. autonomy
    b. determine own fees
    c. develop a personal schedule
    d. the flexibility of time
    e. your own boss
    f. remain in direct service
    g. economic improvement
    h. avoid bureaucratic conflicts

   i. motivated clients

   j. more incentives to improve

   k. skills and abilities challenged

   l. higher status and recognition

   m. possibly more attentive services

   n. ego involvement

2. Cons of a Private Practice

   a. loneliness, less colleague access

   b. dealing with the insurance company

   c. pay for own health insurance

   d. overhead responsibilities

   e. upkeep and repair

   f. advertisement costs

   g. must establish a referral base

   h. less backup in emergencies

   i. accounting, bookkeeping duties/ costs

   j. liability insurance

   k. quarterly taxes are to be paid

   l. continuing education time and finances

   m. technology expenses and training

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

NOTE: Answers to questions 1-30 through 1-36: Recognize in this study guide that the recommended answers are subject to change as managed-care providers alter specific requirements for paneling, reimbursement, and qualifications.

Question 1-30:

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

 a. slander.

 b. libel.

 c. vicarious liability.

 d. interrogatories.

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

Question 1-31:
All 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 the right to set competitive fees for services

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

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

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

Question 1-32:
Which identified disorder is likely to not receive reimbursement under managed care?

    a. obsessive-compulsive

    b. supportive marital therapy

    c. eating disorder

    d. tic disorder

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

Question 1-33:
Managed-care indicates that a diagnosis is to be made by:

    a. the end of the first session.

    b. at least by the third session.

    c. no later than the fifth session.

    d. no more than what the defined amount of time is for the tentative diagnosis.

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

Question 1-34:
Managed-care gatekeepers recognize when a therapist is not current with the up-to-date treatment procedures and or protocol when the therapist does not recommend which one of the following as treatment of choice?

    a. cognitive-behavioral therapy as the therapy of choice

    b. supportive therapy

    c. recovery group involvement

d.   in-vivo and mindfulness techniques

Answer: a. recommends cognitive-behavioral therapy as the therapy of choice.

Question 1-35:
A clinical director is interested in researching therapist effectiveness data as practiced in this private practice. The clinical director might do this by:

a.   requesting each therapist to indicate how many clients he/she has seen over a specified 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 period with a mail survey. Ask each client who has terminated therapy if he/she is better because of the therapy received at this clinical center.

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

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

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

OBJECTIVE 1I: Ethical Standards of Practice

Objective i: ethical standards of professional counseling organizations and credentialing bodies, and applications of ethical and legal considerations in professional counseling (CAREP, 2015, p. 10).

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

Ethics is the study of the nature of morals and values and how they apply 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 (2001) text is a good source for review.

Ethical behavior and decisions will reflect choices made by counselors. Decisions are carried out on the basis of the philosophical foundation held by that counselor and how those decisions affect client care. Ethical behaviors may be mandatory or aspirational. Mandatory ethics is a forced choice, an all or nothing response. There is no gray area. Aspirational values are those in which many variables are considered and less of a final outcome. A licensing board and an ethical committee would likely perceive a dilemma from a mandatory perspective. Aspirational ethics would be a broader perspective and would examine the client variables, present, and past, coping strategies and likely be considered in a gray zone.

This is not to assume that the counselor exercising aspirational ethics does not consider the principles of the profession's code of ethics (autonomy, beneficence, no maleficence and justice).

The primary function of a code of ethics is to serve as a framework for professional behavior and responsibility. Also, the code fulfills the need for professional identity and reflects the maturity of the profession. A code of ethics is a limited document usually set in the broader social, ethical tradition. For a profession to be recognized, it must provide the means to enforce its code. The 2014 Code of Ethics serves six main purposes. The first is to clarify the nature of the ethical responsibilities held by the members. The second identifies ethical considerations relevant to professional counselors and counselors-in-training. The third is to establish principles that define ethical behavior and to clarify for clients the nature of the ethical responsibilities that are held in common with ACA members. Fourth is for the Code to serve as a moral guide to assist members in developing a course of action that will best serve those who utilize counseling services. Fifth, the Code helps to support the mission of ACA. Finally, sixth, the Code serves as a basis for processing inquiries and ethical complaints concerning ACA members (ACA, 2014, p.3.).

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

Professional conduct is defined through guidelines such as principles, regulations, 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 (Harley & Corey, 1997, 2006). Herlihy and Corey and the 2014 Code of Ethics cite the underlying principles of a code of ethics as:

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

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

Outline of the ACA Code of Ethics

The 2014 ACA Code of Ethics serves six purposes and values and contain nine main sections. For a complete set of standards for the ACA Code of Ethics consult the ACA website, www.counseling.org. Brief stimulus statements are listed for each topic to facilitate your study. If you have difficulty recalling the specifics of each section, retrieve the code and reread the entire section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question 1-36:
A client who has been in counseling for three sessions shares that he is seeing another counselor but for a different reason. The appropriate action of the counselor is to:
  a. respect the client's right to see whomever he desires.
  b. continue counseling with the client once it is determined that this counseling is for different purposes.
  c. request that the client tells the other counselor that he is also seeing a second counselor.
  d. secure a written release to contact this counselor to discuss the counseling.

Answer: d. secure a written release to contact this counselor to discuss the counseling. This is the preferred behavior. Once you have secured the release the counselor can contact the counselor and determine the nature of the other relationship. Acquiring this information allows the counselor to

determine if by accepting this client the counselor would or would not be working at cross purposes to the other counselor. See ACA Code A.3. (clients served by others).

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

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

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

Question 1-37:
Jerry and Lyn self-referred to the counseling stating Lyn's concern regarding Jerry's inability to make reasonable decisions. Lyn indicated that Jerry could benefit from counseling because he has made some poor decisions. Lyn said she would be in each session to provide clarification and support and she wanted to be sure he worked on that issue. It was her hope that he would learn how to make better decisions. Before initiating counseling, the counselor would want to:

    a.   clarify who is the client

    b.   seek a release of information from Jerry so the counselor can seek supervision

    c.   provide informed consent guidelines

    d.   indicate to Lyn that she could only remain if she were willing to receive counseling regarding the marriage and decision-making

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

Section A.11. Termination and Referral

Question 1-38:
A counselor may terminate a client contract for all of the following reasons except when the client is:

    a.   no longer producing client material for work

    b.   no longer needs assistance

    c.   likely to benefit

    d.   no longer paying fees as agreed

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

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

Question 1-39:

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

    a.   provide the materials to the client upon a written request.

    b.   tell the client that all materials are incomplete and the materials would be of little value to her.

    c.   tell the client that the counselor would be willing to let her read the notes but only in the presence of this counselor.

    d.   review the policy of the agency about any release of information.

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

Section C: Professional Responsibility
C.1. standards, C.2. competence

Question 1-40:

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

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

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

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

    d.   do not apply for the position.

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

consideration (C.7.b.), harmful practice (C.7.c.), and grounded in theory/scientific foundation-explain risks (C.7.a.).

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

Question 1-41:

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

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

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

    c.   refuse to participate in the prescribed treatment.

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

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

Section E: Evaluation, Assessment, and Interpretation

Question 1-42:

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

    a.   have a manual present during the interpretation.

    b.   hand score the answer sheet as a double check of the scan procedure.

    c.   give a second test to confirm the results of the one being interpreted.

    d.   review the Buros Mental Measurement Yearbook before the interpretation.

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

Section F: Supervision, Training, and Teaching

Question 1-43:

When students apply for admission to a counselor training program, they should be advised that they:

    a.   may find some of their friends in the program and as a result, their friendship may be altered.

    b.   should read the standard of care and the role of a counselor before enrolling.

c. may change as a result of going through different didactic and experiential components of the program and training and that self-growth is an expectation.

d. will have to compete with social workers, family therapists, and psychologists for work positions.

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

Section G: Research and Publication

Question 1-44:

During a research project in which all participants signed a release, within the informed consent procedures all are to be shared except:

a. identify procedures that are experimental

b. describe benefits

c. describe limitations

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

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

Section H.1. Knowledge and Legal Considerations.

Question 1- 45:

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

a. lack of Internet access

b. expensive

c. feelings of disempowerment

d. create limits to relationships through distance

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

Section I: Resolving Ethical Issues

Ethical decisions during client counseling involve supervision, the code of ethics, underlying principles of the code of ethics, legal mandates, counselor and supervisor's awareness of and adopted ethical model (mandatory, aspirational, virtue, and principle) using a decision model for best client care.

Question 1-46:
Counselor A becomes aware that counselor B is unethically taking advantage of certain clients. A few of counselor B's clients are stockbrokers and conversations early during each session interactions are frequently over "hot" stock tips. Counselor B has made it known he acted upon a few of these tips and has done well. Counselor A should:

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

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

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

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

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

Why A Code of Ethics

A code is a limited document and as a result issues arise which require a broader context. Some of these matters are between and among autonomy, welfare, enforcement, forums (state, federal, courts, etc.), conflicting codes, and issues that are not covered by the code. Being knowledgeable about the content of the code means recognizing its provisions as well as its limitations. Corey, Corey, and Callanan (2003) pointed 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 fundamental 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 code is helpful.

Herlihy and Corey (1997, 2006) cited 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 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 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 used in evaluating dilemmas (Beachamp & Childress, 1979, 1994; Cottone & Tarvydas, 2003; Huber & Baruth, 1987). Meara et al. (1996) add 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 and must be treated in a way most beneficial to their circumstances (Cottone & Tarvydas, 2003).

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

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

Question 1-47:
A counselor when sharing informed consent procedures with a client involves more than one of the principles that underlie the 2014 ACA Code of Ethics. The one principle, which may be central to informed consent, is:

a. nonmaleficence.

b. justice.

c. veracity.

d. autonomy.

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

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

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

Results of a survey in 248 university counseling centers supported findings of Pope and Vetter (1992) who compiled data from 679 psychologists. The returned reports of troubling incidents ranked confidentiality and dual relationships first and second on a list of 23 categories.

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

Examples of Major Complaints

Keith-Spiegel and Koocher (1995) and Koocher and Keith-Spiegel (2016) reported that complaints can arise in any area of the code (A-H); however, the majority appear 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: Abandonment is a failure to follow through, lack of termination, and premature or abrupt termination. MacBeth, Wheeler, Sither, and Onek (1994) suggested that abandonment can be avoided by:

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

ACA ETHICS REPORTS:

The American Counseling Association serves the membership of ACA regarding the code of ethics and concerns about violations of the code and to clarify questions for members relating to the meaning of and interpretation of the ethical code. ACA reported a yearly summary of the inquiries, complaints, and sanctions in the Journal of Counseling and Development, although at this time, they are summarized and located on the ACA website within the ethics unit.

Inquiries are contacts to the ethics department for clarification of the ethical code. A complaint is defined as a contact by an ACA member or consumer to file a grievance against a counselor formally. Sanctions are penalties assessed after a panel has reviewed the complaint resulting in no penalty, to discontinue an activity, suspension, or revocation of one's membership.

ACA indicates that exact number or percentage may be slightly different than reported because of different interpretations of the callers inquire might involve more than one subsection of the code.

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; Anderson & Freeman, 2006; Garcia, Glosoff, & Smith, 1994; Garcia, Salo, & Hamilton, 1995; Smith, 1993). Each set of complaints were cited from 1-34 standards violated.

Garcia et al. (1994) stated that standard H (resolving ethical issues) was cited as many as 53 times during one year (1993-94) while standards A, B, and F 38, 19, and nine times respectively. The standards most frequently cited were a 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, two of the seven 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 and counseling relationships 27% of the formal complaints (Kocet & Freeman, 2005).

In the 2006-2007 of the 1,052 informal complaints received by ACA 48% were for confidentiality, 30% for counseling relationship, 10% for professional responsibility, 8% for relationships with other professionals, 5% for supervision, training, and teaching, and 1% for evaluation, assessment, and interpretation. Also, 6 of 27 formal inquiries were referred for adjudication involving ACA members (Sanabria & Freeman, 2008).

ACA has established a three-tier categorizing and processing method for ethical issues such as inquiry, complaints (filing a complaint), and sanctions (were taken). The following information is available at counseling.org for inquiry, complaints, and sanctions:

Year	Inquiries	Complaints	Sanctions
2006-2007	1052		
2010-2011	4943	9	1 (expelled)
2011-2012	6558	6	0
2012-2013	6231	4	0
2013-2014	6467	5	0

INQUIRIES:

2006-2007
  Confidentiality (48%) Responsibility (10%) Relationship (30%)

2013-2014
  Boundary issues (32%) Responsibility (31%) Technology (23%) Licensure (11%)

2013-2012
  Confidentiality (37%) Responsibility (41%) Supervision (7%) Licensure (11%)

2012-2011
  Confidentiality (42%) Responsibility (21%) Supervision 4%) Licensure (22%)

2011-2010
  Confidentiality (32%) Responsibility (19%) Supervision (5%) Licensure (27%)

2003-2004
  Confidentiality (47%   Relationship (27%)

The nature of the inquires involved confidentiality (37%, 42%, 32%, 32%, 48%, 47%), responsibility (31%, 41%, 21%, and 19%), supervision (7%, 4% and 5%), licensure (11 %, 22%, and 27%), and other (4%, 11%, and 17%). Retrieved www.counseling.org/knowledge-center/ethics, 3-21-2014.

A professional group such as ACA does have in place an ethical sanctioning system, that is, a set of enforcement procedures to govern the action of its members. This system for ACA includes different levels of an appropriate response to the violation along with a continuum from no violation, to cease behavior, to being unethical with sanctions voluntarily. These sanctions can include a reprimand for corrections, suspension from ACA, probation for a period, and expulsion from ACA. If 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).

Question 1-48:
The highest-ranking percentage of code inquiries for the years 2003-2014 has been all of the following except:

a. supervision

b. confidentiality

c. licensure

d. boundary issues

Answer: a. supervision. Averages: confidentiality (36%), Responsibility (35.5%), licensure (17.5%), supervision (5.3%)

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. therapist's self-disclosure vs. risks involved

    b. professional vs. personal life

    c. appropriate vs. inappropriate therapist behavior

3. Allegiance dilemmas:

    a. school of thought vs. client welfare

    b. professional community vs. new reference groups

4. Role dilemmas:

    a. educator vs. healer

    b. scientist-practitioner vs. psychotherapist

    c. clinician vs. researcher

5. Responsibility dilemmas:

    a. client welfare vs. client autonomy

6. Impasse dilemmas:

    a. dealing with vs. risking harm

    b. therapist vulnerability vs. resolution

Decision-Making

When a decision arises concerning a dilemma, the counselor must make a judgment in deciding what course of action to take. This judgment necessitates a decision-making strategy that will systematically address 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 is processed in supervision. Do not make ethical decisions in isolation!! In consultation or supervision, flaws in reasoning may surface, other perspectives may be considered, and most importantly, responsibility may be shared. To protect the counselor and provide information for similar situations in the future it is important to document the

decision and its rationale (Keith-Spiegel & Koocher, 1995; Koocher & Keith-Spiegel, 2016). Three models for ethical reasoning and decision-making include:

1. Interpret: Determine if one's actions are bringing about consequences that affect client welfare.

    a. Formulate: Course of action Intuitive level: development perspective and prior learning

       Critical-evaluation level: 3 tiers

       1) Ethical rules composed of autonomy, nonmaleficence, beneficence, justice truthful, confidentiality, informed consent, faithful

       2) Integrating competency: decide how client will act

       3) Implement: perseverance, resoluteness, and character

2. A developmentally experienced-based model for decision-making was proposed by Pelsma and Borgers (1986). These authors suggested 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 to include affective, perceptual, symbolic, and behavior.

3. A third developmental process presented by Van Hoose and Kottler (1985) was developed using stages from the work of Piaget and Kohlberg. Van Hoose's five stage model is as follows:

    a. Punishment Orientation

    b. Institutional Orientation

    c. Societal Orientation

    d. Individual Orientation

    e. Conscience Orientation

Enforcement

Suspected Violations: ACA Ethical Code Section I.2

To be a profession, the professional group must 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. A local or regional ethics committee should be consulted if this is not advised. If this committee does not exist, a written complaint should be filed with the existing state ethics committee. This complaint should contain the said observations, where in the code the violation is addressed, dates of the observations, and the document is to be signed by the observer. The professional group will determine whether the behavior warrants an investigation. Action by the professional group is in the form of educational advice, warning, reprimand, censure, resignation, or expulsion. Individually the ACA Code of Ethics and standards of practice indicate that the counselor must act when he has reasonable cause of self or others acting in an unethical manner (SP 49) or in filing unwarranted complaints (SP-50). Counselors are to cooperate with investigations, proceedings, and requirements of ACA Ethical Code of Ethics and (SP 51).

Legal Issues: Standards and the Law

CACREP Section 1 i. knowledge of and compliance with standards and ACA (2014) I.1 standards of the law

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

Negligence is any conduct that falls below the acceptable professional standard of care. The unacceptable behavior 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 harm. 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 a 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. Informed consent procedures should cover how to handle such grievance complaints.

Tort: A tort is a legal action where one party asserts that the negligent behavior is a civil liability. 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 or 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 by the plaintiff 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.

Legal Information

Freedom of Information Act

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

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

FERPA gives students 18 and older and their parents the right to inspect relevant school records. Freedom of Information Act refers to the capacity of third parties to obtain information from federal files, where the Privacy Act relates to the ability of a person (or a relative) to obtain information about him or her. It provides the parent the right to be informed and give consent when their student undergoes assessment. Parents and students have the right to gain access to their records upon request and must provide written permission for anyone else who is not directly related to the student's education to gain access. This act became known as PL93-380 (USDE, 2008).

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

1. statement of child's present levels of educational performance

2. annual goals and short-term instructional objectives

3. statement of specific education services provided in which child can participate in regular programs

4. projected date for initiation and anticipated duration

5. appropriate objective criteria for determining on an annual basis whether instructional objectives are met

Ethical Issues for Specific Constructs

Privacy/Confidentiality/ Privilege

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

Privacy, confidentiality, and privilege are three similar and yet distinct terms that are relevant to professional ethics. Privacy is an evolving legal term that recognizes the client's right to decide when, where, and what he or she wants to share or withhold regarding 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. Remley and Herlihy (2016) identified 14 exceptions to confidentiality and privilege communication. They listed child abuse, elderly abuse, abuse of dependent children, and harm to self or others, a client needing hospitalization, and when a client requests a release of their record.

Finally, privilege is protected by 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 the information cannot be withheld (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. Privileged communication is incorporated in legislation and court rulings, so civil or criminal liability is possible (Knapp & VandeCreek, 2012; Shah, 1969). The client owns privileged communication, and this privilege is only waived by the client except in extreme circumstances (Reaves, 1999).

Two Types of Privileged Communication:

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

Question 1-49:

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

    a.   the counselor believes the client was a victim of a crime such as incest.

    b.   the counselor thinks his needs have become entangled in the therapeutic relationship.

    c.   the client initiates a lawsuit against the counselor for malpractice.

    d.   a misdemeanor is committed.

Answer: a. the counselor believes the client was a victim of crime such as incest and c. the client initiates a lawsuit against the counselor for malpractice. Alternatives a. and c. permit the counselor to break confidence. So far there have not been questions where there are two correct answers requested for the NCE. The first answer (a) is to protect the client and the second answer (c) is to be able to defend oneself. Attorney/ client, husband/wife, physician/patient, and priest/ penitent have privilege. Some states now extend the privilege to psychologist/client or psychotherapist/ client relationship. Actual laws vary widely. Informed consent in formal consultation (D.2.b.) is covered under limits of confidentiality.

Almost all states granting privilege require some form of licensing, certification, or registration. Keith-Spiegel and Koocher (1995) cited 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, 1995). Some states grant privilege to counselors (Herlihy & Sheeley, 1987).

Question 1-50:

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

    a.   a breach of confidentiality.

    b.   no breach of confidentiality.

    c.   a dual role relationship.

    d.   no issue because Mark Brice's employment is generally known.

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

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

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

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

1. when the client requests it.
2. when a 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, 2012).

MINORS: Confidentiality with minors is a special issue and the issue may be voluntary or involuntary right to give consent. This is covered in A.2.d., inability to give consent. The counselor's role is to attempt to balance the rights of minors to communicate and their parent or guardian rights to be informed and to perform parental duties regarding an awareness of issues. Minors are not granted involuntary informed consent. There are some exceptions, however, where the counselor makes every effort to protect and develop trust in the relationship and maintain the best interest of the client. Wilson (as cited in Gustafson & McNamara, 1987) noted four exceptions in which minors are capable of 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) with 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).

HIPAA goals are to include (www.complianceplusllc.com):

a. improve portability and continuity of health insurance coverage
b. combat fraud in health insurance and healthcare delivery
c. promote the use of MSA (medical saving accounts)
d. improve access to long-term care services and coverage
e. simplify and standardize the administration of health insurance
f. implement and maintain confidentiality of patient information and

g. standardize all electronic transactions

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 includes all records that are held or information disclosed to a covered entity. The interpretation of this rule is that counselors are to provide to the client a written explanation 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. Also, the counselor is to have an established privacy procedure as to who has access to the client records. Client consent is required for the release of information regarding treatment, payment and health care purposes as well as transmission of client information to financial institutions. Exceptions are noted in the Privacy Rule document when information may be released. 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 disclosure is under consideration. The Privacy Rule may be secured at the Web site: http://www.hhs.gov/ocr/hipaa.

The standard 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. under an authorization from an individual
5. as permitted or required by HIPAA for government or other purposes (45 C.F.R. & 164.502[b])

A privacy officer is to be identified 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 health personnel use proper forms. The Health Information Technology for Economic and Clinical Health (HITECH) officer is to inform all employees the specific information regarding breach notifications. According to HIPAA, the definition of breach is the "acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of the protected health information." If there is a breach, the entity is to perform a risk assessment, mitigate the breach, and report the breach to affected clients, the federal government, and possibly the media (Wheeler, 2013). Also, the Omnibus Rule indicates that the counselor, if requested by the client, is not to disclose information to others if the client pays out of pocket expenses except if required by law.

Psychotherapy notes are covered under 45 C.F.R. & 164.508(a) (2) and stipulate that 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 client's record. HIPAA's rationale is that psychotherapy notes are not a part of the health record and not intended to be shared with anyone (Remley & Hurley, 2010). The client is to provide a release before any notes are transmitted elsewhere. There are exceptions for psychotherapy notes that include:

1. use by the counselor of psychotherapy notes for providing treatment, payment, or health care operations

2. training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling

3. use or disclosure by the covered entity to defend a legal action or to other proceedings brought by the individual

4. use with respect to the oversight of the originator of the psychotherapy notes, such as peer review and

5. disclosures required by law (445.CFR & 164.512(j), certain disclosures about decedents (45 CFR & 512(g), and disclosures to avert a serious threat to health or safety (45 CFR & 164.512(j); Remar, Bounds, Rogers & Hardin, 2011, pp 12-13).

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

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

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

a. designate a compliance project leader

b. assemble a HIPAA assessment team

c. prepare an organization-wide risk assessment plan

d. develop a baseline inventory of policies, procedures, practices, systems and forms

e. review 3rd party transactions and EDI relationships

f. conduct technical, physical and administrative security review

The readiness checklist and compliance standards are to ward off breaches assuring the counselor creates and stores electronic records safely and to be sure the computer is password protected.

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 (under 18) have the right to inspect the records and to challenge information contained within the file and to have written authorization obtained before any education records are transferred to any third party (US Department of Education, 2008). Parents or guardians may receive copies of the student records without the permission of the student (Remley & Herlihy, 2010). If the parent's most recent income tax statement in which the child is listed as a dependent (younger than 18) or 18 and attending college the parent has the right to review the records. This does not include case notes if retained as separate from the student file and not made available to anyone else.

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

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

Competence ACA Code: Termination A 11.a. C.2.a., E.2.a.

Section C of the ACA Code of Ethics refers to the ethical area of competence. Competence is assessed by the quality of provided service and the boundaries or scope of competence (Cottone & Tarvydas, 2003). Competence requires the ongoing need to remain current in the practice of counseling, and this can be accomplished through continuing education according to the standards of practice (SP-18) as a must. The standards of practice indicate the counselor must practice only within the boundary of their competence (SP-17). Pipes and Davenport (1990) described competence as accurately representing your training, recognizing limits of competence, seeking and utilizing supervision, recognizing differences among people, and the limits imposed by your personal problems. Welfel (1998) defined competence as composed of three elements: knowledge, skill, and diligence. According to Welfel knowledge is "being schooled in the history, theory, and research in one's field and cognizant of the limits of current understanding" (p. 63). Skill is an acquired understanding of the therapeutic procedures and making appropriate applications of an intervention with a client. Overholser and Fine (1990) divided skills into clinical skills and technical skills. Clinical skills are interviewing skills while technical skills are interventions. Diligence is the constant 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. the degree of personal relevance the client's problems have for the counselor and
   c. client's reaction to the counselor

A client who does not improve may be fostering dependence.

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

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

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

Question 1-51:

At a local mental health facility, the admissions clerk introduces a beginning master level counselor intern to his/her first client. In so doing the clerk identifies the intern as Dr. Larson. On the way to the office, the client thanked the intern using her name, Dr. Larson, for offering her an appointment on short notice. The intern continues with brief comments about the weather until the two of them reach the office where the interview begins. To resolve this dilemma the ethical issue is:

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

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

Question 1-52:

In the previous question, what should be the prerequisite behavior for the counselor?

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

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

Question 1-53:

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

    a.   boundary of competence

    b.   unethical behavior by the director

    c.   agreement with policies and principles

    d.   philosophy

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

Research and Publication
ACA 2014 Code of Ethics Section G.

For research, the 2014 Code of Ethics is essentially the same as the 2005 Code of Ethics. The issues of autonomy and nonmaleficence are important in the selection and utilization of human subjects. Research with human participants is to be conducted utilizing informed consent procedures. Subjects are to be informed (G.2.a.) of the proceedings (G.2.a.1.), techniques, duration, dissemination of results, and the freedom to withdraw at any time (G.2.a.9.). A researcher must be careful to disguise subject results as the utilization and retrieval of computer storage poses a problem of confidentiality. Also, the principal researcher must be careful to give the due reward to those who contribute to the research and writing. In the writing of investigative 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. Also, 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.   The validity of research design includes relevant theory, prior findings, and ethical methods.

2.   Competence for investigators is to be adequately trained and have sufficient knowledge to conduct the research.

3.   Identification of consequences is to anticipate risks and benefits of conducting the research. Caution is to be exercised to retain confidentiality and minimize harm.

4.   Selection of subjects for samples should be such that generalization can take place.

5.   Voluntary informed consent is when subjects willfully agree to participate in the research and are informed of risks and benefits of this involvement.

6.   Compensation for injury provides for compensation where risks are involved.

Question 1-54:

Two researchers believe that paradoxical techniques are useful and more effective than the more acceptable, conventional techniques. To prove this 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. To test this paradoxical technique, the researchers felt it was not necessary to use informed consent procedures. To do so would invalidate the results. If this is ethical, what is to take place?

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

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

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

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

Answer: c. "debriefing" of the subjects should be conducted soon after the study. Although there may be a controversy regarding paradoxical techniques 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. The ACA Code of Ethics (2014) defined deviation from standard practice (G.1.d.), risks (G.2.a.3.), and explanation after data collection for a full clarification of research (G.2.g.).

Question 1-55:

A principal investigator has conducted a drug research survey in the public schools for four years. Employed graduate students were employed in those schools and have assisted in the research. Each year the investigator published the results of the different surveys and after the fourth year 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 print the article in the city paper. The ethical issue in this request is what?

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

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

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

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

Answer: b. the writer needs to be referred to the school officials since the contents of this report belong to the school. The information omitted from this question is whether prior approval had been secured from the school district for data gathering and publication. The lack of prior approval 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 best choice for counselor action is letter b.

Question 1-56:

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

    a.   privacy

    b.   informed consent

c.   volunteerism

    d.   research design

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

Question 1-57:

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

    a.   informed consent

    b.   design error

    c.   sampling strategies

    d.   dual role

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

Evaluation, Assessment, and Interpretation

Ethical issues surface in knowledge, skill, and attitudes regarding testing and evaluation. The most recent ACA code revisions pointed out ethical issues in computer technology and the application of computerized scoring and printouts. Users of instruments are required to have a manual present during interpretations and to be knowledgeable regarding the constructs of validity, reliability, and norming. Bias and unfairness (definitions in Unit 2 and Unit 7) are two terms frequently applied to tests and test items. Psychoeducational assessments of racial and ethnic minority groups have received discriminatory practice in the form of test bias and unfairness. Frequently, minority groups have been over-represented in all special education programs, and biases in intelligence tests have been the instruments for those placements (Gregory, 2004; Gregory & Lee, 1986). Types of biases may include item selection, and in content, construct, and criterion-related validities.

Question 1-58:

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

    a.   counselor should avoid counseling couples based on his/her belief system.

    b.   counselor needs to verify the scoring of the computed assisted source as mistakes are made.

    c.   counselor should not use instrument results as the basis for marriage counseling.

    d.   validity and reliability of the Myers-Briggs Type Indicator are not acceptable for marriage counseling.

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

Question 1-59:

A counselor in a private practice in a small community was approached by a local reporter requesting an interview. The reporter wrote an article in a three-part series regarding test scores and how parents should guide their children. The first article is to comment on standardized testing, the second article regarding the meaning of scores, and the third in terms of how parents can decide whether to homebound teach or continue to mainstream their children. Within the second article were comments about 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 counselor who has been trained in psychometrics should:

    a.   decline the request even though this information is helpful to the community.

    b.   explain to the reporter that you have classroom training in testing, however, you would be willing to write only the content part in which you feel competent.

    c.   recognize this as an opportunity to make counseling services known as a competent and knowledgeable service. Accept the assignment with the stipulation you need sufficient time to acquaint yourself to the most recent data in these three areas.

    d.   consult your lawyer to determine if there could be any liability in writing the articles.

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

Multiple Relationships (Dual Relationships)

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

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

Cottone and Tarvydas (2003) and Corey et al. (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 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, 2006). 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) cited the American Psychological Association definition of a dual relationship existing when a professional develops a "social or another 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, Hartley, & Bowman, 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 client trust and safety. Pope (as cited in Corey et al., 2003) and Blanshan (as cited in Bowman et al., 1995) stated that in addition to impairing professional judgment, dual relationships pose the danger of exploiting the client, due to the more dominant position of the counselor. Furthermore, the client is in a vulnerable situation 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, 1995). Pipes and Davenport (1990) listed 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 agency 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 in a relationship but after termination of a client. Lamb, Strand, Woodburn, Buchko, Lewis and Kang (1994) surveyed 1,000 psychologists (348 returned) and found that 29% of practicing therapists engaged in business relationships with their clients. Borys and Pope (1989) in a study of 4,800 (49% return rate) psychologists, psychiatrists and social workers that a majority of responders to the survey found five dual roles never to be ethical; sexual activity with a client before termination, selling a product to a client, sexual activity with a client after termination of therapy, inviting clients to a personal party or social event, and providing therapy to an employee.

Boundary Issues (Section A.6.)

Corey et al. (2003) defined 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 a clear 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 to see a certain client. Boundary issues or violations are often on a gradient of involvement and need to be processed in supervision. The following section addresses specifically the dual relationship that involves sexual contact between client and counselor. This type of dual role is, unfortunately, overly represented in ethics complaints and under-represented in graduate training programs. Lamb et al. (1994) determined that 6.5% of practicing therapists engaged in sexual relationships with former clients within three months of termination. From available research reports, these authors found an incidence in the range of 3.98% - 11%. The 2014 Code of Ethics specifies five years and includes a supervisory review before a relationship with a former client is possibly renewed (ACA, 2014).

Despite the fact the principle prohibiting sexual contact between therapist and client is the clearest and most concrete of the ethical codes, it remains the most commonly violated (Vasquez, 1988). Keith-

Spiegel and Koocher (1995) state that sexualizing the client/therapist relationship is "dangerous, unprofessional, and grossly unethical" and results in harm to both the client and the therapist.

The principle supporting do no harm to clients is nonmaleficence as well as A.4.a. (avoiding harm). Harm to clients ranges from mistrust of opposite-sex relationships to hospitalization and even suicide. Even minor sexual advances adversely affect clients and can lead to depression and exacerbated emotional problems (Vasquez, 1988). In general, sexual intimacy between a client and counselor is an abuse of the power that counselors have by their professional role. Such relationships also foster dependency in the client and ruin the objectivity of the therapist (Corey et al., 2003).

Regarding 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 the professional loss of career and primary relationship. Although erotic touching is unethical, some forms of nonerotic touching may contribute to a positive therapeutic experience. The ACA Code of Ethics (ACA, 2014) prohibits sexual or romantic relationships with current clients (A.5.a.) and with former clients (A.5.b.).

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

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

Holroyd and Brodsky (1977) and Holroyd and Bouhoutsos (1985) observed 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 motivations concerning physical contact and cultivate their sensitivity as to how touching might be either therapeutic or counterproductive for a client in a particular context of the therapeutic relationship (Corey et al., 2003). Schoener (1995) referred to detrimental relationships by the predictive traits of individual professionals. Individuals who exhibit these traits have:

1. psychotic and severe borderline disorders.
2. manic disorders.
3. impulse control disorders.
4. chronic neurosis and isolation.
5. situational offenders.

6. deficits due to naiveté.

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

One last area of border 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 alerted to motivation, client issues, and the counselor 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 the advisability of taking such actions or even what the intent is of the client. Sexual contact or touching is a clear violation.

Question 1-60:
A male counselor has been in a counselor-client relationship for the past nine months with a female client. Over the duration of therapy, the counselor has treated this client for restricted emotional development. The client indicates that this was a difficulty in her past two marriages. Her husband(s) accused her of not having any feelings and not being able to get close to anybody. She has worked diligently on this problem and is making progress in revealing and understanding her identity. The client has begun to sense her growth and has shared her appreciation with the counselor. As a result of this positive feedback and also being attracted to the client, the counselor recognizes that transference and countertransference have developed. The counselor interpreted the transference to the client. She acknowledges these dynamics but continues to express her good feelings toward the counselor. The counselor struggles with sharing his true feelings with her. What should the counselor do?

a. reveal his own feelings and suggest terminating the counseling relationship so that they can have a personal relationship

b. transfer her to another colleague, giving her the true reasons for the referral

c. deny any feelings and discuss the client's attraction as a natural part of transference that occurs in therapy

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

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

Question 1-61:

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

    a. a dual relationship.

    b. client dependency.

    c. malpractice.

    d. countertransference.

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

Question 1-62:

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 activity 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 the counselor or the client is not eliminated from the tournament, 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 counseling session.

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

Question 1-63:

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

    a. inform the partner that the counselor will have to disqualify himself without an explanation.

    b. inform the partner there is an ethical dilemma in the counselor participating, not with the partner, but with someone else and the counselor will have to disqualify himself.

    c. participate in the tournament and if a set becomes matched with the client, at that time, withdraw.

    d. locate the client and process the dilemma and determine how the client feels about the counselor participating.

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

OBJECTIVE 1J: Technology Impact

Objective 1.j: technology's impact on the counseling profession and 5.e.: the impact of technology on the counseling process (CACREP, 2015, p. 10)

Technology

Section H: Distance counseling, technology, and social media states the need in acquiring knowledge and legal regulations (H.1.), importance of informed consent and security (H.2.a.), need for client verification (H.3.a.) creation of distance counseling relationship (H.4.), maintaining records and web maintenance (H.5.)

Sub-sections of the ACA 2014 Code of Ethics include technological administration (E.7.c.), technology-assisted services (H.4.c), communication differences in electronic media (H.4.f.), and electronic links (H.5.c.).

Silverman (2013) in 2012 predicted the future of psychology would experience four trends. The first trend was diversity (see Unit 2), the second trend was an expanding use of technology involving social networking, Skyping, cell phone, texting, blogging, gaming, podcasting, and tweeting. The benefits of technology for those who have computer skills is that therapy is available on-line to shut-ins, prisoners, and those who have transportation issues, rural populations not served by psychological assistance, and to those who avoid the counseling office. Typically, technology services are less expensive than office-based sessions. Some research articles have revealed that Internet-based therapy is as effective as office-based even though it may be virtual and the relationship, a common factor across treatments, is a relationship with an animated talking head.

The Internet impact is immediate access when texting to assist people at risk, logging clinical information when the client is asked to chart specific symptoms, availability of different forms of gaming can help in anger symptoms and behaviors, administering psychological assessment for anxiety disorders, mood disorders, and substance abuse disorders (Emmelkamp, 2005).

The third trend was a new economy and health care. The fourth trend was emerging markets of performance enhancement and quality of life improvement.

There are ethical risks as there are with face-to-face client therapy. Similar ethical practices are noted for technology to include confidentiality, encryption, and protected passwords. Silverman quoted Maheu's (2012) three basic compliance suggestions for assessment and psychotherapy: (1) learn the risks associated with reporting confidential information, (2) learn how to use risk management, and (3) learn the legal and ethical ramifications associated with offering services as well as the diagnostic cues that are not available with technology (Silverman, 2013, p. 486).

Counselor use of technology via web-based or on-line counseling, distance counseling, and computer-mediated therapy can be employed with clients. Also, technology is used in record keeping (B.6.a, B.6.b., confidentiality of records and documentation, scheduling, appointments, and communicating with clients).

Use of technology by counselors and clients as noted by Silverman includes media and tools for assessing symptoms, goals establishment, treatment, and electronic transmission of client records, web communication, workshops, programs of change, symbolic representation of the human relationship, computer-based treatments (self-help), monitor client treatment interactions, as well in a broader system of communities, networks, and interactivity for information sharing and collaboration. It is imperative that counselors familiarize themselves with HIPAA requirements for electronic transmission of client information thus assuring all parties of confidentiality.

Supervisors-supervisees using on-line supervision are to be competent in the use of technologies and take precautions to protect confidential information through electronic means and password protection (F.2.c.)

Lewis et al. (2002) reported that a counselor could advocate for a client or clients by assisting or teaching them how they can advocate for themselves (A.7.b., confidentiality and advocacy; B.3.c. confidential settings; B.3.e, and transmitting confidential information).

Counselors may need to update their competence because of new technology developments such as social media, interactive media and other forms of available software therapy programs for the general population regarding sharing private information.

Reljic, Harper, and Crethar (2013) reported specific ethics about the use of technologies when a counselor implements a particular therapy intervention. Ethics to be reviewed include:

a. informed consent.
b. avoiding harm (A.4.a.).
c. confidentiality.
d. release of confidential information (B.5.c.).
e. records (B.6.a-creating and maintaining files and documentation).
f. administration (E.7.c.).
g. on-line supervision (F.2.c.).

Allen Ivey suggested during an ACA presentation and Mary Bradford Ivey during a web-based program that neuroscience is to have an impact on therapy for client lifestyle changes. Neuroscience is soon to be the cutting edge evolving into an entirely new perspective in managing mental health and in diagnosing (Montes, 2013).

Advances in neuroimaging and electrophysiology as the new treatment in neuroscience are on the forefront. Researchers are now capable of processing how human thoughts and emotions are connected. The new areas of psychotherapy include (Ivey, Ivey, Zalaquett & Quirk, 2009):

a. neuroplasticity-the brain can change
b. neurogenesis-brain is discarding

c.   attention and focus-attending can be measured

d.   clarification of emotion-emotions fire different parts of the brain

e.   positives-focusing on strengths can overcome negatives

Five areas support the development of mind-body treatments for restoring harmony and health. One example of this application includes the use of meditation, guided imagery, progressive muscle relaxation, hypnosis, and autogenic training for depression. Lin et al. (2010) found music provided relief from depression and contributed to greater personal awareness using the Bonny Method of Guided Imagery and Music (Cook, 2014). Ernst, Pittler, Wider, and Boddy (2008) found music to be beneficial for anxieties and improved quality of life.

Lemon and Wagner (2013) reported emerging practices in the mind-body developments to include:

a.   Mindfulness-Based Stress Reduction (MBSR)

b.   Thought Field Therapy (TFT)

c.   Emotional Freedom Techniques (EFT)

d.   Swish Pattern

Erford (2012) reported that in integrating the left-brain and right brain, a neuroscience approach could offer counselors a different approach to a research-informed practice. Presently, clinicians are educated on the evidence-based treatments (EBTs).

Fields (2014) made a strong case for the use of neuroscience integration of the left-brain and right brain for the centrality of the counseling relationship. He contends that a combination enhances and strengthens the attunement and quality of the interpersonal contact with the counselor, a linguistic and auditory connection. It is his belief that research will support that counselors who follow hunches, experience sudden insights, choose directions without knowing why, or have unexpected feelings that turn out great in therapy will be documented evidence for neuroscience integration (Welling, 2005).

OBJECTIVE 1K: STRATEGIES FOR SELF-EVALUATION

Objective k: strategies for personal and professional self-evaluation and implications for practice (CACREP, 2015, p. 10).

Self-evaluation is critical for effectiveness and best client care and is the primary responsibility of the counselor along with the combined efforts of a supervisor. The ACA code of ethics emphasizes client welfare (F.1.a), impairment (F.5.b.), and evaluation (F.6.a.) (ACA, 2015).

Lambert and Ogles (2004) reported that 5%-10% of adult clients participating in clinical trials leave treatment worse off than when they began treatment. Also, estimates of deterioration are 24% and 14% respectively for children treated in mental health and managed care treatments (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010).

Goldberg et al. (2016) in a large-scale study of 175 experienced therapists involving 6,591 clients in individual therapy using the Outcome Questionnaire 45 to measure change, reported that therapists did not improve with more experience either in time or number of clients. The data revealed that 39.41%

improved while 60.59% deteriorated. Tracey, Wampold, Lichtenberg, and Goodyear (2014) contend that under normal conditions therapists do not improve over time.

Goldberg's results were in contrast to reports published by Orlinsky and Ronnestad (2005) where 4,000 therapists in a 20-year study showed that a majority of the therapists perceived themselves as developing professionally. These types of study results suggest that variables are not similar from study to study.

Training and Routine Outcome Monitoring (Supervision Integration)

Supervision research provides an empirical base for supervisee growth, treatment effectiveness, and is an efficient method to monitor treatment outcome. A key component is a relationship between the supervisor and supervisee and the supervisee and the client. The relationship effectiveness has a direct bearing on the treatment objectives. Monitoring and providing feedback requires a methodology implemented at the beginning of therapy and session-by-session assessment of client change.

Routine outcome monitoring (ROM) tools are used to acquire treatment feedback for client change (positive and less so). Specific objective measures to determine client outcome and to assist clinician decision-making is to observe the pattern of change. Supervisors introduce and integrate evaluation programs to develop methods to obtain and use objective feedback, use outcome monitoring to inform discussions of specific clients in agenda setting, use patterns of outcomes across clients to facilitate supervisee growth and development (problem- solving) and to track and predict treatment change or failure.

Alliance-Focused Training (AFT) focuses on therapist's skills for negotiating problems or ruptures in the alliance (brief relational therapy; BRT). The goal of AFT training is to increase the therapist's ability to recognize, tolerate, and negotiate alliance ruptures by enhancing supervisee self-awareness, affect-regulation, and interpersonal sensitivity (Eubanks-Carter, Muran, & Safran, 2014; Friedlander, 2015). Self-awareness, affect regulation, and interpersonal sensitivity skills are used interdependently (Safran & Muran, 2006). Self-awareness is the supervisee's ability to attune to his or her immediate experience and be better able to detect strains in the alliance (p. 169). Affect regulation is responding empathically and resisting the urge to answer client hostility with a counter hostile response or to avoid behaviors to reduce one's anxiety. Interpersonal sensitivity is the ability to communicate about what is taking place without worsening the rupture.

Training begins with AFT reading, definitions, and an approach for resolving the rupture. When alliance rupture is severe, clients often drop out of therapy, but a less severe break in the relationship may be caused by inadequate negotiation of the goals and tasks for treatment (Friedlander, 2015). Friedlander reported that supervisor's responsiveness is required when the counselor describes the client behavior as an uneasy or shaky alliance. A supervisor's task is to become responsive to the treatment and to also respond to the supervisee's reactions to the therapeutic rupture. Three training exercises included for the AFT model are a videotape analysis of challenging moments, use of awareness-oriented role-plays, and mindfulness.

Safran, Muran, and Eubanks-Carter (2011) researched studies in the repair of the alliance ruptures. Ruptures are defined as tension or breakdown in the alliance relationship and can vary in intensity and

are often a result of miscommunication or misunderstandings between the client and therapist (Saran & Muran, 2006). Three types of ruptures were observed: (a) disagreements about the tasks of therapy, (b) disagreement about the treatment goals, and (c) strains in the client-therapist bond. Interventions include: (a) repeating the therapeutic rationale, (b) changing tasks or goals, (c) clarifying misunderstandings at a surface level, (d) exploring relational themes associated with the rupture, (e) linking the alliance rupture to frequent patterns in a client's life, and new relational experience.

Holt et al. (2015) introduced an evidence-based supervision model to track outcome and to teach principles in clinical supervision. The measures include the STS Clinician Rating Form (Fisher, Beutler, & Williams, 1999; Fisher & Wells, 2005, 2008) and the Therapist Process Rating Scale (TPRS; Malik, Beutler, Alimohamed, & Gallagher-Thompson, 2003). The goal is to assess therapist competence and the exactness in detail of the quality of treatment. Eight principles for supervision include impairment (clients with weak social support systems), three relationships (strong working alliance, therapist relates in an empathic way, resolve alliance ruptures), resistance (use directive therapeutic interventions), two coping principles (externalizing clients, internalizing), and readiness.

Supervision Instrumentation:

Therapist competence and fidelity of treatment application instruments include:

1. STS Clinician Rating Form (Corbella et al., 2003)
2. Therapist Process Rating Scale (TPRS; Malik et al., 2003)

OBJECTIVE 1L: Self-Care

Objective 1l. Self-care strategies appropriate to the counselor role (CACREP, 2015, p. 10).

Wellness

Myers, Sweeney and Witmer (2000) defined wellness as "a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community" (p. 253). Seligman (2002) and Snyder and Lopez (2001) identified characteristics of what constitutes well-being. From these contributions, Sweeney and Witmer (1991) developed a Wheel of Wellness model. Later Myers, Sweeney, and Witmer (2000) revised the original design of self-direction to include 12 subtasks and five major life tasks (spirituality, self-regulation, work, friendship, and love) and correlated with healthy living, quality of life, and longevity. The components of the Wheel of Wellness are a sense of work, nutrition, sense of humor, problem-solving and creativity, exercise, self-care, realistic beliefs, emotional awareness & coping, sense of worth, sense of control, gender identity, and cultural identity. Life tasks are spiritual, self-direction, work and leisure, friendship, and love. This work evolved into the 5F-Wel Inventory that included cognitive-emotional wellness, relational wellness, physical wellness, and spiritual wellness. (Roscoe, 2009).

Reese and Myers (2012) suggested that most models of wellness have omitted the clear benefits of nature, environment, and natural community. The EcoWellness model references supportive literature to illustrate how individuals connect with nature and receive benefit from the restorative and positive effects in psychological, physical, and emotional well-being. There are three domains to access the eco

model, nature (green spaces), environmental identity (special relationship with nature), and transcendence (deep feelings of connectedness). Salovey, Rothman, Detweiler, and Steward (2000) made a further connection in studying the emotional states with physical health. Clients in distress often refer to physical ailments and mood. Emotional experiences linked to changes in physical health have an effect on the immune system. A multitude of research exists regarding the positive and adverse effects of client emotions as it relates to illness and the immune system. It appears that for those individuals exercising a positive set of emotions there is informational value in learning about the risk factors associated with negative emotions. Also, mood does affect people's vulnerability to conditions for deteriorating consequences. Further evidence is available that identifies a direct link between emotional states and psychological resilience. Social support, or lack thereof, may affect health. Salovey, Rothman et al. (2000) provided a contrast for social support with the buffering hypothesis and the direct effect hypothesis stating support that social relationships promote health and well-being regardless of the stress level. Social support may lessen the degree of pressure in a challenging physical, psychological and environmental situation.

Newsome and Gladding (2014) recommended a plan for counselors to initiate and carry out a wellness-oriented lifestyle. The plan called for a review in the areas of physical self-care (sleep, nutrition, exercise), cognitive self-care (evaluating and monitoring, harmful and irrational stress inducing cognitions), and emotional and spiritual self-care (empathic, sensitive, humane, people oriented and committed).

Personal Characteristics

Gladding (2012) compiled a list of features from several authors that included emotional insightfulness, curiosity, ability to listen, enjoyment of conversations, empathy and understanding, introspection, capacity for self-denial, tolerance of intimacy, comfort with power, and humor. Cormier and Cormier (1998) and Cormier, Nurius, and Osborn (2009) summarized many of the qualities as intellectual competence, energy, flexibility, support, goodwill, and self-awareness. The ACA Code of Ethics encourages counselors to develop and maintain effective personal self-care habits (F.8.c) that will decrease the risk of fatigue, burnout symptoms, and eventual impairment (C.2.g.).

Burnout

Osborn (2004) defined burnout as "the process of physical and emotional depletion resulting from conditions of work or, more concisely, prolonged job stress" (p. 319).

 Counselors should periodically conduct self-evaluations for symptoms of burnout and recognize burnout characteristics that are unique to their self-care. Burnout signals include: loss of job enjoyment, guilt, defensiveness, detachment, paranoia, lack of creativity, mechanical-behavior, alienation, rigidity, callousness, pessimism, physical and emotional exhaustion, inability to cope with stress, muscle tension, absenteeism, alcohol and drug abuse, boundary violations, and negative attitudes (Gladding, 2012).

Research during the 1970s and 1980s identified emotional exhaustion, depersonalization, and personal accomplishments as the core constructs of burnout (Maslach, 1981; Maslach & Jackson, 1981). Lizano (2015) conducted a systematized study of the literature and found a paucity of research about the impact of burnout on the affective/psychological, physiological, and behavioral well-being of workers.

The depletion of personal resources is due to stress and feelings of exhaustion caused by fatigue and mental erosion (Leiter & Maslach, 2000a, 2000b; Maslach & Leiter, 2008). Emotional exhaustion was found in every study and from 9 of the 18 studies job satisfaction was a common factor for well-being. Worker's mental health regarding well-being triggered depression and anxiety symptoms (Lizano, 2015).

The interviewer seeks to identify the internal and external causes of burnout stemming from repetition, lack of advancement opportunities, overextension of work, money issues, feedback issues, lack of challenges, politics, supervision issues, boredom and insufficient time for personal and professional development (Gladding). An inventory is a second method to screen for specific counselor burnout characteristics. The Counselor-Burnout Inventory measures five dimensions for burnout syndrome. These dimensions are exhaustion, incompetence, negative work environment, devaluing client and deterioration of personal life (CBI; Lee et al., 2007; Lee, Cho, Kissinger, & Ogle, 2010). They reported that job satisfaction and self-esteem were common characteristics across three clusters and typology of burnout.

Professional orientation and ethical practices and CACREP core curriculum objective 1.l, advocate for developing and acquiring self-care strategies appropriate to the counselor role (CACREP, 2015) and the 2014 Code of Ethics, Section C (Introduction). ACA standards indicate that counselors are to refrain from offering professional services when their personal problems or conflicts may cause harm to a client or others. The ACA Code of Ethics Section C and F.7.b. encourage counselors to engage in self-care and self-growth activities (self-growth, F. 8.c.). A counselor who exhibits self-care and wellness is in a mental, social, and physical position to help clients and to model a healthy lifestyle. Debilitating characteristics such as fatigue and burnout result in impairment (C.2.g.).

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

Self-care strategies: Counselor role (objective 1d)

A component of prevention of counselor burnout and wellness includes activities, plans, and goals for a lifestyle of well-being. The counselor develops patterns of stress responses across the developmental continuum to include sustaining plans for self-awareness and opportunities for growth components including:

a. physical self-care
b. recreational and leisure self-care
c. social support self-care
d. spiritual/religious
e. resiliency (self-attitudes, social attitudes, skills [humor, communication, insight, problem solving, critical thinking, planning], noble abilities (faith, wisdom, creativity, dreams, hope, goal of highest good, courage)

Leisure

Physical self-care and the work style of the counselor leisure considerations is an integral part of a wholesome approach to a wellness-oriented lifestyle. There are 13 different theories of leisure (Dieser, Christenson, & Davis-Gage, 2016). Myers and Sweeney (2004) reported that leisure is one of the wellness subtasks. Wozny (2012) quotes Stebbins' definition of leisure as uncoerced, contextually framed activity engaged in during free time, which people want to do and, using their abilities and resources, actually do in either a satisfying or a fulfilling way (p. 3). Munson and Widmer (1997) researching college students found a significant relationship between leisure behavior and occupational identity. Employed workers who experience higher levels of satisfaction in their jobs and leisure activities also experience increases in psychological health (Pearson, 1998). Grafanaki et al. (2005) reported that leisure is linked to rewards of self-healing, replenishment, and renewal (re-energizing). Stebbins' three forms of leisure include serious leisure, casual leisure, and project-based leisure (Elkington & Stebbins, 2014; Stebbins, 2007).

Serious and Casual Leisure

Dieser, Christenson, and Davis-Gage (2016) and Stebbins (2006) defined leisure as casual and serious. Casual leisure is an immediate, intrinsic, short-lived pleasure requiring little to no training for enjoyment. Stebbins' (1997, 2004) provided examples of casual leisure that included play, relaxation, passive entertainment, active entertainment, sociable conversation and sensory stimulation. Leisure benefits include personal and social rewards. Personal rewards may be enrichment, self-actualization, self-image, self-gratification, and recreation. Social rewards may be in the form of cultural attraction, group accomplishment, and contributions to others (Stebbins, 2006, 2007).

The serious leisure perspective (SLP) further delineates serious leisure from casual leisure according to six characteristics. These characteristics include: a) need to persevere at the activity, b) availability of a leisure career, c) need to put in effort to gain skill and knowledge, d) realization of various exclusive benefits, e) unique ethos and social world, and f) an attractive personal and social identity (http://www.seriousleisure.net/concepts.html). Serious leisure examples are those in which the individual displays a high degree of interest and is usually fulfilling a skill, specific knowledge and acquired experiences (Stebbins, 1992). Dieser et al. (2016) divided serious leisure into three types, amateur, hobbyist, and career volunteer. Incorporating casual and serious leisure into the counseling process is beneficial through retirement years. The wellness benefits include personal satisfaction and fulfillment, enrichment, regeneration and creativity, cultural attraction, and development of friendships and personal accomplishments (Dieser et al., 2016).

The importance of leisure in a lifestyle involves inquiry and client support during the therapy stages of intake, treatment planning, and termination. The Serious Leisure Inventory, Measure of the Leisure Motivation Scale and the client's verbal commitment for activities can make known the client's interest and involvement in personal reward activities.

Compensatory and Spillover Theory

The compensation theory states that people participate in activities that satisfy needs that they cannot fulfil at work although they are influenced by work and may use these activities to compensate for the strains of the work demands.

According to the spillover theory, workers are thought to participate in leisure activities that have characteristics similar to their job-related activities and tasks.

Constraints

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

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

In summary, leisure is a freedom to choose and is not devoted to work or work responsibilities. The primary function is to meet one's personal needs for reflection, self-enrichment, relaxation or pleasure and self-care.

OBJECTIVE 1M: Supervision

Objective m: the role of counseling supervision in the profession (CACREP, 2015, p. 10)

ACA Code of Section F.1-F.11.c

The CACREP 2016 standards for core curriculum objective M highlight knowledge of counseling supervision models, practice and current issues. Section F Supervision, Training and Teaching of the 2014 Code of Ethics (www.counseling .org) topic headings include: counselor supervision and client welfare (F.1.a.), counselor supervision competence (F.2.), supervisor relationship (F.3.), supervisor responsibility (F.4.), student and counselor responsibility (F.5.), counseling supervision evaluation, remediation, and endorsement (F.6.), and responsibilities of counselor educators (F.7.).

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

Bernard and Goodyear's (2013) defined supervision as an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship

is: evaluative and hierarchical, extends over time, has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitors the quality of professional services offered to the clients being evaluated and treated; and serves as a gatekeeper for those who are to enter the counseling profession.

Gatekeeping is also a technique and a role used by leaders to provide space and an opening for member participation (F.6.b., APA 2014). Supervision is a mentoring process that develops a relationship whereby the supervisee experiences support and guidance with a seasoned clinician, one who has knowledge and expertise in the models, styles and practical experiences of supervision. Through this process the supervisee experiences wisdom and a personal style of a counselor-therapist. Mentoring teaches sound judgment for decision-making in ethical practice and assists in the clinical application of a treatment strategy as a discovery process to become an effective counselor.

A supervision course for practitioners has not been a required curriculum course in most master degree counseling programs although all trainees are recipients of supervision. Accredited doctoral programs, however, do require an academic course regarding supervision as well as an experiential supervised supervision for the graduates. It would seem logical that the developers of the NCE do not place an examinee in the role of the supervisor rather the supervisee. As a result, some information will be shared regarding the supervision theories or models and the role of the supervisor (F.2.a, ACA, 2014). It is recommended that each person preparing for the NCE review the 2014 Code of Ethics supervision standard (F.4.c.) to be found on-line for the American Counseling Education and Supervision (ACES), the American Mental Health Counseling Association (AMHCA) and the American Counseling Code of Ethics (2014). In addition, it is recommended that individuals preparing for the NCE also review supervision sections within the Code of Ethics for NBCC, ACA, and AMHCA in order to become aware of dilemmas often encountered in counseling and processed in supervision. In addition, if one has not been trained in supervision it would be helpful for that individual to think about possible questions that might be encountered during the process of a therapy case. Further preparation should include reviewing codes of ethics derived from the ethics and standards as well as ethical violations found in the Ethical Guidelines for Counseling Supervisors processed by ACA. [See online: ACA. ACES (Client Welfare and Rights, Supervisory Role, and Program Administration Role).

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

Feiner (1994) specified the roles of a supervisor as formative, normative and restorative while Bernard and Goodyear (2013) defined the task of the supervisor as facilitating professional development and improving client care.

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

Supervision contracts with supervisees should include learning goals, length and frequency of supervision, and summative evaluations. Haynes, Corey, and Moulton (2003) suggested that a supervisor-supervisee contract is to include purposes and goals for supervision, frequency, duration and structure of meetings, roles and responsibilities of the supervisor and supervisee, description of supervisor background, experience, and areas of expertise, model and method of supervision, documentation responsibilities, evaluations methods, feedback, commitments to follow all applicable agencies policies, professional licensing statutes, and ethical standards, agreement to support healthy boundaries with clients, function within the limits of competence, provide informed consent to clients, reporting procedures for legal, ethical and emergency situations, confidentiality policy and statement of responsibility regarding multicultural issues (p. 198). The contract is essential when a counselor begins the search for an on-going supervisor. A supervision agreement is a written document describing the supervisor's expectations and supervisee conditions set forth to counsel with clients. The supervisor routinely evaluates at least once a year to include the supervisee's personal as well as clinical functioning. If inadequacies are noted, supervisees are advised, a remediation plan with a time line is developed, and the supervisee is made aware of consequences of not addressing and improving the inadequacies (F.5.b.).

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

The 2014 Code of Ethics Section (2013) F.6. highlights the importance of supervision evaluation and remediation (F.9.) and endorsement. F.5.b. addresses limitations and impairments regarding the supervisee's preparation and fit for the counseling tasks. The supervisor is responsible for this evaluation of strengths and limitations. Limitations may, at times, be impairment. Impairment according to Overholser and Fine (1990) includes five areas, that of factual knowledge, generic clinical skills, orientation to specific technical skills, clinical judgment, and interpersonal attributes. Lamb et al. (1987) deem severe deficit to be in the areas of knowledge and application of standards to include ethics, mental health laws, and professional behavior, competency in areas of conceptualization, diagnosis and assessment, and appropriate interventions, and personal functioning, to include awareness of self, the use of supervision and management of personal stress.

The supervisor is to point out strengths of the supervisee in the same areas as limitations are noted. Also, Frame and Stevens-Smith (1995) suggested personal characteristics of strength include being open, flexible, positive and cooperative, willing to take and use feedback, aware of the impact on others, ability

to deal with conflict, accept personal responsibility, and express feelings effectively and appropriately. The supervisor in collaboration with the counselor can assist the counselor-client through monitoring the treatment with a systematized outcome monitoring tool. Swift et al. (2015) reported that the supervisor and counselor through consultation select a monitoring tool that is disorder specific. The supervisor may assist the counselor with how to discuss feedback with the client. The monitoring device can alert the counselor if the relationship deteriorates and provides an opportunity to reassess therapy to avoid early termination. The feedback includes client improvements and growth; target patterns that cut across clients, and a useful guide for the supervision session.

Models

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

Theories, models, and styles represent different approaches such as psychodynamic, developmental, and social models. Psychodynamic models include forms characteristic of psychodynamic, person-centered, cognitive-behavioral, systemic and constructivist (narrative and solution-focused) theories. Developmental models include the integrated developmental model (IDM), process developmental (reflective practice; Loganbill, Hardy, and Delworth (1982) event-based and life span model. Social role models include discrimination, Hawkins and Shohets approach (2000), and the Holloway systems approach to supervision (SAS; Holloway, 1995, 1997).

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

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

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

PSYCHODYNAMIC MODEL: The trainee learns how to be open to experience using a process that often mirrors therapy. Moldawsky (1980) stated that anxiety in the client produces anxiety in the therapist, and unless the therapist is open to the experience, he or she will defend against the anxiety by

characterological or symptomatic defenses and will unconsciously encourage repression in the client, rather than exposure. The therapist is to learn the analytic attitude. This attitude is patience, trust in the analytic process, interest in the client, and respect for the power and tenacity of client resistance (Bermard & Goodyear, 2013).

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

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

SOLUTION-ORIENTED MODEL: The supervisee is the expert based on personal integrity and respect. The supervisor attempts to coax and author expertise from the supervisee's experiences, education, and training rather than provide direct teaching expertise from a superior position. The two steps include process conceptual and implementation. Conceptual is the process of examining what the supervisee wants from supervision and the supervisor. Implementation of the solution is oriented supervision, socializing, saliency, setting goals, and future orientation (Thomas, 1996).

Standards (ACES, AMHCA, AAMFT)

The ACA Code of Ethics standards is listed in Section F within Teaching, Training, and Supervision. The original standards of practice were developed by ACES and referred to as ethical guidelines for counseling supervisors and association for counselor education and supervision in 1993 (Bernard & Goodyear, 2013). Presently the standards of practice are integrated into the 2014 Code of Ethics in the introduction to each section.

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

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

Possible Questions:

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

1. maintaining case notes, records and files.
2. determining if services meet client's needs.
3. corresponding orally with others to maintain professional communications.
4. assisting clients with obtaining social services.

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

Question 1-64:

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

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

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

Question 1-65:

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

a. the cost (value) of the gift
b. reciprocity of a return gift
c. ethnicity of the client
d. countertransference

e.   family members

f.   counselor's motivation for wanting or declining the gift

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

Group Supervision

Group supervision has many of the same purposes as individual supervision. Group composition is 4-8 supervisees coming together to present and receive assistance with cases. CACREP requires a supervision group is composed of six interns. The supervisor is to monitor the quality of the supervisee work and personal understanding as a counselor. Some advantages of group supervision are the economics of time, cost, and expertise, vicarious learning, the breadth of client exposure, feedback with greater quantity and diversity, greater quality, comprehensive picture of the client and supervisee, learning supervision skills, normalizing experiences and mirroring interventions (Bernard & Goodyear, 2013).

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

Supervisors develop a contract with the supervisee to inform them of a variety of expectations and specific requirements. Some of these might be:

a.   frequency, location, length, and duration of supervision meetings.

b.   supervision model of the supervisor and to learn of a model preferred by the supervisee, if known.

c.   liability and fiduciary responsibility of the supervisor (client, feedback, evaluation procedures for the supervisee and the client progress).

d.   the evaluation process, instruments, and frequency.

e.   supervision disclosures to the client (F.1.c.).

f.   standards (F.4.c.).

g.   supervisor responsibility to the supervisee and to the client.

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

Group Supervision Advantages

a.   learn from others

b.   role playing variety (countertransference issues)

c.   economics of time, cost, and expertise

d.   vicarious learning

e. breadth of client exposure

f. supervisee feedback, greater quantity and diversity

g. more comprehensive picture of supervisee

h. learn supervision skills

i. normalizing supervisee's experiences

j. mirroring supervisee's intervention

k. opportunity to conduct case conceptualization to peers and to make problem statement

Group Supervision Disadvantages when Compared to Individual Supervision

a. reduced time to present and get what is desire

b. confidentiality

c. group format is not isomorphic with individual counseling

d. certain group phenomena can impede learning

e. devote too much time to issues of limited relevance or interest

Question 1-66:

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

a. the cost to the agency

b. confidentiality

c. focus is not mirror

d. quantity of supervision time

e. quality of supervision

f.   lack of client exposure

Answers: b., c., d.

Question 1-67:

A supervisor is describing a supervision contract to a supervisee. According to counseling protocol what should be included in the contract?

a. frequency, location, length and duration of supervision meetings

b. type of notes

c. supervision models and expectations

d. fee structure

e. liability and fiduciary responsibility of the supervisor

f. the evaluation process, instruments used and frequency of evaluation

g. therapy techniques required for treatment

h. emergency and critical incident procedures

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

Question 1-68:

The counselor during individual supervision told the supervisor that she was unable to help the client improve in the therapy. The supervisor might make what suggestions?

    a. develop a descriptive metaphor

    b. develop a theoretical orientation

    c. develop homework for the client

    d. request the client to consider a different perspective

    e. consider a referral to another counselor

    f. this is a situation that calls for case consultation

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

Question 1-69:

During individual supervision and before the client's termination the counselor was charged by the supervisor to evaluate her effectiveness. The supervisee requested the supervisor to provide direction to derive this type of information. What methods might the supervisor utilize to provide the most reliable feedback?

    a. bug in the ear (BITE)

    b. ask the client

    c. in vivo

    d. phone ins

    e. client relapse

    f. an empirical study

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

Question 1-70:

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

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

    b. seek consultation from a hypnotherapist

    c. trauma-focused therapy

    d. physical exercise

    e. exercise use of music

    f. continue psychoeducation and supportive therapy

    g. short-term memory training

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

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

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

c. Not indicated

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

e. Music therapy is associated with right brain activation

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

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

Question 1-71:

A counselor decided to seek supervision assistance for best treatment. In selecting a supervisor, the counselor would want to consider which of the following?

    a. supervisor experience

    b. supervisor is listed on the approved supervisor registry

    c. supervisor is within 5-15 minute travel time

    d. supervisor theoretical orientation

    e. the supervisor's training

Answer: a., d., e.

Unit 1 - Terms

ADAPTIVE BEHAVIOR:

The DSM-IV-TR (APA, 2000) defined adaptive behavior with ten skill areas that included communication, community use, fundamental academics, home and school living, health and safety, leisure, self-care, self-direction, social behavior, and work. The American Association of Mental Retardation (2002) used the tripartite model of domains (a) conceptual (academics, self-direction, health, and safety needs) (b) social (social skills, leisure), and (c) practical (self-care, self-direction, home living, community use, health/safety, and work skills). The American Psychiatric Association and the DSM-5 defined adaptive functioning regarding how well an individual meets community standards for personal independence and social responsibility. The operation includes conceptual, social, and practical. Social adaptation includes competence in memory, language, reading, writing, math reasoning, and acquisition of practical knowledge, problem-solving, and judgment. The social domain includes awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment. The functional area includes learning and self-management across life settings, of personal care, job responsibilities, money management, recreation, self-management of behavior, and socialization, personality features, vocational opportunity, cultural experiences and coexisting general medical conditions that influence adaptive function (APA, 2013, p. 37).

ALLIANCE-FOCUSED TRAINING (AFT):

Alliance-Focused Training (AFT) focuses on therapist's skills for negotiating problems, or ruptures in the alliance (brief relational therapy; BRT). The goal of AFT training is to increase the therapists' ability to

recognize, tolerate, and negotiate alliance ruptures by enhancing supervisee self-awareness, affect-regulation, and interpersonal sensitivity (Eubanks-Carter et al., 2014).

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

BINGE EATING DISORDER:
All eating disorders within the Feeding and Eating category have mutually exclusive features and behaviors except Pica. Binge eating is to occur, on an average, at least once a week for three months with a discrete amount of food that is larger than what most people would eat. The eating period is less than two hours and demonstrates a lack of control in continuing to eat. The client has distress of at least three features (APA, 2013, p. 351).

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

CASUAL LEISURE:
Casual leisure is an immediate, intrinsic, short-lived pleasure requiring little to no training.

CERTIFICATION (limited license):
Certification is a none statutory process by which an agency or association grants recognition to an individual for having met certain predetermined professional qualifications (Frets & Mills, 1980).

CHI SIGMA IOTA (CSI):
The International CSI, a professional honor society, was founded in 1985 at Ohio University. It has a clear mission to promote scholarship, research, professionalism, advocacy and clinical excellence in counseling, and to recognize high attainment in the pursuit of academic and excellence in the profession of counseling. Chi Sigma Iota called for a clear identity as a professional counselor, promoting an advocacy agenda, establishing an adequate compensation, partnering with sister professions, promoting rigorous research in client outcomes, preparation for employment, public awareness, and promoting wellness and prevention (retrieved Nov. 1, 2016, csi-net.org).

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

DAVIS, JESSE:
Davis stimulated the guidance movement from within the schools. He encouraged teachings of the church and the golden rule to guidance. Preaching the social gospel philosophy, he thought students

should regard the values and morals of hard work and honesty. A self-analysis, occupational study, and an examination of self about an occupation were the ministry for each person.

DUTY TO WARN:

Duty to warn is an obligation to inform another of 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 duty toward a third party, a protective action, and a decision as to which action best meets the demand. Foreseeable harm occurs when the counselor has knowledge or practice experience in which he/she can predict a destructive 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) defined 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.

EXCEPTION TO PRIVILEGE:

Silence can be broken when a client is potentially violent and dangerous to others (Rule of Silence). There are certain circumstances under which information must be provided by the therapist regarding psychotherapist-client privilege. The following nine exceptions to privilege are noted by Corey, Corey, and Callanan (2003) and by Herlihy and Corey (2006).

1. The therapist is acting in a court-appointed capacity.
2. The therapist assesses a foreseeable risk of suicide.
3. Client lawsuit against the therapist.
4. Client introduces mental condition as a claim for defense.
5. The 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 hazardous 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 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 an 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.

HIPAA:

Health Insurance Portability and Accountability ACT (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. HIPAA goals include (a) improve portability and continuity of health insurance coverage; (b) combat fraud in health insurance and health care delivery; (c) promote the use of MSA (medical saving accounts); (d) improve access to long-term care services and coverage; (d) simplify and standardize the administration of health insurance. (e) implement and maintain the confidentiality of patient information and (f) regulate all electronic transactions.

ICD-10:

International Classification for Diseases and related health problems (ICD) is a medical health classification system for the World Health Organization (WHO). The code lists conditions, signs, and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. ICD-10 lists 68,000 codes compared to 13,000 for ICD-9. All Health Insurance Portability and Accountability Act covered entities must begin using ICD-10-CM by October 1, 2015.

LICENSURE:

The 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 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. Malpractice is a deviation from a professional standard and negligence refers to a deviation from what a competent professional would have done under similar circumstances (Beis, 1984). Three elements accompany the definition of malpractice, and these are:

1. the defendant must have had a duty to the plaintiff
2. damages resulted from negligence or improper action
3. the causal relationship is established between injury/negligence

MENTAL STATUS EXAMINATION:

A mental status examination is an evaluation of the client'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, the process of

reflection, 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.

MCKAS:

The Multicultural Counseling Knowledge and Aware Scale (MCKAS; Ponterotto, Casas, Suzuki, & Alexander, 2001; Ponterotto, Gretchen, & Chauhan, 201; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2000, 2002) is a 32 item, 7 point Likert scale to measure general knowledge related to multicultural counseling and subtle Eurocentric worldview biases.

NCC:

The National Counselor Certification is granted to a graduate of a counseling program after the completion of a required CACREP internship with professional supervisors and passing the National Counselor Examination (NCE). Graduates of non-CACREP programs who take the examination through a state contracted with NBCC may have to meet additional requirements to attain the NCC. The NCC is not a legal justification for practicing without a license granted by individual states of residence.

NDEA:

The National Defense Education Act of 1958 was established to respond to the well-being, personal needs, and education needs of the nation. Title V of this Act provided for grants to states to develop and maintain local guidance programs and to extend grants to institutions of higher education to train guidance personal (Gibson & Mitchell, 1995, 2008).

NVGA:

The National Vocational Guidance Association was organized in 1913 and in 1915 published the first guidance journal (Vocational Guidance)

OARS:

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

PARSONS, FRANK:

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

PORTABILITY:

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

PRIVILEGED COMMUNICATION:

Legal right which exists by statute and which protects the client from having his/her confidence revealed publicly from the witness stand during legal proceedings. The 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).

PROFESSIONALISM:

Van Zandt (1990) defined professionalism as a set of behaviors that a worker relies for a personal standard of excellence in competency, promotes the image of the profession, improves upon skills through professional development, continuous striving for quality and ideals, and exhibits pride in the profession (p. 244).

PUBLIC LAW 94-142:

Part B of the Public Law 94-142 emphasizes and guarantees confidentiality of information and funding to the state. Also, Part B ensures an individualized evaluation for each disabled person. The Individualized Program of Study (IPS) 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

ROM:

Routine outcome monitoring (ROM) tools are used to acquire treatment feedback for client change (positive and less so). Patterns of progress or the lack of progress is an objective measure to determine client change and to assist clinician decision-making.

SPECIALITY AREAS:

Entry-level specialty areas were first adopted along with the first set of CACREP standards and included the Association for Counselor Education and Supervision and the American School Counselor Association, and American College Personnel Association (Bobby, 2013). Presently the six specialty areas include career; clinical mental health; clinical rehabilitation; college counseling and student affairs; marriage, couple, and family, and school counseling. Specialty area examinations and certifications are available upon meeting specific requirements.

SPECIFIER (DSM-5™):

Specifiers define a more homogeneous subgrouping of a disorder that shares certain features such as major depressive disorder with anxious distress. A DSM-5 disorder may include a specifier. The purpose of a specifier is to provide instruction for a particular reason for the presenting issue. The specifier is coded in the fourth, fifth, or sixth digit. The diagnostician may specify the intensity, with a subtype (performance), specify the course (partial remission), specify the severity (mild, moderate), and specify the features with mixed type (APA, 2013).

SUPER, DONALD:

Donald Super was a vocational theorist who authored the Career Development Assessment in Counseling (C-DAC) composed of stages and tasks. The counselor is a cyclical counselor using a segmental approach of terms. 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 the developmental growth of the counselor. Supervision is intended to:

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

The legal aspects of supervision are:

1. to see that the counselor provides information to clients that are 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

TIERED LICENSING:

Tiered licensing refers to levels of preparation for the full license to practice. A full license informs the public that all state requirements to practice have been reviewed and accepted. A permit to practice under certain conditions is less than a full license and may be called provisional. Some rule requirements are yet to be completed such as years of supervised work experience and supervision requirements met and approved. From state-to-state, the specifics of this regulation may be different regarding hours and years, but the categories (work experience, supervision) are likely to be in all state laws. Some state laws use the associate license in which the counselor may take a specialized examination such as the National Counseling Examination (NCE) and a written or oral legal examination to qualify for the associate license. After a designated set of requirements (years of practice and supervision) are met after attaining the associate license a second examination may be required and passed such as the National Clinical Mental Health Examination (NCMHE) to achieve the full independent license.

TRIPARTITE:

Tripartite has several applications for counseling. From a knowledge perspective tripartite refers to three divisions in developing and counseling clients, acquiring information, developing skills, and reviewing one's attitudes regarding people (knowledge, skills, attitudes).

UNSPECIFIED:

A diagnostician may choose to assign unspecified as a part of the diagnosis when the chief complaint does not meet the criteria for a disorder. (APA, 2013, p. 15). It is the clinician's decision to use other specified or unspecified preceding a disorder (unspecified major depression).

Z-CODE:

A V-code or Z-code is a diagnostic code when the clinical attention or focus and symptoms do not meet the criteria for a DSM-5™ disorder. The DSM-5™ V and Z codes are listed as stressors and respectively

relate to the ICD-9 and ICD-10. A relational problem is when a pattern of interaction or behaviors between clients (siblings or spouses) does not meet full criteria for a disorder although there is significant impairment in functioning (Value Options, 2006). Brief, problem-solving therapy is the treatment of choice.

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

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

Unit 1 - References

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UNIT 2 - Social and Cultural Diversity

Introduction

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

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

CACREP Objectives

Those preparing for the NCE may want to visit the Web address for the full social and cultural diversity standard objectives, www.cacrep.org.

These objectives are minimal statements for social and cultural diversity. Full descriptions are to be found online for the 2016 CACREP standards (CACREP, 2015, p. 2).

a. multicultural and pluralistic trends, nationally and internationally
b. theories and models of multicultural counseling, cultural identity development and social justice and advocacy
c. multicultural competencies
d. the impact of heritage, attitudes, beliefs, understanding, and acculturative experiences on an individual's view of others
e. effects of power and privilege for counseling and clients
f. help-seeking behaviors of diverse clients
g. the impact of diverse client-spiritual beliefs on client and counselor worldview
h. strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination

Question 2-1: (Objective A.)
The term that refers to understanding the multicultural characteristics of a race from another race is:

a. etic
b. emic
c. cultural switching
d. externalization

Answer: a. etic is to understand characteristics of a race from another race, an outside perspective regarding beliefs and customs. The person may compare this view from an internal viewpoint (emic).

Question 2-2: (Objective B.)
Which one of the following would provide for components of client characteristics for a diverse client?

a. cultural accommodation
b. racism acknowledgment
c. cognitive match
d. cultural genogram

Answer: d. cultural genogram. A cultural genogram is similar to the Adlerian genogram, a method to map family characteristics (marriage, divorce, death, children, etc.). Cultural accommodation (Leong & Lee, 2006), cognitive-match (Sue & Zane, 1987), and racism acknowledgment are considered sensitive models (Fuertes, Mueller, Walker, & Ladany, 2002).

Question 2-3: (Objective B)

A theoretical model or framework in which the counselor recommends exploring sex role socialization, power, dominance, marginalization, and subordination is?

    a. Relational-cultural Theory.

    b. Developmental-Model of Psychotherapy (MLM).

    c. Racism-focused Counseling Model.

    d. Multicultural Counseling and Therapy (MCT).

Answer: a. Relational-Cultural Theory

Question 2-4 (Objective C.)

The American Counseling Association regarding counselor competency recommends the tripartite skill model. In addition to this model of knowledge, skills, and attitude, an alternative recommendation is a skill that goes beyond this model that will account for the difference between the counselor who is highly effective and a counselor who is ineffective or merely adaptive. This advanced skill is:

    a. wisdom.

    b. research.

    c. cultural boundary awareness.

    d. automatization of habitual thought.

Answer: wisdom

Question 2-5 (Objective D)

Which bias of the following will most likely be evident when counseling a family of diversity?

    a. age

    b. gender

    c. education

    d. status

Answer: b. gender

Question 2-6 (Objective D)

Which option identifies two of the four social justice core tenets?

    a. truth and loyalty

    b. harmony and empowerment

    c. participation and new skill

    d. equity and access

Answer: d. equity and access. Harmony and participation are the other two.

Question 2-7: (Objective D.)

When a minority client experiences repeated slights resulting in an inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism is known as:

a. invisible syndrome

b. bias

c. cognitive-dissonance

d. attribution

Answer: a. invisible syndrome. Franklin (1999) is credited with defining the invisible syndrome and how these slights frequently turn into racially adaptive behaviors for African American men as they attempt to manage racism (p. 24). Tovar-Murray and Tovar-Murray (2012) reported that African American men experienced unconnectedness and marginalization with feelings moving from hopelessness to anger. Black churches and barbershops were safe havens for community resources.

Question 2-8; (Objective E)

The major factor when oppression is evident:

a. power

b. privilege

c. empowerment

d. racism

Answer: a. power

Question 2-9: (Objective F)

Cited as avoidance factors in seeking to counsel include all except:

a. treatment fears

b. referral fears

c. social stigma

d. fear of emotion

Answer: b. referral fears

Question 2-10: (Objective G)

A positive outcome for a counselor to recognize the influence of his/her spirituality in clinical practice is:

a. commitment to a religion

b. self-care

c. appraisal of the client's religion

d. skills acquired in a spiritual study

Answer: b. self-care

Question 2-11: (Objective H.)

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 the above.

Answer: d. all the above

Question 2-12: (Objective H.)

All methods are helpful to eliminate oppression and barriers for equal treatment except?

a. public demonstration

b. seeking public office

c. an editorial initiative

d. supporting existing alliances

Answer: b. seeking public office

Question 2-13 (Objective H)

_____refers to the counselor's invitation for a client of diversity to explore issues of diversity?

a. broaching

b. open-ended

c. collaboration

d. mimesis

Answer: a. broaching

Question 2-14: (Objective E.)

The purpose in training counselors in the worldview is:

a. that today many clients are from a variety of countries throughout the world.

b. the advances in technology and Internet access demand counselors to have this knowledge.

c. to better assist the counselor in knowing which clients to accept.

d. that it represents the person's values, beliefs, opinions, and assumptions.

Answer: d. that it represents the person's values, beliefs, opinions, and assumptions. Pederson's (2002) definition of the worldview.

Question 2-15: (Objective H.)

Technology and the Internet are recognized acceptable means to conduct self-advocacy for diversity clients and to secure assistance when oppression exists, but this technology may not be available to the poor and minority because:

a. the poor and minority do not ascribe to veto boundaries and ethical guidelines.

b. technology does not address language in equal measures.

c. the problems of the poor do not lend themselves to the type of help that technology or Internet counseling offers.

d. the poor and minority do not have access to the Internet or e-mail communication.

Answer: d. the poor and minority may not have access to the Internet or e-mail communication. According to Hughes (cited in Remley & Herlihy, 2005), approximately 12% of the population with incomes under $15,000 had access to these resources.

Question 2-16: (Objective H.)

A different problem for counselors is to offer services to 'poor' clients, but due to lack of income, they may not be able to pay for counseling. In these circumstances the counselor or agency might consider:

a. securing training interns from a university to counsel those who are unable to pay.

b. to stay in business, they must have paying customers and 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 financially strapped client to the client's religious leader(s) for assistance.

Answer: c. offering pro-bono services. The ACA Ethical Code indicates that professionals have an obligation to give back to the profession. Pro-bono services can be accomplished through some type of ratio with paying clients. Section A.10.b.

Terms

Terms are defined within and at the conclusion of the chapter.

Ableism	Gender Role Conflict
Acculturation	Invisibility Syndrome
Adultism	Marginalization
Androgyny	Micro Invalidation
Broaching	Power Literacy
Classism	Racism
CoBRA	Role Conflict
Correspondent Bias	Role Strain
Counterculture	Set-point Theory
Cultural Encapsulation	Sexism
Culture	Strength-based Model
EMIC	White Privilege (WP)
Enculturation	White Supremacy
Ethnic Group	Xenophobia

Preview Questions

Question 2-17:

A nonverbal communication that examines gestures, movements of the body, limbs, hands, feet, and length of gaze (time) is:

a. paralanguage.

b. proxemics.

c. motor symptoms.

d. kinetics.

Answers: d. kinetics. Kinetics is a study of motion.

Question 2-18:

The geriatric client often experiences the problem of forgetting because of traces of memory decay over time. This type of traces of memory decay is known as:

a. Alzheimer's disease.

b. interference theory.

c. decay theory.

d. fugue.

Answers: c. decay theory. Decay theory is also known as Trace Decay theory and indicates that the memories leave a trace in the brain. Forgetting results may be due to automatic decay or fading of the memory. Short term memory is held for 15 to 30 seconds unless rehearsed.

Question 2-19:

A mixture of male and female characteristics is known as:

a. androgyny.

b. DNA crossing.

c. synesthesia.

d. type C personality.

Answers: a. androgyny. A term associated with Sandra Bem and her Bem Sex-Role Inventory. Bem's inventory identified four gender role orientations: masculine, feminine, androgynous, and undifferentiated.

Question 2-20:

The information we possess regarding an event, the assumed causes we perceive, and the consequences we anticipate are three parts of:

a. operant conditioning.

b. honi phenomenon.

c. cognitive dissonance.

d. attribution theory.

Answers: d. attribution theory. Attribution theory, a theory espoused by Heider, indicates that when we try to explain the behavior of others, we look for internal attributes. When we try to explain our behaviors, we make external attributes that tend to be situational or environmental.

Question 2-21:

The organization which has offered a waystation for the terminally ill to die with dignity and comfort is:

a. iconic.

b. incubus.

c. hospice.

d. thanatology.

Answers: c. hospice. Hospice care is palliative care for the terminally ill. Hospice originated as early as 1065, but later historians note that the Religious Sisters of Charity opened one of the first hospice centers in Dublin, Ireland in 1879. Cicely Saunders created the philosophy of caring for the hospice patient rather than the disease.

Question 2-22:

The belief has been expressed that violent movies, television, books, and football games, like dreams, can allow people to release aggression. This discharge is known as:

a. displacement.

b. catharsis.

c. risky shift phenomenon.

d. deindividuation.

Answers: b. catharsis.

OBJECTIVE 2A: Multicultural and Pluralistic Characteristics

Objective 2a. Multicultural and pluralistic characteristics within and among diverse groups nationally and internationally (CACREP, 2015, p. 10)

Multicultural counseling skills are to become aware of the role of the counselor in respecting the dignity and human rights of individuals. National and international persons representing different worldviews and value systems require the sensitivity extended to others that one would want for oneself. New paradigms for multicultural counseling are at the forefront along with the counselor's charge to conduct a personal review of implicit and explicit values, beliefs, and conduct when interacting with persons of different backgrounds. The counselor is to commit to interpersonal and intrapersonal congruence in philosophy and actions when counseling diverse clients.

Competencies and dimensions of personal identity have been the framework for counselor-based training (Arredondo & Arciniega, 2001). The tripartite model may need to be expanded to include a multicultural dimensional approach for a deeper understanding of an expanding diverse population in global communities. In addition to group diversity populations of African-Americans, Hispanic-Americans, Native-Americans, Asian-Americans, and White Caucasians in the United States a growing population of immigrants (12.5%) was evident by 2014 (Tomlinson-Clarke, 2000, 2013a, b; Tomlinson-Clarke & Clarke, 2013). The census bureau conducts surveys every ten years and estimates the foreign-born immigrant counts are likely to be under-represented. Increasing numbers of Muslin-Americans, Somalia-Americans and other groups are populating the United States, and global understandings go beyond acquiring knowledge and interventions for four dominant diversity groups.

Counselors can better understand developmental experiences of clients through self-reflection and assess competency and commitment for advocacy skills.

Glockshuber (2005) and Minami (2008) reported that the first component of the tripartite model, an awareness understanding of attitudes and beliefs, is critical. Awareness and knowledge of attitudes and beliefs are essential for counselor development. However, attitudes and beliefs are different. A racial-ethnic understanding reflects a high attitude competency. The knowledge component of the model emphasized an understanding of the worldview through cognitive empathy and that there should be a consideration for knowledge and cultural empathy (Tomlinson-Clarke, 2013). Intervention skills, the third component, require selecting techniques and treatments that are dependent on the ability to acquire and utilize cultural awareness and cultural knowledge (Sue & Sue, 2013). In summary, a wellness approach incorporates self-reflection and counselor competencies for understanding differing worldviews through a commitment to continued learning with a built in on-going systematic review.

Advocacy regarding clients, client services, and modeling change at a political level are required action by the profession, counselors, and clients. Gaining necessary skills and acting on ethical behaviors are avenues for new directions.

The effects of physical, emotional, and economic expressions and effects of racism, oppression, injustice, white power and privilege on persons of color are plentiful. Malott and Schaefle (2015) reported adverse effects from a variety of research findings to include:

a. hypertension and altered cardiovascular (Brondolo, Rieppi, Kelly, & Gerin, 2003)
b. poorer self-rated health status (Clark & Gochett, 2006)
c. reduced marital quality (Trail, Goff, Bradbury, & Karney, 2012)
d. multiple manifestations of psychological distress (Moradi & Risco, 2006)
e. depressive and anxiety symptoms (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014)
f. reduced academic performance (Wang & Huguley, 2012)
g. trauma symptoms (Helms, Nicolas, & Green, 2010)
h. disparities in mental health and health care services (Becker, Starrels, Heo, Li, Weiner, & Turner, 2011)
i. housing and school segregation (Farkas, 2003)

OBJECTIVE 2B: Theories-Models of Multicultural Counseling

Objective 2b. theories and models of multicultural counseling, cultural identity development, and social justice and advocacy (CACREP, 2015, p. 10)

Counselors employ theory and intervention strategies and their attitudes toward cultural backgrounds may affect choices in these strategies. Baruth and Manning (2003) suggested that counselors study models of cultural deficiency and cultural differences, genetic deficiency (deficits), cultural deficiency (deficits), culturally different, and approaches such as etic-emic, autoplastic and alloplastic, existentialist, communication (verbal/nonverbal language), lifespan differences, and

intracultural as well as generational differences, sexual orientation, disability, geographical, and socioeconomic differences.

A transtheoretical approach focusing on wisdom for effective multicultural counseling includes culture, context, dialectical thinking, awareness, metacognition, deep interpersonal insight, and advanced empathy. Understanding the approach to wisdom may require an understanding of the different definitions offered by several authors that include cognition, affect, coping skills, insight into the nature of self and others, good judgment, and characteristics of listening, concern for others, maturity, profound psychological understanding of others, high capacity for self-knowledge and awareness, take an overview of problems, and the ability to frame a problem for solution (Hanna et al., 1999). According to these authors, wisdom is composed of dialectical and metacognition functioning. Metacognition, the second component of wisdom, is the ability or skill to 'be aware of being aware' (Pesut, 1990, p. 109).

A distinction these authors make regarding wisdom and intelligence is in the traits and characteristics of each. Wisdom is a concern for the recognition of limits, presuppositions, and origins of knowledge. Intelligence regarding knowledge is a concern for the recall, classification, analysis and application of knowledge. What may be unique to this approach, especially for training, is that wisdom tends to deautomatize habitual thought routines and behaviors whereas intelligence tends to automatize. Characteristics of wisdom include affect and awareness (recognition of affect deautomatization, sagacity) and cognition (dialectical thinking, efficient coping skills, tolerance of ambiguity, perspicacity, problem finding and solving and metacognition). This approach focuses on depth, fluidity, and richness of understanding (Hanna, et al.). The complexity of this method to train counselors for multicultural counseling needs further study.

Dialectical reasoning uses opposing views in thought processes, focuses on the essence of a problem, uses multiple levels of meanings in communication, combines meaning, penetrates interpersonal insight and discernment (perspicacity), recognizes context, and can move from culture to culture without confusion. Knowledge can be transferred from culture to culture. Hanna, Bemark, and Chunk (1999) suggested that dialectical thinking takes place when the counselor can see beyond ethnocentrism to differentiate the limits and assumptions of a cultural mindset, thus begins the process of deautomatize. Caution is recommended with this brief reflection on this newer approach to multicultural counseling without further understanding of the specifics of the introduction.

Question 2-23:
Dialectical thinking or reasoning principles endorse all except:

   a. opposing views in thought processes
   b. cutting to the essence of a problem
   c. multiple levels of meanings in communication
   d. separate meanings rather than combine them

Answer: d. separate meanings rather than combine them. Dialectical reasoning connects or bridges meanings.

Several European therapy models or theories are viewed by some minorities as harmful helping attitudes and are underutilized by minorities (Frey & Roysircar, 2006). The counselor is to develop cultural self-awareness, promote social acceptance and examine beliefs one holds regarding respect and dignity

for all people. When reviewing sensitive cultural models, various authors list specific counselor training that incorporates self-awareness. Roysircar (2009) listed the following culturally sensitive treatment models and some counselor recommendations.

1. Cultural Accommodation Model (CAM) views clients as belonging to three groups
   a. members of humanity and share traits and characteristics with all people
   b. clients perceived in the "group dimension" (race, gender, class)
   c. the client is observed as an individual, separate but distinct from the group
2. Multicultural Relationship Model (MCRM)-counselors are to learn five interpersonal engagements to create a connection:
   a. affective communication
   b. relationship building
   c. diunital/dialectical reasoning
   d. observation of a client's local culture
   e. model management through self-reflexivity
3. Cognitive-Match Model
   a. what is at stake in the client's local social world to determine what is culturally significant to the client
   b. empower the client
   c. utilize family support
4. Racism Acknowledgement Model (RAM)
   a. address oppression, racial identity development, and recognition of various intersecting group identities
5. Accultural Model
   a. play role of adviser, advocate, facilitator of support systems and healing systems
6. Spirituality or Religion Model

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 apply to clients from other cultures (Katz, 1985). Sue (1978a, 1981) described four stages in theory development about multicultural counseling that reveals influences of bias and prejudice:

1. Pathological View of Minorities: Some minorities could never fit into white society.

   Section E.5.c. of the Code of Ethics (ACA, 2014) refers to social prejudices in misdiagnosis and pathologizing of certain individuals and groups and asks counselors to address bias in themselves or others.
2. Genetic Deficiency Model: Cultural minorities are biologically inferior to white
3. Cultural Deficiency Model: The environments of minority members are deviant or inferior.

4. Culturally Different Model: Minorities are not deviant or pathological but must function in two cultures simultaneously. Individuals encounter the stress of stereotyping, racism, and discrimination as part of a minority culture.

Lee, Arnold, House, and Toporek (2003) provide examples of advocacy competencies. The six major areas are client/student empowerment, client/student advocacy, community collaboration, systems advocacy, public information, and social/political advocacy. Within each of the six competency areas are specific actions to be determined.

THEORIES AND MODELS

Racism-Focused Counseling Model

A racism-focused counseling model is an approach to broaching a variety of forms of racial discrimination experienced by diverse client groups of color (Malott & Schaefle, 2015). Cultural competencies are needed skills to become aware of and understand the impact of personal biases, knowledge of client's worldviews, and expertise in interventions to deliver those services. Leach, Aten, Boyer, Strain and Bradshaw (2010) extended the counselor requirements for understanding the developmental processes and complex interactions of sociocultural identities.

The second stage of this model involves selecting a framework pertinent to the racism experienced such as a mental health that is biopsychosocial (interplay of the environment and emotional and social status), feminist perspective (cultural power differentials effect of oppression and marginalization) and trauma-focused (Jones & Smith, 2012).

Stage three involves creating a conversation that is respectful of the degree of ease and comfort a person of color may have in discussing racism experiences. An integrated/congruent broach is recommended to elicit and provide for a comfort level discussion.

Stage four involves creating interventions that target client resiliency strengthened through counselor efforts in exploring and creating a positive meaning and instilling pride in identity status, processing emotional reactions to discrimination (adverse effects), and encouraging positive client involvement with family (Zayas, 2001). Coping strategies include avoidance, emotion-focused, problem-focused, and religion (Brown, Phillips, Abdullah, Vinson, & Robertson, 2011), contextual perspective taking (Guerin, 2005), and trauma-informed care (TIC; Hopper, Bassuk, & Olivet, 2010).

In summary, the model includes counselor multicultural and racial competencies, a framework that recognizes racism's role in the client's concern, eliciting and broaching, cultural formulation interviewing, and interventions designed to enhance identity, coping strategies and skills.

Multi-level Model of Psychotherapy (MLM)

In meeting social justice, human rights, and advocacy for immigrant mental health needs it is important to develop a comprehensive knowledge and intervention of cultural, sociopolitical and historical backgrounds (Bemak & Chung, 2008; Bemak, Chung, & Pederson, 2003; Chung, Bemak, Ortiz, & Sandovalp-Perez, 2008). The Multi-Level Model (MLM) consists of five levels of interventions:

Level 1: Mental health education includes psychoeducation

Level 2: Individual, group, and family counseling

Level 3: Cultural empowerment using social justice advocacy

Level 4: Integration of traditional and Western healing practices

Level 5: Addressing social justice and human rights issues

Developmental Counseling and Therapy (DCT)

The DCT model of treatment includes culture-related issues involving race, ethnicity, gender, sexual orientation, spirituality, racism aggressions regarding adverse effects and other elements of a case formulation, mutual identification or therapeutic goals, and a treatment plan. The relationship is one of equal participation emphasizing an active collaboration in the diagnosis, case formulation, goal development, and a client's liberation (Crethar, Rivera, & Nash, 2008; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). The theory is based on a psychosocial view of the client's distress resulting from environmental insults and a developmental perspective of the presenting complaint. The framework of a case conceptualization is an intrapsychic understanding of the presenting issue. Interventions are based upon the client's current psychological functioning; the role counseling is involved in stimulating the client's mental health and psychological liberation (Ivey et al., 2005).

Earlier Multicultural Counseling Theories

a. theory of multicultural counseling (Sue, Ivey, & Pederson, 1996)

b. social constructionist approach (Gonzales, Biever, & Gardner, 1994)

c. Ho's perspective on internalized culture, culturocentrism, and transcendence (Ho, 1995)

d. Coleman's model an ecosystemic perspective. Six strategies include, (a) assimilate monoculturation, (b) acculturation, (c) alternation, (d) separation, and (e) fusion that individuals may use to cope with cultural diversity (Coleman, 1995)

e. Rameriz's (1988) multicultural model and Locke and Bailey's (2014) model of psychotherapy (Rameriz, 1999)

f. Locke (1993) and Locke and Bailey (2014) model of multicultural understanding

g. Steenbarger's multi-contextual model (1993)

h. racial interaction model of racial identity (Helms, 1990)

IDENTITY MODELS

Racial and Cultural Identity Models

Cross's model was one of the first models to help explain Black identity. Several models have been developed since the Cross model such as Helm's people of color, white identity model, Ponterotto's cultural identity model, Phinney's ethnic identity, and for biracial and multiracial, gender, feminist, sex, lesbian/gay, bisexual, adolescent, and spiritual identities.

Dobbins and Skillings (1991) recognize how Erikson, in his ego formation, saw the importance of identity as the link to one's culture. This identity, individual and group formed, is the "self-knowledge of one's 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 (1971, 1978, 1987). 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 self and culture.

Stage 2: Dissonance – Conflicts about the dominant system, cultural confusion. In fact, this stage is a questioning of one's oppressed identity.

Stage 3: Resistance and Immersion – Self-appreciation and rejection of dominant society. In fact, the person immerses into the oppressed subculture.

Stage 4: Introspection – Evaluates attitude toward dominant society. In fact, the person begins to see the limitations of a devalued sense of self.

Stage 5: Synergetic Articulation and Awareness – Accepts cultural identity. In fact, the person begins to integrate the oppressed part of self into the self-identity.

Question 2-24:
At which of Sue's Minority Identity Model stage would an individual most likely feel that societal forces such as racism and discrimination are against him/her and 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 owns 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 firm 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 coming 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.

Question 2-25:
During the stage of immersion/emersion of the Minority Identity Model, the individual will search for understanding of the ways by which one can benefit from racism?

 a. Conformity

 b. Dissonance

 c. Introspection

 d. Synergetic Articulation and Awareness

Answer: Introspection

White Racial Consciousness Model

Rowe, Bennett, and Atkinson (1994) explain their model as one of two levels and heavily attitudinal. The levels are unachieved and achieved and incorporated within this model are two levels of seven attitudes.

Stage 1: Avoidant – Lack of consideration of one's white identity and avoidance of racial issues

Stage 2: Dependent – Have not considered alternatives to held set of attitudes regarding white racial consciousness currently

Stage 3: Dissonant – An unclear feeling about the certainty about their sense of white consciousness; will take in new information yet lack commitment to the ideas

Stage 4: Dominative – Strong ethnocentric perspective that justifies dominance by majority culture

Stage 5: Conflictive – Opposed to overt discriminatory practices yet opposed to programs aimed at reducing racism

Stage 6: Reactive – Recognize racial discrimination as a significant behavior in American society

Stage 7: Integrative – An integrated sense of Whiteness about racial/ethnic minorities and do not need to be reactive

Social Justice

Demonstration of multicultural/diversity competence in counselor education and training programs is through recruitment of faculty and students of diversity to a program of study. This is a beginning

action statement for social justice. Field placement is the time to act on human rights through academic learning, fairness, and held personal values or positive changes in respect and care for the dignity of each person.

Social justice infers the maintenance of equal rights and fundamental rights as defined by the U.S. Constitution and equitable distribution of resources, profits, and opportunities (Rawls, 1971). Crethar et al. (2008) reported the principles for social justice counseling that included equity, access, participation, and harmony. The counselor-client interactions are based upon the counselor demonstrating social justice core tenets and competencies by inviting clients to participate in decisions that affect their lives, can have the ability to access knowledge, power, resources, and services needed, and gain a sense of social adjustment for the best outcome of services.

The next three paragraphs will be repeated in Unit 4 Career Development because Career-Infused Career Counselling (CICC; Arthur & Collins, 2010, 2011; Collins & Arthur, 2010) advocates for social justice and recommends advocacy training and skill development. The over-arching principle is that the counselor is aware and consistent in acquiring knowledge that social, economic, and political forces do shape career development. An accepting diverse workplace will create an atmosphere where all aspects of the culture are open, and employees can appropriately express their spirituality, political affiliations, sexual orientation, disabilities, gender, ethnic background, age, socioeconomic status, in essence, who they are without fear of discrimination. When these opportunities are not open and available to members of less dominant groups or members of marginal populations, adverse effects are documented in the literature such as conflicts, poorer work performance, isolation, social divisions, and dissatisfaction.

The evolution of CICC is a reflective theory of practice and principles that require a fundamental understanding that culture and career issues shift over time. Presently challenged are past work theories because questions have arisen regarding desired results for diverse populations. Those authors based their theories on a work culture of a constant work role consisting of work for a lifetime in one career path. A principle receiving more attention for counselors, managers, and organizational personnel is the concept that past theories may have become obsolete because of a shift in work constancy and unchallenged assumptions. Those theories are based upon assumptions that are consistent with Western values such as individualism and autonomy, work role, affluence, and progression. Finally, past theories have values with little meaning when compared to values of a collective nature in a work world that is constantly changing (Arthur & Popadiuk, 2010).

Work and work roles are not constant as they are changing (Fouad, 2007). A current social issue is that those in non-dominant positions are unable to exert appropriate power and privilege in self-care for work needs. The oppressed do not experience work and work-related opportunities like others, rather experience racism, sexism, ageism, marginalization and religiously biased forms of discrimination in preparation, training, hiring, promotions and work-related performance (evaluations). Butterfield, Borgen, Amundson, and Eriebach (2010) conducted an exploratory study in what helped and hindered workers and found that the environment, organizations, and management style did not prepare workers for change, an ability to meet change, to maintain an even keel in the face of change, and therefore experienced difficulty handling change when change is thrust upon them

CICC emphases principles for self-awareness, awareness of the cultures of other people, and an awareness of the influences of culture on the working alliance. The first principle relates to diversity for

individuals outside the dominant culture because of ethnicity, gender, religion, marginalization, abilities, sexual orientation, age, and, for some, social class as second-class status. Those with more than one of non-dominant identity have experienced multiple issues and difficulties in engaging, establishing, positioning, and advancing in work-related roles. Once a person of a diverse culture is in the work organization, hindering factors set the stage for detachment and feelings of exhaustion due to isolation and none integration that promotes discrimination and cultural assumptions

Three domains guide the counselor in meeting competencies of social justice and social barriers. The first is an increasing awareness of his/her cultural identity. The second domain is an awareness of the client's cultural identities. The third domain is to establish an effective cultural working alliance with clients. Purposeful selection of interventions based upon an understanding of systemic and social influences is intended to empower the client to go beyond adapting and coping with barriers but also for adjustment and acceptance in academic, social, and occupational work environment (Arthur, 2008).

OBJECTIVE 2C: MULTICULTURAL COMPETENCIES

Objective 2c: multicultural counseling competencies (CACREP, 2015, p. 10)

Preparation for counseling with diverse clients includes achieving self-awareness regarding one's beliefs and attitudes toward individuals that are different than oneself (Section A: An introduction, A.2.c. A.4.a., imposing values, A. 4.b., values, B.1.a., client rights, and 5.5.b., cultural sensitivity to problems identified and experienced and socioeconomics.

Culture is a behavior, shared knowledge and values, ethnicity and nationality, worldview, and underlying philosophical constructs. Patrick (2007, p. 54) illustrated the need to examine the philosophical constructs of ontological (nature of reality), epistemology (knowledge), cosmological (order) and axiological (values) for a fuller definition of culture. Another perspective is to understand the culture from a universal approach interpreting culture from the etic-emic debate. Etic is an approach that believes humans are similar whereas emic approach studies culture for specific characteristics and behaviors within groups. Another method is within-group differences versus between-group differences.

The tripartite model of awareness encourages counselors to become aware of different client worldviews, so that applied interventions are agreed upon, interviewing is based on a clarified interpretation and understanding, counselor attitudes and beliefs are dealt with through a self-reflection assessment. Worldviews of language, cultural values, perceptions of presenting causes, and counselor-client communication are to be in union with client involvement.

Sue, Arredondo, and McDavis (1992) defined 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. Axelson (1993) defined 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 static configurations identified in the cultures of counselor and client" (p. 13). Ivey, Bradford-Ivey, and Simek-Morgan (1993) described 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) delineated, as does Ivey et al. (1993) that there are two trends. First is the universe approach, which implies that every session contains multicultural issues, while the second approach is geared toward a more culture-specific understanding. Finally, a counselor needs to understand identity development of the culture of the client throughout life-span development.

Multicultural counseling is further defined by how counselors demonstrate cultural competence. Caldwell et al. (2008) surveyed 99 service providers for their definition of multicultural competence. The outcome of Caldwell's study yielded six themes for multicultural competencies: client focused (reflected participant's focus on the clients' culture without factoring in their own cultural identity), acknowledgment of cultural differences (understanding the client's culture, awareness of cultural differences, awareness of culture, and respect), textbook consistent (participant's recognition of the need for knowledge and awareness of client characteristics), resource driven (willingness to seek and utilize community resources), skills-based (empathy and understanding), and self-integration (cultural worldview, self-awareness, and knowledge base were key components).

There does not appear to be a consistent definition of multicultural competence in the literature. ACA stated that if counselors provide services to clients, the counselor was to be knowledgeable, have acquired skills and reviewed self-attitudes. The definition has expanded to add three domains to include counselor awareness of own assumptions, values, and biases; understanding the worldview of the culturally different client and developing appropriate intervention strategies and techniques. Constantine and Ladany (2001) identified six dimensions of competence:

1. self-awareness
2. general multicultural knowledge
3. multicultural counseling self-efficacy
4. ability to understand unique client variables
5. effective counseling alliance
6. multicultural counseling skills.

Sue et al. (1992) stated a culturally competent counselor is one who is self-aware of values and biases, understands client worldviews and intervenes in a culturally appropriate manner. Sue's model describes a competent multicultural counselor to be accountable for knowledge, skills, attitude and beliefs.

Question: 2-26:
The logic a counselor might hold in understanding culture from a universal perspective practicing an etic approach would be:

a. clients are more similar than dissimilar.
b. traditional mental health services do not meet the needs of ethnic minority clients.
c. that treating clients of all cultures is to treat behaviors and issues related to those presenting behaviors.
d. clients are living in an integrated society and change requires accommodating to the larger culture.

Answer: a. clients are more alike than dissimilar. Sue's (1977) research points out that traditional counseling services do not meet minority needs.

Cross-cultural counseling includes culture, class, ethnicity, and language differences; differences in cognitive styles; problems of identity; various forms of oppressions and biases, and the acculturation of various subcultural groups (Copeland, 1983).

Multicultural competence begins with a definition of bias. According to Boysen (2009), a definition of bias has expanded to include implicit and explicit bias definitions from the writings of Greenwald and Banaji (1995) and Greenwald, McGhee, and Schwartz (1998). Explicit bias is a conscious and intentional self-report. Implicit bias is covert without conscious intention and not self-reported. Explicit bias is the easier to detect as this form is intentional, the behavior is overt, and the message is sent verbally, non-verbally, physically and through a combination of group behaviors. A person conveys verbal or non-verbal implicit biases in acquired values within the family, cultural group or the larger society desirability and below the surface of awareness. These types of biases are not only for people in general but also for counselors, service providers, and clients representing diversity and for minority group members toward other minority groups and the majority culture. Furr and Funder (1998) researched personal negativity and personal biases. The results of their study suggested that people who are optimistically negative have a tendency for:

a. a desire for personal control.
b. egocentric thinking.
c. selective comparisons with others who are less fortunate or more at risk than oneself.
d. positive illusions.
e. the availability of personal examples.
f. a desire to enhance or protect self-esteem.
g. a desire to make downward social comparisons.

Helweg-Larsen and Sheppard (2001, 2002) further refined this data and found that an optimistic bias is a result of negative affect, perceived control and characteristics of the comparison situation appear to influence the optimistic bias consistently.

The continued development of self-knowledge allows the counselor to understand and appreciate others. Each counselor begins with understanding his/her ethnicity, culture, and race and then how this understanding affects oneself and others. Dobbins and Skillings (1991) provided some of the following definitions as to how individual and societal concerns are expressed and experienced. When the meaning of those terms is to inflict oppression, racism, or prejudice the counselor is to be sensitive and employ skill sets to provide the client an opportunity to express and work toward a resolution. Understanding the meaning of terms, especially those a part of the client's race or culture is important. Following are some terms:

Acculturation "is the degree to which immigrants identify with and conform to a new culture of a different society, or the extent to which they integrate new cultural values into their value system" (Phinney, 1990). Four models of acculturation include assimilation, separation, integration, and marginalization (Hays & Erford, 2010, p. 18 for interpretive meanings for the different models).

Acculturation refers to the socialization influences and how one's racial identity is practiced (Hays & Erford, 2010).

Ageism is the belief and practice that the primary determinant of a human characteristic is that one age is better than another age. The inference is that discrimination is apparent when one age group has higher vulnerability and less access to resources and power than another group (Hays & Erford, 2010).

Bias "is a tendency or inclination in the form of preference given that other points of consideration have been taken into account" (p. 41).

Broaching the subject of race, ethnicity, and culture is a starting point for the counselor and client. Due to the sensitivity of discrimination experienced by people of color the counselor is to be respectful and sensitive to any affront that might be a consequence of a direct request. The counselor is to use appropriate advanced levels of communication when using broaching. Daly-Vines et al. (2007) recommended that the counselor consider how sociopolitical factors affect and influence the client's counseling concerns. Cultural meanings, terminology (language), and the perceived cause of the concern require elaborations for the counselor to fully understand a client's different background. The ability to translate meanings is a combined effort to develop the relationship. The client can inform the meanings, understandings, and knowledge necessary to reduce discomfort and reveal mutual respect through the counselor's receptivity. Day-Vines outlined a competency-based broaching continuum to develop and invite exploration of diversity issues in a consistent and ongoing attitude of openness with a genuine commitment by the counselor. Significant to increasing the level of broaching is to understand the impact communication has with a client raised in a different culture and with a different set of values. Implications can be further complicated when there is a lack of understanding or acceptance of the person's identity development. Broaching styles continuum reflect increasing openness with attitude following the style.

The conceptual broaching model level and attitudes (behaviors) includes:

a. avoidant: a race-neutral perspective maintaining issues related to race warrant little attention
b. disintegration-first acknowledgment of white identity, conflict results
c. reintegration-idealizes whites, assumes original stereotypes
d. pseudo-independence-intellectualized acceptance of own and others' race
e. immersion/emersion-honest appraisal of racism
f. autonomy-internalizes a multicultural identity, infusing broaching style (p. 407)

Classism "consists of attitudes and beliefs to maintain a social class. Classism is accomplished through marginalization to feel comfortable in one's social class (Liu, 2011, 2012)." Liu (2012) defined upward, downward, lateral, and internalized classism. Downward classism refers to "negative attitudes or behaviors of individuals who are in power or a higher social class and are used to marginalize and discriminate against those perceived to be in a lesser class." Upward classism is the "prejudice and discrimination that occurs against those who are perceived to be in a higher social class" (Liu, 2011, p. 200). Lateral classism happens "when individuals evaluate themselves based on what other people within the social class have and do (p. 86)." Internalized classism includes feelings of anxiety, depression, anger, and frustration arising from not being able to maintain one's social class standing. Liu reported that internalized racism is dependent on the other three forms. Colbow et al. (2016) reported that classism

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beliefs and practices developed as a result of institutionalized practices taught and practiced involving racism, sexism, Protestant work ethic, materialism, and life satisfaction (psychological social well-being).

Cultural switching is the bilingual influence that has opened pathways for legitimacy and deviance. Cultural competence is allowing for the ability to be knowledgeable and to function in two cultures as for an Asian-American when in Asia having a strong sense of identity and while in America having an American sense of identity.

Ethnocentrism "is a positive bias for one's ethnicity as well as a possible prejudice about others" (p. 41).

Invincible Syndrome and Cultural Switching

Franklin (1999) introduced the term invisible syndrome that refers to repeated racial slights that may manifest into racially adaptive behaviors. The syndrome is an inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism.

Microaggression:

Sue, Capodilupo, and Holder (2008) defined racial microaggressions as brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, negative racial slights and insults to the target person. Three forms of microassaults, microinsults, and microinvalidations are:

1. Microassaults: overt forms-avoidant-conscious of discrimination and unintentionally hurt the assaulted person. Example: a white woman is walking toward a black man and crosses the street to another side. Avoiding or passing near the black men may represent her stereotype about black people that they are dangerous or criminal.
2. Microinsults: rude or insensitive behaviors-degrade a person's racial heritage or identity. Example: telling Asian American woman that "she speaks good English" although she is born in America. Or saying "Mexicans are good brickers," or a clerk follows a black person around the store (criminality).
3. Microinvalidations: negates or denies the thoughts, feelings, or experiences of a people of color. A white person tells a person of color "Racism doesn't exist anymore."

A study by Nadal, Escobar, Prado, David and Haynes (2012) identified 13 categories of microaggressions. Two categories matched for Black Americans (assumption of criminality or deviance, and inferior status or intellect) and five were new (use of racist language, the assumption of Filipino stereotypes, exclusion from the Asian-American community, the assumption of universal Filipino experience, and mistaken identity). Six of the themes were experienced by Asian Americans such as:

a) alien in one's land
b) second-class citizen
c) invalidation of inter-ethnic differences
d) eroticization and sexualization of women and demasculinization of men

e) pathologizing of cultural values and behaviors

f) invisibility and lack of knowledge of Filipino Americans

Nadal, Whitman, Davis, Frazo, and Davidoff (2016) conducted an extensive literature review that focused on the negative impact of microaggression experienced by gay, lesbian, bisexual, transgender, queer, and gender queer people between 2010 and 2015 and found 35 peer-reviewed papers or dissertations. Nadal et al. (2010) reported eight themes experienced by this population of individuals that included:

a. use of heterosexist or transphobic terminology (slurs)

b. endorsement of heteronormative or gender-conforming culture/behaviors

c. the assumption of universal LGBTQ experiences

d. exoticization (fetishized or dehumanized)

e. discomfort/disapproval of the LGBTQ experience

f. denial of the reality of heterosexism/transphobia (that does not exist)

g. the assumption of sexual pathology/abnormality

h. denial of individual heterosexism/transphobia

In summary, Pierce, Carew, Pierce-Gonzalez, and Willis (1978) stated that microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color:"(p. 271).

Racism: Jones (1997) identified three forms of racism, individual (examples are overt racial slurs and hate crime), institutional (social systems), and cultural (dominant culture is considered superior). Racism "combines the preference for a given group of people with contempt for different groups (p. 41)." Dobbins and Skillings included 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 (Webster, 1981) and states that racism is composed of an assumption that traits and skills 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, 2005), unintentional racism can manifest itself in the following ways:

1. avoiding cultural differences and assume all are alike

2. color conscious and a tendency to attribute a problem to cultural background

3. ignoring or blinded by one's countertransference

4. co-dependency relationships with clients out of a need to be needed

5. misunderstanding defensive reactions to stereotypical thinking

6. failure to learn a client's cultural way of communicating (as cited in Remley & Herlihy, 2005, p. 53)

What is important for the counselors working with diverse groups is to recognize when providing treatment is to incorporate or be aware of these forms of direct and indirect forms of insults, adverse effects, and to enlist the client to share with the counselor those unrecognized. Counselors should recognize that many of the traditional European treatments applied to people of diversity have not been appropriate therefore recommended are training access and use of more culture sensitive models.

Competency standards of the ACA Code of Ethics (C.2., C.2.a) emphasize that counselors gain knowledge, personal awareness, sensitivity, and skills pertinent to working with a diverse client population. Of importance is to learn historical experiences that have influenced the culture, family values, and experiences, personality, identity development and use of mental health service.

Several CACREP objectives address strategies and support advocating for diverse populations. Advocating for individuals, couples, family, groups, and community members require social justice and advocating for the rights and dignity of all people. The ACA Code of Ethics (A.7.a., A.7.b.) documents mental health issues, injustices, and counselor competencies regarding how to speak for clients as well for groups of individuals.

Arredondo, Tovar-Blank, and Parham (2009) outlined the evolution and trends of multicultural counseling and the development of counselor competencies. A brief summary includes significant contributions and efforts to promote and develop the awareness of injustices diversity clients experience daily. The combined efforts of counseling professionals set in motion the need to develop counselor standards and guidelines, advocacy competencies standards, and worldview training. Arredondo et al. (2009) outlined previous historical efforts in focusing the profession's need to develop a systematic set of changes in the status quo. Mental health professionals united in creating a systematic set of guidelines for advocacy, constructive confrontation, and for a self-directed and collective leadership (p. 261). Historically, Arredondo listed areas of development and specific innovations that include:

1. leadership development in culture-specific organizations
    a. formation of Association of Non-White Concerns (ANWC) evolving into Association of Multicultural Counseling and Development (AMCD)
2. multicultural counseling competencies (MCC) to respond to cultural misunderstandings in counseling relationships, language differences, class-bound values, and culture-bound values (Sue, 1977)
    a. Internal-external locus of control (IE-EC) and internal and external locus of responsibility (IE-ER). Sue's contributions emanating from this work reflected skill sets needed for counselors to recognize and respond to multicultural issues of privilege for some clients and disenfranchisement for others, the power of cultural beliefs, and the historical and social factors worldviews (Sue, 1978 c). These issues reinforced cultural competencies and awareness of biases/assumptions and a client's worldview.
    b. Triad Model is designed to desensitize counselors-in-training who do not share the same cultural background as their client and to become aware through training of cultural, ethnic, and racial differences existing between the counselor and client (Pederson, 1988)
    c. White and Parham (1999) urged the profession and counselors to develop a culture-specific therapeutic knowledge base in providing services for people of color. White reported the characteristics of the impact of oppression, lack of cultural worldview knowledge and that values were a source of strength, language styles and cultural adaptation, and the influence of an identity status.
    d. The landmark identity model was the 1975 Cross Model renamed to the Racial/Cultural Identity Development Model that provided the framework of multicultural competencies (Sue & Sue, 2003).
3. formation of multicultural competency landmarks

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a. Sue et al. (1992) developed ten competencies as the groundwork for the development of 31 counselor competencies in three areas: (1) counselor awareness of biases and assumptions, (2) counselor awareness of the client's worldview, and (3) culturally appropriate interventions and strategies.

4. personal and professional resistance

a. multicultural and feminist clients experience biases regarding individual rights and equal distribution of resources and opportunities because of xenophobia, privilege, unexamined privilege, and pseudointellectual resistance stemming from immigration of foreigners, terrorism, unintentional classist, racist, and sexist behaviors, culturally uninformed perspectives, heuristic practice, and other forms of oppression.

Arredondo et al. (2009) summarized historical events and identified trends that included combined efforts by the profession and counselors to meet the continuing and evolving multicultural needs. Significant areas to guide this development included understanding oppression, injustice, dignity, and respect across multiple-heritage populations, importance of client religious and spiritual values, global immigration, natural disasters, global warming, poverty, and national forces.

Multicultural feminist issues include social injustice, racism, and oppression. Social justice recognizes that oppression impinges on individual rights, freedom for all, equity, access, harmony, and full participation in those human rights. Women experience the same types of oppression as the client of color and deserve the same equal rights that are often denied (Arredondo & Perez, 2003; Crethar et al., 2008).

Theory development has expanded to provide frameworks in developing a system in which to exercise and provide for multicultural competencies regarding social justice. The Relational-Cultural Theory promoted by Jean Baker Miller through her well-being research emphasized the importance of a relational stance related to sex role, socialization, power, dominance, marginalization, and subordination and how those behaviors affect mental health.

Multicultural Skills

The counselor role when serving diverse clients is to maintain awareness and sensitivity regarding the cultural meaning of confidentiality and privacy (B.1.a.). The counselor is to respect differencing views regarding disclosures and who has access to shared material.

Preparation for counseling with diverse clients includes achieving self-awareness in relation to self and others regarding one's beliefs and attitudes toward individuals who are different from oneself (Section A introduction, A.2.c., A.4.a., imposing values, A. 4.b.,values, B.1.a., client rights, and 5.5.b., cultural sensitivity to problems identified and experienced and socioeconomics.

A recent advancement in cultural competencies is the development of methods to measure counselor competence. Several instruments provide multicultural feedback for awareness, knowledge, and skills. Instruments include:

a. Cross-Cultural Counseling Inventory-Revised (LaFromboise, Coleman, & Hernandez 1991)

b. Multicultural Counseling Awareness Scale-B (Ponterotto et al.,1996; Ponterotto et al., 2002; Ponterotto, Sanchez, & Magids, 1991)

c. Multicultural Awareness, Knowledge Skills Survey-Counselor Edition-Revised (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003)

d. Multicultural Assessment Survey Form I (MCAS, D'Andrea, 2004, 2008)

The development of these instruments provides a means for the counselor to become aware of the skill set and to learn to deepen and expand the competencies to help all clients especially those experiencing oppression, discrimination, marginalization, and racism.

Cultural Formulation Interview (CFI)

The Cultural Formulation Interview (CFI) was included in the DSM-5 to assist counselors in communicating with clients of culture (APA, 2013). The interview design is to train counselors in how to effectively invite (broach) the client to express areas of distress fully. Three components are central to this interview process. The three elements are cultural syndromes (clusters of symptoms and attributes), cultural idioms of distress (ways of expressing distress-terms), and cultural explanations (client's perceived causes for the distress). The CFI provides attention to the values, orientations, knowledge, and practices from specific diversity groups, individual backgrounds and experiences, and influences of family, friends, and the community of the client (p. 750).

Worldview

Before culturally sensitive models emerged, ACA recommended that counselors be accountable for three tasks when providing services to diverse client backgrounds or identity. The first is to acquire the information that is pertinent for a client of cultural diversity. Second is training in theories, techniques, and strategies used for client care or treatment. The third is to review one's attitude regarding a cultural group that is different than from that of the counselor. From an informational viewpoint, Sodowsky and Johnson (1994) defined worldview as one's input shared by members of one's reference group. The data consist of individual experiences, moral, social, religious, educational, sociological, economic, and political meanings and understandings. Sue's definition of worldview was the way in which an individual perceives how he or she relates (relationship) to the world. Sue incorporated into the worldview Rotter's (1975) internal and external locus of control. In further developing the worldview Sue added the dimension of responsibility to the internal and external locus of control (Sue, 1978 b, c).

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's (1991) model of the worldview was based on the earlier work of Kluckhohn's values identity model. Ibrahim's model was based on human nature, social relationships, nature, time orientation, and activity orientation. More specifically, the model is divided into dimensions, which will assist in surfacing the ethnicity, culture, gender, age, life stage, socioeconomic status, education, religion, and philosophy of life, beliefs, values, and assumptions. The model components were 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 is assimilated and to what degree acculturation has taken place. These scales include (Ibrahim, 1991):

1. Human nature: good, bad, or a combination
2. Social relationship: lineal-hierarchical, collateral-mutual, individualistic
3. Nature: subjugate and control, Live in harmony, accept power and control
4. Time orientation: past-present-future oriented
5. Activity orientation: being, being-in-becoming, and doing

A brief example of this model for African-American women developed by Jackson and Sears (1992) includes:

1. Human nature: view people as good and bad
2. Social relationship: group and interpersonal
3. Nature: live in harmony (oneness)
4. Time orientation: past and present
5. Activity orientation: being

Each of the five scales will expand on the actual behaviors to determine if the individual adheres to the cultural givens. In either situation, the person expresses how these practices cause issues. Addressing the identity model provides an understanding of the ethnic and cultural identification along with assimilation and acculturation.

OBJECTIVE 2D: IMPACT ON SELF AND OTHERS

Objective 2d. the impact of heritage, attitudes, beliefs, understandings, and acculturative experiences on an individual's views of others (CACREP, 2015, p.10)

Counseling with Select Minority Populations

Counselors interact with others from a needs-based perspective regarding their acquired perception, learning, value system, religious or spiritual beliefs and attitudes. Clients seeking to counsel because of racism, discrimination, bias, oppression, microaggression, and race-related issues have encountered race-related events and resulting health-related outcomes (Crusto, Dantzler, Roberts, & Hooper, 2015). In these instances, information regarding these incidents become the counseling issue of impact. Race-related incidents affect physical and mental health outcomes (Ford, 2008). Waelde et al. (2010) reviewed the Race-Related Event Scale (RES; developed by Waelde) a brief screening measure for stressful and potentially traumatizing race-related experiences. The RES contains 22 different types of events. Four cultural and heritage groups and gender are included to develop a sense of the breadth of learning and acceptance for working with diverse clients.

When counseling with minority populations, it is important that counselors ethically integrate professional ethics with personal values. When a counselor utilizes a decision-making strategy to conduct

this process to understand and implement their resolve, it will be easier to acculturate and broach with minority clients.

Ametrano (2014) referenced four strategies from the combined work of Handelsman, Gottlieb, and Knapp (2005) and Berry (2003). These models are marginalization, separation, assimilation, and integration. Each model or strategy has a high and low identification with the culture of origin and with a new professional culture. Marginalization occurs when the counselor has limited awareness or understanding regarding ethical issues that are a part of the client's case. A separation strategy occurs when the counselor has a well-developed personal moral sense but does not identify with the values of the profession. A strategy of assimilation takes place when there is a full acceptance of the new culture's values and discards values of their culture of origin. An integration strategy is an adoption of the new profession's values while maintaining essential components of the counselor's personal values (Ametrano, 2014, Berry, 2003; Handelsman et al., 2005).

The counselor's integration of professional ethics and personal values along with the DSM-5™'s new emphasis regarding interviewing clients of culture will advocate for client understanding and care. The DSM-5™ points out the importance to interview for cultural syndromes, idiom, cultural explanation or perceived cause (as a label, attribution, or feature of an explanatory belief of a presenting complaint) and folk classification of a disease that is often used by laypersons or healers (APA, 2013, p. 14).

Located on-line are helpful interview versions referred to as the cultural formulation interview (CFI) to guide an interviewer with instructions that focus on cultural definitions of the problem, cultural perceptions of cause, context (support, stressors and supports, role of cultural identity), factors influencing self-coping and past help seeking (self-coping, past help-seeking, barriers) and factors influencing cultural factors affecting current help seeking (preferences, clinician-patient relationship).

Broaching behavior refers to "a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (Day-Vines et al., 2007). An invitation would openly indicate that the counselor and client are from different cultural and ethnic backgrounds and asks if the client is open to working with someone from a different culture (identify culture). The suggesting of broaching has literature support reflecting that counselors who do broach are viewed by clients of color as being credible (Atkinson, Casas & Abreu, 1992; Day-Vines et al., 2007). The race has biological connotations, and ethnicity refers to groups in which members share a cultural heritage and culture is an integrated pattern of behaviors that includes communication, action, customs, beliefs, values and instructions of a racial, ethnic, religious or social group (Leighton, 1982).

The Multicultural Counseling Competency Model standards indicate that counselors display competencies in a) awareness of personal assumptions; values and biases; b) worldview understanding of culturally diverse clients; and c) develop appropriate interventions.

Day-Vines et al. (2007) identified five broaching styles:

1. avoidant (race neutral)
2. isolating (no approach)
3. continuing/incongruent (explore presenting problem and issues of race)
4. integrated/congruent (approaches the race, ethnicity and culture and incorporates the counselor's behavior into his/her identity)

5. infusing along with counselor interpretations, behaviors, and applications (a way of being and do not broach because it is expected of them rather than who they are.

These authors have developed a broaching and racial identity development model. Unique within this model are the same racial identity status terms (contact, disintegration, reintegration, pseudo-independence, immersion/emersion, and autonomy), description of ethnic identity functioning, and attitudes toward broaching.

The following are general characteristics of specific minority populations. Avoiding stereotyping individuals based on general assumptions is important. Do not let the following generalities blind the reader to the uniqueness of the individual client. Statistics are subject to change and therefore are only an indication of directions (large or small) at the time of each study. Information for each of the four populations does not reflect all individuals or subgroups of the identified population. As an example, Filipinos are one group of at least 40 Asian-American ethnicities and languages. Caution is recommended when considering differences and similarities as they may exist not only for the 40 ethnicities but also with other populations and ethnicities (Nadal et al., 2012).

NATIVE AMERICANS

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

1. Approximately 2.9 million Native Americans and Alaskan Eskimos currently live in the U.S or Alaska, although at one point the population dropped from 3 million to 600,000 (U.S. Bureau of the Census, 1991, 1992, 2001, 2010). The six largest populations (100,000 or more) or tribes are Cherokee, Navajo, Choctaw, Mexican-American Indian, Chippewa, Sioux, Apache, Blackfeet, Creek, and Iroquois.

2. There are about 252 tribal languages spoken, and approximately 563 federally recognized Native American entities or tribes (Thomason, 1991). Of the 563 tribes or nations 228 are located in Alaska (U.S. Bureau of Census, 2001).

3. According to Atkinson et al. (1993): "For nearly 500 years, American Indians have been fighting a defensive war for their right to freedom, their lands, their organizations, their traditions and beliefs, their way of life, and their very lives. They have experienced massacres by the U.S. Army, have seen the Bureau of Indian Affairs systematically destroy their leadership and way of life, have known promises broken, have had their land taken away from them, and have watched their children die because of inadequate healthcare, poverty, and suicide. By almost every measure of impoverishment and deprivation, the American Indian is the poorest of the poor" (p. 119).

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

1. Holistic philosophy. Everything is connected. Mind, body, and spirit are one process, with little separation between religion, medicine, and daily activity (as opposed to analytical Anglo-American values). All of life is a spiritual process (Lee, 1999; Thomason, 1991). Byrnes (2008) identifies four-valued objects in the universe. These four include God, self, others, and the world.

2. A deep reverence for nature and life. Live in harmony and balance with nature as opposed to subjugating it (Baruth & Manning, 2003).

3. The tribal member may resent a demand for self-disclosure in traditional counseling situations. Some perceive counselor's questions as intrusive or inappropriate.

4. Cooperation, conscious submission of self to the welfare of the tribe (as opposed to competitive striving, achieving orientation of Anglo-American culture). Tribe comes before family (Baruth & Manning, 2003).

5. Reliance on extended family. Families work together to solve problems (Sutton & Broken Nose, 1996). A profound respect for elders.

6. Anonymity, humility valued. Time is not rigidly structured (Thomason, 1991). When in the present it is represented by where you have been and where you are going. Common knowledge of time is when you are ready and when things are completed.

7. Sacred rites involve the land and natural rights on native or reservation lands. Sacred or Holy places are for prayer, visions, and burial grounds.

8. Religion is a belief in a higher power, Great Spirit, a reverence for plants and animals that intermingle with the physical world. The medicine circle.

9. Issues out of balance represent a violation of sacred social or natural customs of the tribe (Locus, 1988).

10. Healing and worship are one in the same (Garrett & Garrett, 2002).

Social and economic concerns: (Atkinson et al., 1993, Russell, 2004)

1. High unemployment rate, 3-11 times national average

2. Median income 25%-50% that of whites

3. High-school dropout rate 48-60%

4. Suicide rate 190% times more than all Americans

5. High levels of drug use

6. Alcoholism double the national average

7. Arrest rates ten times those for whites, three times those for African-Americans

8. High infant-mortality rate

Guidelines for counselors:

1. Open up the issue and invite dialogue for Native-American/white relationships early in therapy. Work toward moving beyond stereotypes to the personal relationship. A genuine interest in identity regarding tribal affiliation can be a source to begin connection or engagement. The counselor may need to depersonalize client's anger toward whites.

2. Show sincere respect, interest, and trustworthiness. Studies have demonstrated that perceived trustworthiness is more important to successful treatment than the ethnic similarity between client and counselor.

3. Use silence as an affirmative act and speak softly. Respect for non-verbal communication.

4. Describe options and suggest solutions. Short-term, historical, action-oriented, problem-focused, directive approaches often are more successful.

5. Seek out exposure to Native American culture and acculturation. Storytelling is rich in the Native American culture and tribal means to pass along their history.

6. Recognize that many Native American clients may feel pulled between traditional tribal culture and mainstream culture (Thomason, 1991).

7. Be familiar with general ideas about healing and medicine from the Native American views of the sacred circle, mind, body, spirit, and natural environment and the number 4.

8. Follow the client's lead regarding the nonverbal behavior (Thomason, 1991).

Worldview

1. Human Nature: Good

2. Social relationship: collateral, extended to the family even though not a blood decedent.

3. Nature: Live in harmony and balance

4. Time orientation: present, one of transition when one knows it is time to begin and when it ends

5. Activity orientation: being, a natural flow of the energy of life, an attitude of to be.

HISPANIC-LATINO AMERICANS

General information: According to Sue and Sue (2008) the term Hispanic is controversial as the term implies the influence of colonialism and ignores American influences on Latino lives. Latinos and Latinas are words that frequently identify a collection of ethnic groups of people who have a similar language and live in the United States (Lee, 1999). The Office of Management and Budget (OMB) required that Hispanic and Latino be used in combination rather than separate categories.

1. The fastest growing ethnic minority in America. During the 1980s, Latino Americans increased five times faster than the nation, reaching 22.3 million (U.S. Bureau of the Census, 1992). The largest groups in number are Mexicans, Puerto Ricans, Cubans, and Caribbean Hispanics/Central and South Americans respectively (Hays & Erford, 2010).

2. The latest 2010 census revealed an increase population of 55.8 million representing 16.3% of the population.

3. Spanish-speaking. Least "Americanized" of the ethnic groups (Zunker, 1990).

4. Have experienced discrimination in the U.S. for many years, thus reducing the group's sense of self-esteem, self-identity, and hope.

Value orientations:

1. Reliance on extended family, therefore often reluctant to use counseling services (Gladding, 2001, 2007). The family is strongly patriarchal and child rearing values of cooperation, as opposed to competition or achievement.

2. Often strong ties to Spanish-speaking country of origin.

3. Religion largely Roman Catholic and religious values include sacrificial living, being charitable to others, enduring wrongs done against them, remaining free from sin, being Christ-like, and placing importance on one's spiritual life, rather than on acquisition of material goods.

4. Cultural values of family, machismo (honor, loyalty, and a code of ethics), spirituality, and personalismo (personal contact and individual interactions) are important.

Guidelines for counselors:

1. Explain the counseling process. Latinos often lack knowledge of the process, despite a high regard for mental-health therapists.

2. Counselors should be aware of meanings for machismo, marianismo, familismo, personalismo, and confianza to understand the connectedness to family, interpersonal relationships, and gender roles (Hays & Erford, 2010). One example is confianza, when translated into English, means trust and confidence central to building a relationship with the counselor.

3. Collateral, build trust as trust issues are paramount, due to a long history of discrimination.

4. Be willing to include the dominant male family member (authority of husband).

5. Be prepared to deal with psychosomatic complaints caused by the unique stresses on Hispanic-Americans.

6. Language issues (switching/bilingual) and acculturation are important.

Worldview

1. Human Nature: Good

2. Social relationship: Extended to the family even though not a blood decedent.

3. Nature: Live in harmony and balance

4. Time orientation: present, one of transition when one knows it is time to begin and when it ends

5. Activity orientation: Being, a natural flow of the energy of life, an attitude of to be.

ASIAN-AMERICANS

General Information:

1. The Asian-American population was 7 million in 1990 and doubled by 2010 (Atkinson, et al., 1993). The 2010 U. S. census data revealed 14.7 million Asian alone (U.S. Census Brief, the Asian population: 2010). There were another 2.6 million with a combination of Asian American alone and other races for a combined total of 17.3 million.

2. The population includes more than 20 different ethnic backgrounds, each with a different language and religion. The majority are Chinese, Japanese, Korean, Filipino, Vietnamese, Cambodian, Laotian, or Samoan. Nadal et al. (2012) indicated there are 40 distinct Asian American ethnicities and some 20 major religions.

3. Probably the most neglected minority. Called the "minority of minorities." Asians are stereotyped as tranquil and well disciplined, with a low incidence of juvenile delinquency, crime, alcoholism, and divorce. The stereotype of the "inscrutable Oriental" makes Asian-Americans less attractive to mental health professionals who seek out YAVIS clients.

4. There are few bilingual counselors to present unique problems to this minority.

5. Cultural frame may be switching

Values orientation:

1. Philosophical orientation is mainly Confucianism. Five ethics are involved: 1) loyalty between Lord and subordinates; 2) intimacy between father and son; 3) propriety between husband and wife; 4) order between elder and junior; 5) trust between friends. The two cultures of Asian and American identities are a cultural influence requiring switching.

2. Most Eastern religions are included, such as Buddhism, Confucianism, Hinduism, Islam, Judaism, Taoism, and Christianity. Buddhism is the most popular religion of Chinese, Koreans, Indochinese,

and Japanese; Shintoism is the national religion of Japanese; Taoism is prevalent among Chinese, Koreans, and Indochinese.

3. Mental illness is regarded as the result of bad blood or sin and will result in "losing face" and ostracism. Problems are usually kept at home until they are out of hand.

4. Time schedules are not accustomed when reporting for treatment. Often expect "first come, first served."

5. Suspicious of "talk therapy." Not likely to discuss problems in marriage, job, school, friends, family, or sex life with the counselor. View questioning by the counselor as a sign of incompetence.

6. Value authority. Often passive or submissive to authority and cultural inhibitions concerning aggressiveness.

7. Collectivistic-value family to include extended family often is a characteristic of influencing (family identity and independence). Respect is highly valued for adults and elders and protecting the honor of the family. Obligation and respect are valued, and the men are the decision-makers in the family.

Guidelines for counselors (Gladding, 2001, 2007):

1. Establish a clear-cut structure for the counseling process. Explain the process to the client.

2. Allow questions about you and the process.

3. Refrain from assessment. Utilize concrete goals, structure and solution-focused approaches

4. Become educated about family and cultural values.

5. Assume authority figure role for short-term therapy.

6. Cultural switching may be a theme for some issues. The bilingual influence has opened pathways for legitimacy and cultural competence allowing for the ability to be knowledgeable and to function in two cultures. When in Asia there is a strong sense of Asian identity and while in America an American sense of identity (Hong, Morris, Chiu, & Benet-Martinez, 2000).

7. Asian Americans may need smaller dosages of medications than Anglo-Americans. Interpret side effects of drugs because the client may understand the possible weakness in the muscles as a deficiency in necessary strength.

8. Use bilingual counselors.

Worldview

1. Human Nature: Good and bad

2. Social relationship: Collectivistic, collateral, extended to the family.

3. Nature: Live in harmony and balance

4. Time orientation: Present

5. Activity orientation: Being-in-doing

AFRICAN-AMERICANS

General information:

1. The 2010 U.S. Census data in two categories (Black alone and Black combined) registered 38.9 million Black alone and 3.1 Black combined for a total of 42 million African Americans.

2. African-Americans are a diverse group displaying a broad range of beliefs (Gladding, 2001 2007). Individual differences make stereotyping harmful.

3. Many white therapists' clients are white; therefore, white therapists have little experience with African-Americans in counseling.

4. African-Americans come from different socioeconomic strata: upper class 10%, middle class 40%; lower class 50%. Sowell (as cited in Axelson, 1993) proposed that black people represent three subgroups. These are: "Free Blacks," "Freed Slaves," and "West Indian immigrants." African American history has a deep-seated history of slavery, abuse, stereotyping, discrimination, servitude, and struggles for freedom, and from oppression, stigmatism, and colorism.

5. Compared to whites, African-Americans are significantly less often the recipients of individual or group psychotherapy. They spend less time in the hospital and are often discharged without a referral. Based on population figures African Americans are pathologized more than any other ethnic group.

Value orientations (Priest, 1991):

a. Emphasis is on the Afrocentric view, that of a collective (family, community) rather than on the individual. The person is validated regarding the others. Extended family provides emotional and psychological support. Failure to include family members can be viewed as alienation by the client.

b. Spirituality and religion are of primary importance (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 there is mistrust of white therapists due to experiences of racism and accompanying emotional and psychological distress.

Guidelines for counselors:

1. Address the realities of oppression, racism, and discrimination. Validate the client's experience of social and economic injustice

2. Engender trust

3. Become aware of personal, cultural perspectives

4. Avoid stereotyping. In selecting a treatment, the primary consideration is the individual client's needs, not ethnicity

5. Goals range from survival/coping in dominant culture to becoming an activist for social change and social justice

6. Franklin (2004) illustrated the effects of the invisibility syndrome and repeated racial slights in light of efforts to maintain a healthy racial identity. Invisibility can lead to psychosocial issues as a result of; (1) Blacks are confused about the supportive efforts of individual Whites versus the destructive actions by Whites as a collective use, (2) Blacks are confused about whether they are being accepted, and (3) Blacks are confused about when, where, and how to adapt to racism" (p. 768). As a result, there may be a link between invisibility and how African American men's low sense of self-worth stems from the racial slights (Franklin & Boyd-Franklin, 2000).

Worldview

1. Human Nature: Good

2. Social relationship: Collateral or collective, kinship, and affiliation extended to the family even though not a blood decedent.

3. Nature: Live in harmony

4. Time orientation: Present and flexible

5. Activity orientation: Being

Question 2-27:

All 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 is working in a counseling center in Japan.

d. The Anglo-American therapist is offering to counsel to international exchange students at an American college.

Answer: b. Caucasian Jewish therapist and a Caucasian Southern Baptist client. If the presenting concern is not a spiritual or religious issue, individuals representing the same culture frequently follow different religions and may lack an issue in treatment.

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 counseling issues for those in counseling roles.

Identity Formation and Status

James Marcia had made major contributions to the field of identity through his research on identity status. Marcia believed 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 a person avoids the crises of choice and 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 promises have been made which were likely forced by the parents (usually middle adolescence)

Identity Moratorium: Several crises experienced, but no promises made (usually middle adolescence)

Identity Achievement: Several crises experienced, and commitments have been made (usually late adolescence)

Self-Image

A major developmental task for young adolescents is forming a new self-image. Characteristics of a self-image include but are not limited to:

1. Competence

    Research emphasizes that girls are concerned about appearing too bright or intelligent.

2. Self-concept or Self-esteem

    How the person perceives himself/herself and receives feedback. The self-concept is often acted out in some of the following ways:

    a. Girls are socially more competent, make friends easier, share their feelings, grades are higher than boys, see mistakes as their inadequacies, spend more time on homework, are afraid of success, less pleased about being female, feel less able and competent, and less attractive to others when compared to boys.

    b. Boys rate themselves as smart, see mistakes as bad luck, are competitive, share fewer feelings, spend less time on homework than girls

3. Issues which worry girls more than boys

    their looks, school performance, how well other kids like them, how their friends treat them, fear of losing best friends, sexual abuse.

4. Fear of success

    a term coined by Matina Horner describing "a fear of accomplishing one's goals or of succeeding in society's eyes" (Reber, 1985, p. 744)

5. Concerns adolescents face

    Sexual activity, binge drinking, depression, frequent alcohol use, attempted suicide, tobacco use, depression, theft, group fighting, absenteeism, and vandalism.

Cole and Hall (1964) outlined the goals of adolescence to be social and maturational. These are achieving social poise, self-control, constructive expression of emotions, and self-acceptance of sociability.

Question 2-28:
A life-cycle theorist believes which 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 sequential fashion.
    d. Psychological changes are continuous throughout life.

Answer: d. Psychological changes are continuous throughout life. Life-cycle theorists believe life-cycle development is an increasing number of role transitions

Gender Issues: Women

Although both sexes have much in common, recognized is the socialization process that 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 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, Holyroyd, Payton, Rubinstein, Rosenkrantz, Sherman, & Zell, 1978). Sexism most often manifests itself through counselors:

1. supporting traditional sex-role notions that serve to limit choices and options.
2. having lowered expectations of female clients.
3. using psychoanalytic concepts that are sexist (i.e., penis envy).
4. respond to female clients as sex objects (i.e., sexual harassment and sexual abuse).

In addition to overt behaviors, counselors should become sensitive to their gender identity development and how it subtly or not so subtly impacts work with male and female clients (McNamara & Rickard, 1989).

Women's Identity Development

Relationship Models

The limitations of traditional theories, which were often based on research with homogeneous groups of relatively privileged men and reflected Western society's devaluation of women and their unique experiences, gave rise to new feminist theories that emphasized the relational capacities of women and the centrality of relationships in women's identity development. Five of these models, summarized by Enns (1991), are briefly outlined below. The first three are modifications of traditional stage theories of development. The final two models are feminist psychodynamic models. None of these are used as a "blueprint" because of the wide range of individual diversity to be found within the subgroup (Enns, 1991).

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 character elements (Marcia, 1966). Marcia believed that for one to develop an identity, the person must experience a crisis in ideas during childhood. The individual will consider options and then make a commitment and as a result, achieve a clearer identity. If one does not make a commitment, confusion in his/her identity is likely. Marcia believed that a person had two options:

1. to bypass the identity stage (follow or adopt parental standards and values)
2. continue to question and attempt to resolve and make a commitment and investment of self.

Marcia believed that a person might 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: some crises experienced but no commitments made
4. identity achievement: some crises experienced and resolved, permanent commitments made

Josselson (1987) applied these pathways and 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, and it can be an upsetting time for women. They tend to design their lives with the acuity of vision, are responsive to social problems, take risks, are charming, and are aware of the choice.

3. Achievement identity: a flexible, interdependent self-concept based on exploration and testing. These women develop an integration of need for self-assertion and connection. These women separated from their childhood and forged individuated identities and internalized values. They sort through options, develop life plans, are often flexible, open to experience, focus on the internal self and are independent.

4. Identity diffusion: the lowest group in psychological functioning and sophistication. They experience difficulties with intimate relationships and exhibit low ego development. They experience the highest anxiety of the four pathways and have an undifferentiated sex-role orientation. Josselson (1987) developed four subgroups for this pathway:

   a. foreclosed diffusion
   b. moratorium diffusion
   c. severe psychopathology
   d. previous developmental deficits

Spence (as cited in Josselson, 1987) defined a healthy identity associated with achievement, individualism, self-determination, mastery, and personal success.

Women's Ways of Knowing

This model of intellectual development arose from the realization that women do not seem to follow Perry's model that was based primarily on male Harvard University students (Perry, 1970). Belenky, Clinchy, Goldberger, and Tarule (1986) described five positions that women adopt as they approach knowledge. These reflect women's development but are not a linear progression or hierarchy (as cited in Enns, 1991).

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

The Self-In-Relationship Model

Jordan and Surrey (as cited in Enns, 1991) emphasize the positive contribution of the mother-daughter dyad in women's development. The outcome of healthy development is relationship-differentiation, rather than separation-individuation.

Developmental problems are not the result of a failure to separate, but the result of difficulties in remaining connected while establishing a differentiated self-concept. Western culture makes it difficult for women to meet their basic needs for interpersonal relatedness while maintaining a positive sense of self.

1. early emotional attentiveness between mother and daughter
2. mutual empathy and bonding
3. expectation that relationships are a major source of growth
4. mutual empowerment, which encourages maturation within relationships; daughters learn to be both givers and receivers in relationships

Feminist Object Relations

Eichenbaum and Orbach (1983) emphasized how women have internalized father's values that have been conveyed through the mother-daughter relationship. The mother unconsciously projects on her daughter the negative, culturally prescribed feelings that she has about herself. This theory explains how traditional patterns of socialization can be internalized without conscious, overt "teaching" of conventional values and roles.

1. Daughter identifies with mother's care-taking role and develops sensitivity to others' needs.
2. Mother unconsciously rejects daughter's "needy" side and leads her daughter to deny her needs and to give up expectations of being nurtured.
3. Daughter responds to others' needs as a way of dealing with her unmet need to be nurtured while searching for a nurturing relationship to make her feel complete.
4. Outcome: self-sacrificing, lack of sense of self.

Strengths of Relationship Models

1. Affirm previously devalued relational qualities in women.
2. A positive view of relationships in identity formation.

3. Connectedness is viewed as a strength. (Traditional models place a higher value on separateness/autonomy.)

Weaknesses of Relationship Models

1. Emphasis on differences between men and women can create artificial dichotomies that perpetuate inequalities

2. Emphasis on mother/daughter relationship results in "mother blaming" and does not consider how fathers, families, and broader sociopolitical context influence development (Enns, 1991)

3. Can result in over-romanticizing women's long-term caregiving roles and fail to recognize women's achievement needs

4. Lack of emphasis on promoting social change through political activism

Question 2-29:

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. regarding achievement.

d. in context with male associates, father, brother, husband.

Answer: a. in the context of intimate relationships

Models of Androgyny

Collier (1982) and Collier and Collins (2005) recommended 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) presented several models of androgyny for understanding the evolving nature of the dimensions of masculinity and femininity.

1. Conjoint models:

    a. Modulation or balance—both extremes and when both present each tends to modulate the other

    b. Additive widest acceptance—high levels of both

    c. Interactive—combination of masculinity and femininity

2. Developmental:

    a. Kaplan's Hybrid Stage—synthesis and integration of dimensions or qualities such as anger/love, assertiveness/dependency, coexist.

    b. Sex-Role Transcendence—sex role standards become irrelevant in determining behavior.

3. Cognitive Schema theory:

Sandra Bem is perhaps the name most closely associated with androgyny. Her cognitive schema theory views androgyny as a method for processing information; whereas "androgynous persons do not use sex-related connotations as guides in their information processing, and may, in fact, be unaware of sex-appropriate distinctions in a given situation" (Cook, 1985, p. 23).

Bem Sex Role Inventory

Bem developed a scale called the Bem Sex Role Inventory, which measures the extent to which an individual displays traditionally male and female characteristics. Twenty of the items are highly associated with the societal view of masculinity, such as athletic, dominant, and risk-taking, while the other 20 items are more "feminine"-like qualities, such as gentle and yielding. Within the inventory is an androgyny scale. This scale measures to what degree the individual reveals a balance between the traditional male and female characteristics (Reber, 1985).

4. Personality trait model:

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

Question 2-30:

Which of the following androgyny theorists is against gender stereotyping and believes that children's thinking should not be guided by traditional roles for males and females?

a. Kaplan

b. Kohlberg

c. Mussen

d. Bem

Answer: d. Bem. Sandra Bem challenged the traditional idea of a male-female continuum. She believed that a balancing of desirable male and female traits resulted in psychological androgyny. There are two separate dimensions of personality. Therefore, the androgynous person possesses masculine and feminine qualities.

Feminist Identity Model

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

Stage 1: Passive-Acceptance – The female buys into the traditional male-oriented system, accepting all traditional sex roles.

Stage 2: Revelation – A crisis occurs to bring the inconsistencies and discriminations to awareness. Anger and guilt emerge over past passivity. Men are negative and women as positive.

Stage 3: Embeddedness-Emanation – Close emotional ties with other women are developed so that anger can be released in a supportive environment.

Stage 4: Synthesis – An autonomous positive feminist identity is created when personal and feminist values merge.

Stage 5: Active Commitment – A meaningful and efficient 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 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 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 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 personal freedom, responsibility, and self-reliance (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 identity. Both are egalitarian models.

Question 2-31:
An alternative model to Kohlberg's Moral Stages that specifically relates to women was developed by:

    a. Margaret Mead.

    b. Erik Erikson.

    c. Sandra Bem.

    d. Carol Gilligan.

Answer: d. Carol Gilligan. Carol Gilligan charged that Kohlberg's theory was biased, as he utilized an all-male interview database for this theory. Gilligan theorized that girls were reared to be nurturing, empathic, and concerned with the needs of others, and to define their sense of "goodness" in this way.

Gerontological Counseling

People over age 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 difficult to find 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 problems are associated with developmental human growth and others with lifespan experiences.

Developmental Issues

1. Retirement: Older people often struggle with feeling incompetent and underutilized. Very often they are thrust into an environment that removes opportunities to exercise competence and fulfilling achievement needs and, as a result, suffer low self-esteem and feelings of unproductively.

2. Changing Roles: Confusion over age-appropriate behavior and expectations of society is often an issue. Older people suffer from ageism and sexism. The loss of previous roles and significant others can lead to feelings of depression and grief.

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

Relationship Issues

1. Marital Adjustment: Widowers and widows must find new supportive relationships. Friendships may have been underdeveloped.

2. Divorce: Although marital satisfaction is often higher in later life than in earlier stages, divorce is common (Skolnick, 1981). In 1979, 11,000 divorces were granted to people over 65 (Atchley, 1993).

3. Remarriage: Remarriage raises issues around support or lack of support from family members (McKain, 1969; Vinick, 1979).

4. Disabled or Ill Spouse: Taking care of a partner with a long-term illness or disability creates strain and stress in relationships. Resentment often surfaces and is material for counseling (Johnson, 1985). The fear of senile dementia and Alzheimer's disease begins early for some personality types or those who have a family history of these conditions.

5. Sexual Difficulties

   a. Women: Many women experience painful intercourse, lack of an available partner, lingering Victorian concepts prohibiting sexual expression, physical infirmities in the desired partner, inhibited sexual desire, and use of menopause as an excuse for total abstinence.

   b. Men: Performance declines with age, yet sexually active males can remain active into their 80s although some men struggle with impotence.

6. Sandwich Generation: Some consider this time in life as individuals experiencing issues with aging parents, adult children, and grandchildren.

Grief/Loss Issues

1. Physical illness and physical decline

2. Death of spouse and significant others

3. One's death: keen awareness of limited life span

4. Loss of choice

Age-Related Mental Health Issues

1. Depression

2. Suicide. Blazer (as cited in Gintner, 1995) reported that older adults account for 25% of all completed suicides. This is about twice the rate of their presence in society (12%).

3. Neurocognitive Disorders: Delirium, dementia, and depression are common.

   a. Delirium: reduced consciousness, decreased ability to maintain focus, shift attention to outside stimuli, a cognitive disturbance such as memory problem, disorientation, language disturbance and perceptual disturbance.

   b. Dementia: many cognitive symptoms 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 a deficit in higher cognitive functioning such as abstract thinking-planning-organizing.

   c. Depression: depression symptoms include a depressed mood, reflected in somatoform symptom forms, such as sleep disturbances, lack of appetite, and a lack of energy. These physical symptoms, plus bereavement, adjustment disorder, and dysthymia, are clues that depression is a reasonable diagnosis (Gintner, 1995).

Physical, Psychological, and Social Aspects of Aging

Vickers (as cited in Gintner, 1995) indicates that 80% of those over 65 have a chronic physical disease.

1. Physical Aspects (Atchley, 1989, 1993)

   a. The decline in the functioning of the immune system that leads to increased vulnerability to disease.

   b. Loss of capacity for peak performance.

   c. Many declines in physical functioning can be compensated for (i.e., wearing glasses, using a cane, hearing aid, etc.) so that older people can remain actively engaged until well after 75 years of age.

2. Psychological Aspects (Atchley, 1989, 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 to enhance it through intimacy, vocational development, and mentoring activities.

3. Process theories

   a. Identity development occurs as an individual interacts with the environment and subsequently organizes and interprets his or her experience and assigns subjective meanings (Atchley, 1989). Older adults have usually formed stable identities. The reduction in social responsibilities in later adulthood often reduces role conflict and further stabilizes identity (Atchley, 1989). Identity crisis, which results from an extreme change in the individual or environment requires a fundamental reorganization of the self-concept and can happen in later adulthood. Issues are a disability, the death of a spouse, or retirement. Whether an event

leads to an identity crisis depends on the individual's subjective interpretation of the event (Atchley, 1989).

4. Social Aspects (Atchley, 1989, 1993)

   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 function less well in social roles simply because of chronological age.

   b. Age Norms: There are often arbitrary rules about how people of a certain age should behave or how they can act. 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 experience and are denied opportunities to learn more skills and develop new knowledge that would help them remain efficient and integrated into society. For example, senior citizens need basic computer skills which few have the opportunity to learn.

Question 2-32:

As a person ages, she or he can expect to decline in all areas except:

   a. reaction time.

   b. memory.

   c. creativity.

   d. coordination.

Answer: c. creativity. The long-term memory remains much intact, while short-term-memory appears to diminish. Creativity continues as long as the mind can function.

Stages of Death/Grief

Elizabeth Kubler-Ross developed five stages of dying and grief. Kalish (1976, 1985) pointed out that these stages occur with considerable fluctuation and are not necessarily uniform procedures for everyone. 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, 1989).

Stage 1: Denial and Isolation

Stage 2: Anger and Rage

Stage 3: Bargaining

Stage 4: Depression

Stage 5: Acceptance

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:

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Stage 1: The initial awareness of loss—shock, confusion, numbness, detachment, disbelief, and disorientation

Stage 2: Attempts at limiting awareness by holding on—concentrating one's thoughts and emotional energy on the positive aspects of the loss and use of inner resources available

Stage 3: Attempts at limiting awareness by letting go—recognizing one's personal limits to the loss—letting go of unrealistic goals, unwarranted assumptions, and unnecessary illusions

Stage 4: Awareness of the extent of loss—mourning, lonely, helpless, and hopeless

Stage 5: Gaining perspective on the loss—reaching a point of acceptance, discovering balance and realization of the extent and limits of the loss

Stage 6: Resolving the loss—can see and pursue activities unconnected with the loss

Stage 7: Reformulating loss in a context of growth—personal growth of strengths and limits, morality, and finiteness of time.

Stage 8: Transforming loss into new levels of attachment—recognition of a greater capacity for growth, love, joy, and peace, and willingness to help others (Renger, Midyett, Mas, Eri, McDermont, Papenfuss, Eichling, Baker, & Johnson, 2000)

OBJECTIVE 2E POWER AND PRIVILEGE

Objective 2e. the effects of power and privilege for counselors and clients (CACREP, 2015, p. 10)

Power and privilege separately and when exercised together are two factors evident in almost all forms of oppression. Intentional and unintentional expressions of power and privilege have resulted in negative consequences for members of diverse populations. Privilege and power produce an effect where one person or group has unfair advantage by use of excess, control, choice or influence. Negative effects are evident in all forms of racism, marginalization, sexism, heterosexism, classism, ableism, and ageism (Hays & Erford, 2010). Cultural categories most often addressed with oppression and privilege include race/ethnicity, gender, sexual orientation, socioeconomic status, and religion (Hays, Chang, & Decker, 2007).

Privilege is often exercising power resulting in advantage taken. Privilege is a regular and unearned benefit groups in society (McIntosh, 1998, 2006, 2016). Individual and personal relationships regarding social class, gender, race, class, religion, and economics have been privilege taken. Also, white privilege taken is interpreted when white people achieve societal rewards by skin color (McIntosh, 1998). Neville, Worthington, and Spanierman (2001) viewed white privilege as multidimensional operating on micro (individual and group advantages, entitlements, social validations) and macro levels (benefits, right, and immunities, never defend that they are white). Power and privilege are forms of oppression that result in different forms of deprivation. Forms of deprivation are through force (abuse, primary oppression), overt or covert oppressive acts (benefit from or do not object to the privilege or power), by living conditions, stigma, and labels resulting in victims of the physical, emotional, and psychological feeling a sense of

worthlessness. The factors that contribute to the misuse of privilege and power are both internal and external.

Experienced racial micro and macroaggressions (insults, invalidations) are evidence of direct and subtle forms of the adverse effects of power and privilege. Sue et al. (2007) and Sue et al. (2008) reported negative effects for people of color and developed a taxonomy for microaggression that included:

a.   racism detrimentally affects the mental health of Black Americans (ACA, 1999)

b.   counseling may represent cultural oppression for culturally diverse groups (Ridley, 1989, 2005)

c.   high rates of underuse of mental health services and premature termination may be due to individual and institutional bias (Kearney, Draper, & Baron, 2005)

d.   the assumed universality of the Black American experience, the assumed superiority of White cultural values and communication styles, the assumption of criminality, the assumption of inferiority, second-class citizens, and the assumption of inferior status. Several of these themes represent "credentials" and "social class."

Sue and Sue (2008) summarized many of the negative effects of microaggression including (a) often reflect an invisible worldview of White supremacy in otherwise well-intended individuals; (b) are manifested in individuals, institutions, and the U.S. culture; (c) induce enormous psychological distress in people of color; and (d) create disparity in education, employment, and health care (p. 337). A climate of distrust, fear, avoidance, and termination are eventual outcomes because of a non-acceptance prevails due to a lack of respect and empathy. Elements of individual and institutional power and privilege become linked with experienced day-to-day interactions.

OBJECTIVE 2F: HELP-SEEKING BEHAVIORS

Objective 2f. help seeking behaviors of diverse clients (CACREP, 2015, p. A0)

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 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.

School 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. Minority members expressed 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 an unfortunate history in correcting social ills (Sanford, 1969). Sundberg (1981) in his review of the cross-cultural literature found the emphasis on white, middle-class, English-speaking counselors working with Afro-American and Hispanic clients. Displeasures include:

a. 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).

b. Minorities are diagnosed differently and receive less-preferred forms of treatment than do majority clients (Belkin, 1988).

c. Lee (1968) found that psychiatric inpatients with a lower-class status received a diagnosis of mental illness more often than higher socioeconomic residents.

d. Studies show that clinical psychologists confer less favorable diagnoses on female as opposed to male clients (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970).

Schwartz and Feisthamel (2009) researched past mental health service trends for African Americans especially in assessment and utilization of counseling and counselors. Avoiding mental health service due to a disproportionate diagnosis for African Americans when compared to European American clients is common. The data revealed that skepticism and suspicion were evident suggesting that counselors held negative attitudes and a consistent bias. This study of trends supported previous perceptions and behaviors that African Americans were more likely to receive more severe clinical diagnoses of a psychotic, schizophrenia, and childhood disorder than European Americans received.

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 help-seeking and the counseling process for clients of color (Gladding, 2001, 2007; Lee, 1999). This unit specifically addresses issues related to Native Americans (1.3%), Hispanic or Latino-Americans (18.1%), Asian-Americans (5.8%), and African-Americans (13.4%) since these minorities presently make up 38.6 percent of the United States population, making it even more imperative for counselors to be able to understand and address their special needs (U.S. Census, 2018). https://www.census.gov/quickfacts/fact/table/US/PST045218

Reasons cited for clients avoiding or non-seeking counseling appear to be avoidance factors that include:

a. embarrassment

b. sought only after an inability to resolve personal issues as a last resort

c. misunderstood by the counselor

d. a sign of weakness

e. consequences in going to counseling are severe

f. financial difficulties and numerous reasons exist making it difficult for clients of color to seek and maintain a counseling relationship.

Latinos continue to underuse counseling services (Abreu & Sasaki, 2004) when language switching and lack of emotional expression are evident during counseling and may contribute to non-use of mental health services (Ramos-Sanchez, 2007, 2009). Also, the lack of personality depth or refinement may also have an impact on the effectiveness. Vogel, Wester, and Larson (2007) summarized five avoidance factors that included social stigma, treatment fears, fear of emotion, anticipated utility and risks, and self-disclosure. The summarized avoidance factors although lacking research added social stigma and self-esteem as potential barriers. Social stigma judgment is a significant barrier to seeking help. Ang, Lau, Tan, and Lim (2007) and Sibicky and Dovidio (1986) devised a list of avoidance factors to include:

a. fear of being judged negatively (Deane & Chamberlain, 1994)
b. treatment concerns as aversive expectations, treated by the counselor (Kushner & Sher, 1989)
c. fear of discussing emotions, painful (Komiya, Good, & Sherrod, 2000)
d. usefulness, lack of benefit, and risk (Vogel, Wester, Wei, & Boysen, 2005)
e. self-disclosure of personal information and stressful issues (Vogel & Wester, 2003)
f. social norms and an implicit standard close to the person (lacking research; Angermeyer, Matschinger, & Riedel-Heller, 2001)
g. self-esteem, a fear of embarrassment, cost and benefit, feelings of inferiority, incompetency as barriers to seeking help (Nadal, 1991)

Value systems and mores appear to be avoidance factors in seeking help. Vogel and associates reported from several research articles about race and ethnicity and those articles will be condensed to include:

a. African Americans "toughing it out" (Broman, 1996), prefer to handle their problems without displaying signs of distress (Wallace & Constantine, 2005)
b. Asian-Americans value self-control and restraining of feelings (Leong, 1986)
c. Mexican-American youths use family and friends (Offer, Howard, Schonert, & Ostriv, 1991)
d. Japanese-Americans use family and friends (Narikiyo & Kameoka, 1992)

Duncan (2003) reported that African American men underutilized psychological counseling services even though distress signs exist and yet do not seek psychological help. Collectivism and communalism, and Africentric cultural values have been suggested as factors affecting attitudes for avoiding counseling services and African American men may even suppress the intensity of stress and make personal decisions that psychological help is a last resort.

In summary, psychological help-seeking avoidance has no single source or reason rather a combination of factors to include race and ethnicity values based on heritage, age, family, and problem type.

OBJECTIVE 2G: Spiritual Beliefs Impact: Worldview

Objective 2 g. the impact of spiritual beliefs on clients' and counselors' worldview (CACREP, 2015, p. 10)

Sink and Bultsma (2014) briefly reviewed the developmental aspect of religion or spiritual growth of individuals. The counseling literature for adolescent spiritual development is sparse. Developmental theory includes aspects of spiritual growth from different perspectives such as Erikson, Piaget, Kohlberg, Fowler, and Vygotsky. In preparation for a clearer view of the role spirituality is involved in one's worldview requires the sameness or difference attributed to spirituality and religiosity. According to Markstrom, Huey, Stiles, and Krause (2010) religiosity includes adherence to established doctrines and devotion to the higher power and participating in the rituals and practices related to a religious system. Spirituality is a broader theme that includes a search for meaning and purpose in life.

Literature findings suggest benefits for developing adolescents who have a healthy spirituality include facing threatening illnesses and abuse or other traumatic events (Mahoney, 2010). Also, Raftopoulos and Bates (2011) stated that for school-aged children higher levels of spiritual/religious involvement and resiliency are positively associated with overall well-being, prosocial behavior, coping skills, and self-regulatory skills.

Social psychological factors or outcomes include positive elements or qualities of development for incorporating a worldview that contributes to assets that include an existential well-being, present-centeredness (mindfulness), life purpose and satisfaction, meaning-making, and spiritual connectedness. (Fredrickson, 2007; Proctor, Linley, & Maltby, 2010).

Roscoe (2009) summarized the work of several authors' spiritual wellness definitions and characteristics that include:

a. components of spiritual wellness include a religious and spiritual history, life satisfaction, purpose and meaning in life, beliefs about death, and attitudes toward the relational aspects of living (Crose, Nicholas, Gobble, & Frank, 1992)

b. additional components defined spiritual wellness consisting of ten dimensions regarding compliance of the absolute or divine, meaning, connectedness, mystery, sense of freedom, experience-ritual-practice, forgiveness, hope, knowledge-learning, and present-centeredness (Ingersoll, 1998)

c. positive perception of meaning and purpose in life and recognition and acceptance of a unifying force between mind and body (Adams, Bezner, & Steinhardt, 1997)

d. a basic purpose in life and the pursuit of a fulfilling life, give and receive love, joy, and peace, and willingness to help others (Renger et al., 2000)

The Association for Multicultural Counseling and Development created spiritual competencies for spiritual, ethical, and religious values as a guide to assist counselors in practicing with clients expressing a preference for a spiritual component. Religious beliefs are frequently infused in coping strategies and called upon when under stress. Robertson, Smith, Ray, and Jones, (2009) summarized outcome benefits for spiritual beliefs and practice that include:

a. a coping process in a collaborative relationship with a 'God' involving strategies of well-being, self-esteem and life satisfaction and the moderation of pain, anxiety, and depression (Keefe et al., 2001)

b. Keefe also reported that daily practice of religious beliefs is positively related to mental health coping strategies and can facilitate adaptation (Robertson, Smith, Ray, & Jones, 2009)

c. religiously oriented imagery, visualization, and journaling have proven to be beneficial (Cole, 2005)

d. meditation enhances mental and physical functioning (lowering levels of anxiety and higher pain tolerance (Wachholtz & Paragament, 2005)

e. colloquial (meditative prayer is helpful with well-being (Poloma & Pendleton, 1991) and serves as a buffer for excessive worry, anxiety, and self-focused attention (James & Wells, 2003)

f. sacred writings are a source of inspiration, guidance, and insight

There are as many religious or spiritual beliefs as there are religions and much of the counseling literature has focused on efficiently working with the religious issues (Coyle & Lochner, 2011; Crossley & Salter, 2005). Clients may not present religious concerns for fear of the counselor's religious preferences or perceptions. The counselor dynamics may add to the complexity because of the therapist's values, life history, and personality. Blair (2015) researched the spirituality of therapists and how this influenced the therapeutic practice, meaning of the spiritual beliefs, assumptions, and practices during the session. The composition of the study included psychiatrists, psychologists, and counselors. Results revealed that spiritual identity, meditation, and prayer were helpful in becoming calmer and more focused and reported as elements of their self-care. A second finding in working with the client's spirituality gave the therapists an acute awareness of their spirituality (learning from the client). The third significant result was finding harmony between spirituality and broader professional context. Several of the participants found training in therapy was often challenging dependent on the therapeutic orientation and basic philosophy.

Treatment:

Few alternative religion-oriented approaches have been researched therefore the integration of spiritual issues and selecting intervention strategies is difficult.

A religiously oriented cognitive behavioral therapy approach yields positive effects in moderating pain and encouraging healthy religious attitudes for a successful adaptation. Prayer, meditation, and ritual were instrumental in developing hope and meaning in life (Robertson et al., 2009).

Forgiveness is the willingness to give up resentment in the face of another's injustice and in responding with beneficence to the offender even though the offender has no right to the forgiver's moral goodness (Enright, 2012). Anger is usually associated with the offense. The Enright Process Model of Forgiveness includes four phases beginning with uncovering and confronting the nature of the offense and the consequences. Phase two is decision-making involving an understanding of forgiveness and deciding to forgive based on this knowledge. Phase three is working on forgiving that means gaining a cognitive understanding and viewing the offender in a new light resulting in a positive effect of the offender, the self, and the relationship. Phase four is a deepening increase in the meaning of the suffering, gaining a sense of connectedness with the offender, and experiencing a decrease in the adverse effect. There is a reconciliation that takes place for the person.

Worthington (2001) developed the Pyramid Model to REACH forgiveness consisting of six steps: a) defining, b) forgiveness and reconciliation, (c) building empathy, (d) encouraging altruistic responses, (e) facilitating commitment, and (f) forgiving and maintaining a hold on their forgiveness.

Ethical concerns for counselors include informed consent, respecting the client's religious or spiritual orientation, refraining from imposing counselor values, and referring to spiritual leaders when the client's needs have exceeded those of the counselor (Richards & Bergin, 1997). It is important that the counseling care is within the values and belief system consistent with the client's religious or spiritual traditions. Religious or spirituality beliefs and procedures are a component of the 12-step based group and individual therapy for substance use disorder and for assessment and treatment decisions for Dissociative Identity Disorder.

OBJECTIVE 2H: STRATEGIES FOR ELIMINATING OPPRESSION and DISCRIMINATION

Objective 2h. strategies for identifying and eliminating barriers, prejudices, and processes of intentional and unintentional oppression and discrimination (CACREP, 2015, p. 10)

Barriers in Cross-cultural Counseling

The first step for multicultural counselor preparation is to develop strategy building for identifying and eliminating barriers to a fuller understanding and implementation of advocacy skills.

The Code of Ethics (ACA, 2014) addresses multicultural/diversity in counselor education programs regarding faculty and student diversity and competence (F.11.a, b., c.). The code subsections encourage recruiting and retaining a diverse student body and faculty and to value and recognize the various cultures and types of abilities faculty and students bring to the program. Section A.2.c. emphasizes communicating information that is developmentally and culturally appropriate and sensitive to include clear language regarding informed consent. Qualified interpreters should be secured where needed to ensure comprehension by clients or students.

Multiculturalism can be defined from an inclusive or exclusive perspective. An exclusive definition is limited to ethnic minority and racial groups (Locke, 1993). Inclusive definitions relate to "differentness across terms such as cross-cultural, multicultural, culturally sensitive, cultural competence, and culturally relevant interventions" found throughout the literature (Weinrach & Thomas, 1996). Included within this definition are an emphasis on age, culture, disability, educational level, religion, sexual orientation, race, gender and socioeconomic status. Pederson (1990) broadens the definition of culture to include ethnographic, demographic, status, and affiliation variables. He further breaks the concept of ethnographic into ethnicity, nationality, religion, and language while demographics include age, gender. and place of residence. Status includes social, economic, and educational variables. Affiliation is the membership of the individual in informal or formal networks.

Locke (1993) postulated that a counselor must go through certain areas of awareness when counseling a culturally different client. This process is called the Multicultural Awareness Continuum.

Multicultural Awareness Continuum

1. Self-awareness of one's culture: Self-understanding is necessary to understand others. Awareness provides the counselor a sense of the cultural "baggage" he or she brings to the situation.

2. 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?

3. Awareness of individual differences: A counselor must not over generalize what he or she knows about a culture to all members of that culture. Awareness helps to achieve the uniqueness of the individual.

4. Awareness of other cultures: An awareness of the different dynamics of distinct cultures is essential. A counselor must be knowledgeable about the different languages, body languages, and other nonverbal behaviors to which cultural significance is attached.

5. Awareness of diversity: It is important to recognize that the United States is much like a "salad bowl" where each culture is maintaining a unique cultural identity but capable of living and working with other cultures.

6. Skills/techniques: Mastering skills on the continuum is to put into practice the necessary skills to work with different cultures. Techniques for working with the culturally different individuals 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) provided the following guideline to train counselors in effective cross-cultural counseling.

a. recognize which values and assumptions you hold regarding the desirability or undesirability of human behavior.

b. become aware of the general characteristics of counseling that cut across many schools of thought. Recognize the cultural values implicit in counseling theories and traditions.

c. understand the sociopolitical forces (oppression and racism) that have impacted the identity and perspective of minority cultures.

d. share the worldview of your clients without imposing value judgment.

e. be eclectic in practice so that skills and techniques can be matched to clients lifestyles and experiences.

Language, class-bound values, culture-bound values represent three broad areas known to be barriers in multi-diversity counseling.

a. Language: affects rapport, causes misidentification of strengths and weaknesses. The counselor should be aware of minority-group nonverbal communication styles.

b. Class-bound values: includes attitudes, behaviors, and beliefs concerning such things as importance of keeping appointments, expectations of advice and suggestions from the counselor, and differing sexual mores

c. Culture-bound values: involve attitudes, beliefs, customs, and institutions identified as integral parts of a group's social structure (Belkin, 1988). Examples of interference with cross-culture counseling include: referring to a client as "culturally deprived," straight male counselors making sexual remarks about females in front of gay clients, focusing on self-disclosure and emotional expression when it is incongruent with some cultural values (Asian-Americans, for example), and 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.

The DSM-5 included three Self-Rated Level 1 Cross-Cutting Symptom Measures and the Cultural Formulation Interview (CFI) to assist the interviewer during the intake assessment for the importance of the client's cultural identity, cultural conceptualization of distress, psychosocial stressors and cultural characteristics of vulnerability and resilience, and cultural features of the relationship between the individual and clinician. Environmental barriers can be accessed when considering the cultural concepts of distress that include cultural syndromes, cultural idioms (language), and client explanations for the perceived causes for the distress (APA, 2013). Barriers that reside between the counselor and client can be discussed and resolved during assessment and counseling utilizing the Cultural Formulation Interview. If the counselor demonstrates high levels of broaching attitudes and high levels of counselor self-reflection, a deeper and wider knowledge base for identity status and awareness of the worldview of the client, and a high attitude in cognitive and affective empathy is understood.

Types of Cross-cultural Counseling Relationships

a. The counselor is a member of the dominant American population, and the client is a member of a racial or ethnic minority.

b. An individual from a Western-oriented country transports therapy to a person of a non-Western country.

c. International students are offered counseling services in the United States.

d. Ethnic-racial professionals counsel members of the dominant culture or members of another subcultural group.

e. Isolating: approaches race in a simplistic and superficial manner

f. Continuing/incongruent: invites the client to explore the relationship between his/her presenting problems and issues related to race although with a limited skill set to explore the issues of race fully

g. Integrated/congruent: broaches race, ethnicity, and culture efficiently and incorporates information into the counselor's professional identity reinforcing that race shapes the client's personal and sociopolitical experience

h. Infusing: broach ways of being, a lifestyle and helps the client resolve ramifications of race and that the counselor has a commitment to social justice and equality.

Unit 2 - Terms

ABLEISM:

A term denoting discrimination or prejudice against individuals that reflects ability or functioning capacity that is developmental and based on age, gender, socioeconomic status, education, geographic location and references a set of social attitudes. Ableism projects an image that this person cannot function as a full person (Castaneda & Peters, 2000).

ACCULTURATION:

The influences a person goes through in response to the dominant culture (Casa & Pytluk, 1995). Acculturation theory defines how people adapt to a culture's customs, values, and beliefs (Kwak & Berry, 2001).

ADULTISM:

Discrimination against young people and consists of beliefs and actions that do not reflect respect and contribute to forms of discrimination (oppression and disempowerment).

ANDROGYNY:

Combining of male and female characteristics based on the premise that each person, to some degree, possesses both masculine and feminine behaviors.

BROACHING:

From a communication standpoint broaching is an invitation made by the counselor to ask of a client of diversity to help the counselor understand in a fuller way the background of the client. A style of broaching by the counselor is to seek understandings and knowledge necessary to develop the relationship, reduce any discomfort, and reveal an acceptance of the client's input. Day-Vines reported on a continuum for broaching skills for competency. Broaching behavior is a consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity (Day-Vines, et al., 2007).

CLASSISM:

Characteristics of worth and ability based on social class including oppression of subordinated groups by the dominant group (Collins & Yeskel, 2005). Types of classism include upward, downward, lateral, and internalized (Colbow et al., 2016; Smith, Foley, & Chaney, 2008Pe).

CoBRA:

Color-blind racial attitudes (CoBRA) consist of negative stereotypes in blaming the victim. A prejudicial person denies the existence of ideological and structured racism and believes that race does not play a meaningful role in the lives of people and their experiences. An individual who is prejudiced may not reveal the idea of inferiority/superiority, however, may unknowingly promote and display discrimination (Neville et al., 2001, cited in Ponterotto et al., 2006).

CORRESPONDENT BIAS:

A tendency to infer behaviors of a person to inherent characteristics instead of situational dispositions (Franklin & Boyd-Franklin, 2000). An example might be skin color that assumes ethnicity and attached negative stigmas/stereotype.

COUNTERCULTURE:

A group affiliation that stands in opposition to the cultural norms and values prevalent within the dominant culture.

CULTURAL:

Encapsulation is the tendency for individuals living in an environment and are a member of a cultural group (dominant) developing assumptions that are normalized for that group and surround themselves with members of a cultural group. A cultural framework becomes intact, and behaviors and actions are interpreted and displayed onto others within different cultural backgrounds or worldviews.

CULTURE:

The total of knowledge, beliefs, morals, customs, norms, practices, social institutions, and ideologies acquired by a member of society. Culture includes beliefs, values, and practices in religious and spiritual traditions (Cooper & Leong, 2008, p. 133).

EMIC:

Understanding culture from a position within the system, helping a counselor better able to understand the client's worldview. To live within a particular culture would be to learn the EMIC view.

ENCULTURATION:

Enculturation is a process of socialization into one's cultural group by family members, peers, and community adults.

ETHNIC GROUP:

Formed by real and assumed physiological traits and national and regional group traditions. An ethnic group shares a common identity and common heritage. Henderson indicated 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 an ethnic group (cited in Baruth & Manning, 2003).

GENDER ROLE CONFLICT:

When rigid, sexist, or restrictive gender roles learned during socialization result in the restriction, devaluation, or violation of others or oneself. Gender conflict may exist for restrictive emotionality, control, power and competition, homophobia, restrictive sexual and emotional behavior, obsession with achievement and success, health problems resulting from role socialization (O'Neil, 2008; O'Neil, Good, & Holmes, 1995)

INVISIBILITY SYNDROME:

The invisibility syndrome consists of repeated slights integrated into racially adapted behaviors for African males to manage racism. Franklin (1999) coined this syndrome to mean "an inner struggle with the feeling that one's talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism" (p. 761). These stereotype threats may reflect the fear of confirming a negative racial stereotype (Aronson, Quinn, & Spencer, 1998).

MARGINALIZATION:

Handelsman (2005) defined marginalization as existing when an individual is not aware of personal values or a sense of ethics. It reflects a minimum understanding or level of cultural identification with both a personal and professional integrated set of values or morals.

MICRO-INVALIDATION:

Microassaults, microinsults, and microinvalidations are all forms of microaggressions that are brief, frequent intentional and unintentional verbal, behavioral and environmental indignities that convey derogatory slights and insults to the client that are often based on some cultural dimension of difference such as race, sexual orientation, disability, and gender (Sue et al., 2007, p. 273).

POWER LITERACY:

Skills that enable a counselor to recognize social conflict and imbalances in power between social groups and to think and act systematically. Welsh (2000) indicated that with power literacy the counselor is accountable for one's actions to use power truthfully.

RACISM:

Racism is prejudice with power, history in context, and systems driven.

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 holds 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 individual should be treated by his/her sex without regard to other criteria, such as interests and abilities" (Gladding, 2001, p. 110).

STRENGTHS-BASED MODEL:

A method designed to build upon client strengths and resources. This approach views client resistance and denial as healthy (van Wormer & Davis, 2003).

WHITE PRIVILEGE:

Societal reports are received based on skin color and other determinants defined by unearned entitlements and conferred dominance (McIntosh, 1998). White privilege deniers are individuals who reinforce white privilege. Statements of denial is when a racial conflict exists and include:

a. you're the real racist for talking about race
b. just don't talk about racism and it will go away

c. you don't have the experience so it must not be true

d. I don't understand this, so it must not be true, but I am not a bad person

e. I never enslaved or colonized anyone, so white privilege has nothing to do with me

f. I know an exception to the rule

g. you're too angry about this

h. there's no such thing as race.' (Johnson, 2016, p.)

WHITE SUPREMACY:

White supremacy and privilege is a system of power and domination (consciously or unconsciously) embedded in the logic, thought, speech, action, perceptions, and affective response of people who classify themselves as White (Welsing, 1991, p. 340).

XENOPHOBIA:

A type of social phobia in which the person has an extreme fear or even hatred of strangers or foreigners, their customs, their religions. Xenophobia is a racially-based intolerance of immigrants (United Nations, 2012).

Unit 2 – References

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UNIT 3 - Human Growth and Development

Introduction

Human growth refers to the changes a person goes through from conception to death. These changes include behavioral, physical, cognitive, emotional, moral, personality and social development as influenced both biologically and environmentally. Siegelman and Shaffer (1995) defined lifespan development as physical, cognitive, and psychosocial.

When reviewing each of the above content areas be sure you can answer any question which will reflect how one progresses through a developmental stage or phase of life. An example is Erikson's Psychosocial Stages. Proceeding from stage to stage a conflict at each stage is to be resolved according to Erikson's psychosocial theory. 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 counts toward your total score.

CACREP Objectives

The complete CACREP objectives for Human Growth and Development can be downloaded from the CACREP website. The 2016 standard curriculum objectives for Human Growth and Development are (CACREP, 2015, P. 10-11):

a.   theories of individual and family development through life-span

b.   theories of learning

c. theories of normal and abnormal behavior

d. theories of etiology of addictions and addictive behaviors

e. biological, neurological, and physiological factors that affect human development, functioning, and behavior

f. systematic and environmental factors that affect human development, functioning, and behavior

g. effects of crisis, disasters, and trauma

h. framework for understanding differing abilities and strategies for interventions

i. ethical and culturally relevant strategies for promoting resilience and optimum development, wellness

Question 3-1: (Objective A.)

A developmental theorist believes that children form personal attachments in phases. This person is:

a. James Marcia

b. Jane Ainsworth

c. Arnold Gesell

d. Lev Vygotsky

Answer: b. Jane Ainsworth

Question 3-2: (Objective A.)

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 individual scores on various intelligence, aptitude, and achievement tests. What type of research is appropriate?

a. longitudinal

b. survey

c. naturalistic

d. correlational

Answer: a. longitudinal

Question 3-3: (Objective B.)

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. The iconic stage is imaginal.

Question 3-4: (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. world exposure and activities that cause precursors to more fully developed ideas.

Answer: d. world exposure and activities that cause precursors to more fully developed ideas. Piaget believed the child had precursors to forming concepts.

Question 3-5 (Objective C)

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself and displayed in social and personal contexts. When personality traits become inflexible and maladaptive, there are impairments and distress with inner experiences and behavior. The DSM-5 uses which approach to explain the qualitatively distinct clinical syndromes that differ from normal personality development?

a. categorical

b. dimensional

c. symmetrical

d. systemic

Answer: a. categorical

Question 3-6 (Objective C)

The personality disorders grouped into three clusters are based upon:

a. maladaptive variants.

b. descriptive similarities.

c. percentage of frequency of occurrence in society.

d. alphabetical order.

Answer: b. descriptive similarities

Question 3-7 (Objective C):

According to Erik Erikson, the conflict between industry vs. inferiority takes place at about what age?

a. retirement age

b. elementary-school age

c. young adulthood

d. adolescence

e. middle age

Answer: b. elementary-school age

Question 3-8: (Objective D)

The term that applies to the taking of two drugs in combination and has a magnified effect is:

a. synergistic effect.

b. persistent depressive disorder.

c. polydrug interaction.

d. tolerance.

Answers: a. synergistic effect. Three forms of drug interactions: 1. an additive effect is the effects of two drugs taken concurrently, 2. Antagonistic is when one drug blocks the effects of another drug, and 3. Synergism (potentiating) is when the effect of a drug is enhanced by the presence of another drug (Witters, Venturelli, & Hanson, 1993)

Question 3-9: (Objective D)

A client in treatment for polydrug use and anger management broke a house rule and was informed by the clinical manager he was expelled from the program. He told the manager he misbehaved because of his temper and cannot control his anger. The term for this behavior is:

    a. alloplastic.

    b. scapegoating.

    c. Kitty Genovese syndrome.

    d. diffusion.

Answer: a. alloplastic. (defense mechanism).
The client is indicating his deficiencies and inadequacies (anger control) are beyond his control for his misconduct. He does not assume responsibility. If he did assume responsibility the term would be autoplastic. Alloplastic, a term devised by Sigmund Freud is an attempt by the client to change his circumstances and failures.

Question 3-10: (Objective D.)

Marlatt advocated for harm reduction as a method or treatment for addiction that endorses all of the following principles except:

    a. managing one's daily functioning versus moralistic idealism.

    b. alternative to moral/criminal and disease models.

    c. holding the same level of consumption but not to increase.

    d. meeting the individual where he or she is.

Answer: c. holding the same level of consumption but not to increase. This approach is to prevent or at least reduce the harmful effects of use, not use itself (Marlatt & Witkiewitz, 2002).

Question 3-11: (Objective E.)

Wellness over the lifespan includes a well thought out plan for optimal development. Most plans include physical, mental, nutrition, spirituality, self-care, leisure and several other components. Literature support for exercise suggests some advantages. All are considered exercise benefits except:

    a. essential in preventing disease

    b. the key ingredient to healthy aging

    c. increases strength and confidence

    d. little effect on self-esteem

Answer: d. little effect on self-esteem. a) Ory & Cox, 1994, b) U.S. DHHS, 1990, c) Fontane, 1996, d) International Society of Sports Psychology, 1992-increases self-esteem.

Question 3-12: (Objective F.)

During an intake assessment, a client indicates that she is in an abusive relationship with her husband. The most appropriate therapy for this client is:

    a. individual therapy.

    b. group therapy.

    c. a battered wives support group.

    d. to refer to a battered women's shelter.

Answer: a. individual therapy. Individual therapy would be the choice until a counselor can determine how severely hurt, emotionally, physically, and otherwise. A referral to a shelter may be considered except this question asked for therapy.

Question 3-13: (Objective G.)

Vygotsky did not use the term developmental crises. It was his belief a crisis in intellect took place when which one of the following existed in the early life of the child?

    a. speech and practical activity did not merge

    b. intellect and physical development were not commensurate

    c. nutrition was less than adequate

    d. social engagements with other playmates were non-existent.

Answer: a. speech and practical activity did not emerge. Both start out as independent, and with the merging of speech, practical activity and abstract intelligence is the result.

Question 3-14 (Objective H)

Neurological development differs because of deficits in personal, social, academic, or occupational functioning in the form of very specific limitations of learning to global impairments in social skills or intelligence. Developmentally, these limitations typically occur:

    a. before a child enters school.

    b. between entering school and early adolescents.

    c. teenage years.

    d. early adulthood.

Answer: a. before a child enters school

Question 3-15: (Objective I.)

A counselor, who has been counseling a family for eight sessions during supervision received feedback from his/her supervisor that he or she is experiencing boundary naiveté issues. The supervisor is suggesting that the counselor is:

    a. lacking cognitive knowledge.

    b. lacking affective awareness.

    c. experiencing a social deficit and maybe a knowledge deficit.

    d. experiencing impulse control issues.

Answer: c. experiencing a social deficit and maybe a knowledge deficit. The two possible choices are a and c; however, letter a. is only partially correct.

Terms and People

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

Addiction

Addiction Models

Centration

Cohort Effect

Compassion Fatigue Dembers
    Ideational Addiction

Developmental Norm

Equilibration

Harlow, Harry

Harm Reduction

Hedonism

Hierarchical

Imprinting

Internal-External Locus of Control

James Lange

Learning

Mainstreaming

Maturity

McClelland, David

Neuroscience

Opponent Process Theory

REM

Resiliency

Schachter Cognition

Schema

Social Exchange Theory

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 methods center upon the idea of change. Change occurs 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 from 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 ideas do not point out what influences the movement to an advanced stage. These authors suggest that a disadvantage of the stage-hierarchy theories is that there is little understanding 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, the unwanted pregnancy of a sexual partner, sexually transmitted diseases, and drug problems. Other authors suggest for both males and females that social development is taking place, often creating a

same-sex grouping or cliques, narrowing to couples, concurrently with body image, sexual orientation, and attraction to the opposite gender.

OBJECTIVE 3A: Individual & Family Life Cycle

Objective 3 a. theories of individual and family development across the lifespan (CACREP, 2015, p. 10)

Specific ethical family references in the ACA Code of Ethics are expanded in groups and families (B.4.), couples and family counseling (B.4.b.), sensitive to cultural diversity in family (B.5.b.), friends or family members (F.3.d.), and the ability/inability to remain objective (ACA, 2014)

Family Life Cycle

Duvall (1977) proposed an eight-stage family life cycle. The stages are (Table 14.1, p. 440):

1. a married couple (without children)
2. childbearing
3. family with preschool children
4. family with school-aged children
5. family with teenagers
6. family launches young adults
7. a family without children
8. aging family

Siegelman and Shaffer (1991) highlight the following trends:

1. increased years without children
2. increased numbers of single adults
3. postponement of marriage
4. decreased childbearing
5. increased female participation in the workforce
6. increased divorce
7. increased numbers of single-parent families

Theories of Human Development across Life-Span

Human growth can be explained by a collective sense by understanding a variety of theories that attempt to provide meaning for the lifespan. One prominent theory developer for each area of human functioning will be included.

Ethological: study of behavior in the natural setting-example-Bowlby ethological theory of attachment

Humanistic: development of a self-unified system (self-concept)-Abraham Maslow, Carl Rogers

Language: learning rules of language, phonology, semantics, syntax, and pragmatics-Jerome Bruner

Learning: cognitive development, changes in mental processes involved in perception, language use, learning, and thought. Jean Piaget's theory and Lev Vygotsky

Moral: to be good, truthful, kind, wise, just, courageous, and virtuous-Kohlberg moral development theory.

Physical: includes changes in the growth of the body and its organs-Robert Havighurst and Arnold Gesell

Erikson's psychosocial theory of crises reflect changes in personal and interpersonal aspects of development such as motives and emotions, personality traits, interpersonal skills and relationships, and roles played in the family.

Included for study for each developmental area at least one theorist will be reviewed for differences in four critical areas in which issues surface for counseling. These have come to be known as the assumptions of human nature vs. nurture, activity vs. passivity, continuity vs. discontinuity, and universality vs. particularity.

Psychoanalytical Theory

Psychoanalytical theorists assume that biological forces drive people and that the individual must struggle to control or channel them. They also believe that development proceeds in stages and that personality characteristics developed in childhood remain stable over time.

SIGMUND FREUD

Freud believed biological drives (sex and aggression) were the primary motivators of human behavior. He believed the personality developed in psychosexual stages. For more about Freud's theory of personality, see Units Helping Relationships and Group Work.

Pregenital Period:

Oral Stage - Pleasure focuses on the mouth. Age birth to 10 months

Anal Stage - Pleasure focuses around the anus and the process of elimination. Age 1 to 3 years

Phallic Stage - Pleasure focuses around the genitals. Age 3 to 5 years

Latency - Dormancy of sexual desires. Age 6 to 12 years

Genital - Period of normal adult sexual behavior that begins at puberty and carries on throughout adulthood

ERIK ERIKSON

Erikson (1968), a social learning theorist, was a close follower of Freud. His theory is considered Neo-Freudian. He based his theory on the types of learning and social interaction that take place at different age levels, rather than on the 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 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 the social expansion of the child.

Autonomy vs. Shame Age 2 years: Growing mastery of motor skills. If not allowed some independence at this stage, the child may begin to feel ashamed and begin doubting one's own powers. Parents are central to the 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 and curiosity develops. Sharing with others takes place as well as role exploration, which develops the initiative. Parents are central to the 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 the industry. Peers are central to the 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 and peers are central to the social expansion of the child.

Intimacy vs. Isolation (young adulthood): The stage at which meaningful and intimate relationships are developed. Peers are central to the 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 the social expansion.

Question 3-16:
According to Erikson's psychosocial stages by what age does a child begin investigating various roles, for example, playing house or pretending to be a fireman?

  a. birth to 2 years
  b. age 3-5
  c. age 6-11
  d. age 12-18

Answer: b. age 3-5. During the initiative vs. guilt stage, trying out new roles develops the initiative. When these attempts fail, the result is guilt.

JANE LOEVINGER

Ego Development: Ego development plays a significant role in individual differences in a person of any age. Jane Loevinger believed that Erik Erikson's psychosocial development theory is much like her ego development theory. She believed that stages are critical in revealing one's impulsiveness, self-protectiveness, conformity, conscientiousness, and autonomy.

Characteristics of Conception of Ego Development

1. Stages are possible 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 applies to all ages.

Stages of Ego Development

1. Presocial Stage - Awareness of objects. Baby constructs a self-differentiated from the 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 and understanding of rules.
5. Conformist Stage - Development of trust. Identification of one's welfare with family and the obeying of 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 and self-fulfillment is a goal.
10. Integrated Stage - Consolidation of a sense of identity (Loevinger, 1976).

Social Development

LAWRENCE KOHLBERG

Kohlberg developed a theory of moral development considered to be a stage hierarchy. He believed that an individual's morality requires weighing the views of others against self-interest (Dacey & Travers, 2002). Kohlberg's theory places an individual's moral development at one of three levels. He suggested age parameters for each level, but these should not be considered fixed. For example, a 13-year-old could be at the preconventional stage and an adult could be at the conventional level. In fact, Kohlberg's research reveals that over 60% of his middle-class male subjects had not reached the postconventional level (Keller, Eckensberger, & Rosen, 1989). 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 chooses 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 the power of authority and the consequences of action.

Conventional (ages around 10-13) Conformity to the existing social order and a desire to maintain that order. Most adults operate at this level, according to Kohlberg.

Post Conventional (14-adulthood) Governed by universal moral principles that are independent of the authority of groups who believe in them. Legal principles are important.

Question 3-17:
According to Kohlberg, most adults operate at what moral level?

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

Answer: b. Conventional.

Values Clarification: Specific reference to purposeful attention to values clarification, beliefs, and attitudes are highlighted in the 2014 Code of Ethics in Sections A. 4.b. (personal values), F.8.c. (self-growth), and F.8.d. (personal concerns).

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. Gilligan's three-stage model is like Kohlberg's stages although is normed with women.

Stage 1: Preconventional based on individual survival and self-interest

Transition: awareness of other's needs and interpretation of self-interest as "selfish"

Stage 2: Conventional-responsibility to others; goodness is equated with self-sacrificial giving

Transition: awareness of the legitimacy of one's needs

Stage 3: Postconventional- balance of self-care and care for others; integration; morality of care and nonviolence

Values Development: SIDNEY SIMON

According to Sidney Simon, the goal of the values clarification process is not to install a set of values and beliefs, but to help people apply the following three steps and seven subprocesses of valuing in their lives to already-formed values and those still developing (Simon, Howe, & Kirshenbaum, 1972).

1. Choosing from alternatives
   a. chosen freely
   b. chosen from alternatives
   c. chosen after considering consequences
2. Prizing one's beliefs and behaviors
   a. prizing and cherishing
   b. publicly affirming
3. Acting on one's beliefs
   a. act upon
   b. act with consistency

Question 3-18:

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 stages of valuing has John not applied in his life?

a. choosing
b. choosing freely
c. acting
d. prizing

Answer: c. acting

Ethological Theory

Ethology is the study of the biological bases of behavior. The basic thesis of the ethological approach is that all animals, including man, possess species-wide characteristics that are the foundations for the development of some social behaviors. People are born with certain innate behaviors that are the result of evolution and the process of natural selection. Ethnologists do admit that learning can modify these innate behaviors, but these innate behaviors also affect the learning experiences themselves and are therefore worth studying.

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

KONRAD LORENZ

Nobel Prize-winning ethnologist Lorenz has shown that there is a short period early in the lives of goslings 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 early in life during which a permanent and binding attachment to an object is formed, the time during which imprinting takes place (McMahon & McMahon, 1986).

JOHN BOWLBY

Human infants are born with some behavior systems ready to be activated by appropriate "elicitors" or "releasers." Bowlby believed 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 can 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 the caretaker 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. Denying care to others is followed by despair, withdrawal, and finally detachment. Finally, the child will accept the care of others. Theorists who interpret attachment theory suggest that a failure to form these attachments during early life leads to psychological concerns later in life, often surfacing during the adult years. Ainsworth (1989) and Bowlby's (1988) interpretation of attachment for the adjusted child is that as his/her cognitive development expands, the child internalizes the caregiver in the form of expectations. These expectations are in the form of the child being able to:

1. access the adult and responsiveness to the child.
2. elicit responses from the adult.

Bowlby (1988) referred to these as working models and Ainsworth (1989) developed three behavior patterns that reflect different adaptations for attachment. These are:

1. secure - explore their environment and protest separation behaviors from the adult
2. avoidant - explore without their base (adult) and ignore separation, avoid a reunion
3. anxious-ambivalent - refuse to explore and express anxiety during separation

Attachment Theory: MARY AINSWORTH

Ainsworth (1989) worked with John Bowlby and believed 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 the caregiver and resists separation. The first apparent attachment is formed, frequently with the mother. Shortly after that, 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 can make adjustments based on another person.

Her four classifications are (Dacey & Travers, 2002):

1. Securely attached: the mother is the base from which to explore, separation intensified attachment, exhibited a large amount of distress, ceased exploration, and upon reunion sought contact.

2. Avoidantly attached: rarely cried during separation and avoided mothers at the 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 four patterns noted above with Bowlby that were later modified by Bartholomew and Horrowitz (1991) in their efforts to measure attachment. The modified terms and brief descriptions are as follows:

1. secure (find intimacy and autonomy comforting)-secure

2. preoccupied (relationships a priority)-resistant-ambivalent

3. unfocused-disorganized-disorganizes/disorganized/fearful

4. dismissing (counterdependent and dismiss intimacy)-avoidant

Main (1996) has extended the attachment research to establish the link of early attachment to present continuity and classifies adult as:

1. Autonomous: value relationships, attachments help their development

2. Dismissing: denied influence of attachment on their lives

3. Preoccupied: speak of parents in angry format

4. Unresolved/Disorganized: unresolved loss

Descriptions of these classifications have been abbreviated and for a fuller description of the research and classifications consult Main (1996).

Adult attachment styles have been found to be related to attachment history (Krauss & Haverkamp (1996). Internal models develop over time from early caregiver relationships in determining adult relationships (bond between child and parent). Internal working models within an attachment perspective are important for counseling and therapeutic change. Bowlby (1988) formulated five key tasks for use with individuals and families that include: (a) establishing a safe base, (b) exploring past

attachments and current relational difficulties, (c) exploring the client-counselor relationship, (d) linking the past with the present and (e) revising internal working models.

Question 3-19:

A counselor 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 home. He misses his father, wants him to be at home (return from his trips), and yet has feelings of anger when he does come home. He finds that he develops reasons to be away from the home when he knows his father is returning. While away he feels a gnawing desire to be there for his father's return. The counselor would identify this as which one of Ainsworth's attachment patterns?

    a.   anxious/ambivalent

    b.   secure

    c.   avoidant

    d.   strange situation

Answer: a. anxious/ambivalent. The two characteristics of the pattern have to do with responses to separation and reunion.

Physical Growth and Maturation

ARNOLD GESELL

Arnold Gesell established norms for the development of early-motor and sensory-motor behavior. The design of these norms was an attempt to chart the course of human growth according to significant markers, which would signal normal, accelerated, or slow development in the individual child. This view of human development stresses the maturational "readiness" of children to perform 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. The child's development is sequential and progresses through stages (Gesell, 1949).

1. Day Cycle: Growth is an expanding process that occurs every day.
2. Self-regulatory fluctuations: Instability and growth occur at the same time, moving the person toward maturation.
3. Constitutional Individuality: Each child is unique and has his 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, and responsiveness to training and social conventions

Developmental Stages

INFANCY (Birth to two weeks old.)
Completed when umbilical cord falls from the 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. a 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: When the infant's expectations are not met, they are surprised. Changes in bodily functions are measured in the breathing or by a galvanic skin response.

Visual Cliff: A testing tool that simulates a drop-off to test depth perception of infants.

Object Permanence: When babies 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 of age for girls, and 14 years for boys (Parten, 1932, Tomlin, 2008)

1. toy age until the school year

2. formal education begins at age 6

3. after children become sexually mature, they are adolescents

4. Mildred Parten's six levels or stages of social play/interaction (Gander & Gardiner, 1981)

    a. Unoccupied play (behavior): not playing or watching anyone

    b. Onlooker play: most of the time watching others play-do not engage in play

    c. Solitary play: plays alone, no connection or conversation is made

    d. Parallel play: plays alone but with toys that are shared with others and limited communication

    e. Associated play: child shares materials and interacts with other children, but does not share the same goal of the play (independent)

    f. Cooperative play: child plays with others and engages in same goals of play with others, such as playing house with an agreement on the rules

    g. Children who learn to play, take turns, work and play with others show a higher degree of success later in life

LATE CHILDHOOD (six years to sexual maturity)

1. troublesome era

2. reject parental standards

3. age of conformity, acceptance by their peers

4. skills

    a. self-help

    b. social-help

    c. school

    d. play

5. play interests include constructive play; exploring, curiosity; collecting - from skills to cards, and games/sports

6. antagonistic attitude toward opposite sex

Reversible thinking: The child not only sees that the liquid can change shape and remain the same in volume, but the child knows that it could return to the first shape if poured in the original container.

Metacognition Process of monitoring one's 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. the task is to make a 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 practices. Masters and Johnson (1966) developed a four-phase response cycle. A description of each phase is as follows:

1. Excitement Phase: This is the period of sexual stimulation where heart, respiration, and blood pressure rates increase. Additional physiological activity occurs such as erection, engorgements, etc.

2. Plateau Phase: This phase prepares the body for orgasm. There is increased stimulation of the body parts and functions.

3. Orgasm Phase: Heart and respiration reach their peaks. Muscles in female and male sexual organs contract rhythmically.

4. Resolution Phase: The body returns to a comfortable and level state.

ROBERT HAVIGHURST

Robert Havighurst described four stages of adulthood: early adulthood, middle adulthood, later adulthood, and very old age. Each stage is composed of three or four tasks to be accomplished. Havighurst (1951) listed three tasks for each stage of life. These tasks ideally were midway between the needs of the individual and the ends of society. To succeed in life, a person needs to accomplish these tasks 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 the 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 learn a skill. Havighurst

referred to these times as teachable moments that happen at sensitive periods or times. If an individual did not learn the appropriate skill during the sequence, it would be difficult to learn later. 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 relationships, 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 reduced 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 (centers attention and actions on other people rather than themselves
4. increased autonomy

OBJECTIVE 3B: Learning-Personality

Objective 3 b. theories of normal and abnormal personality development (CACREP, 2015, p. 10)

Learning Theories

Learning theorists believe that human beings are born neither good nor bad. The prominent idea is that people do nothing more than responding to their environment. Some of the ways learning can occur are classical conditioning (Pavlov), operant conditioning (Skinner), and observational learning (Bandura).

IVAN PAVLOV

Classical Conditioning: Unconditional stimulus - the stimulus that already evokes an unconditional response.
Example: meat (UCS) —> salivation (UCR)

Conditioned Stimulus - Pairing the unconditioned stimulus with the stimulus will eventually evoke a similar response when presented alone.
Example: meat (UCS) —> salivation (UCR) buzzer (CS)

After several pairings, the CS (buzzer) will hopefully be able to evoke a conditioned response (salivation) when presented without the UCS (meat).
Example: buzzer (CS) —> salivation (CR)

Delayed conditioning in which the conditioned stimulus is presented and continued throughout the presentation of the unconditioned stimulus is the most effective way to condition a response.

Classical Techniques (Developed by various theorists)

Systematic Desensitization - Developed by Wolpe from the work of Jacobsen (anxiety/fear) (relaxation response). Based on principles of counterconditioning.

Reactive or Internal Inhibition - Flooding, the 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.

Operant Conditioning: A response is learned because of the consequences that follow. The organism must do something before it can be conditioned.

1. Primary reinforcement satisfies a primary need. (Example: food)

2. Secondary reinforcement includes reinforcers that have somehow been associated with primary reinforcers in the past so that they have acquired reinforcing qualities. (example: money)

3. Positive reinforcement occurs when something positive or pleasant is received by an organism after a response. (example: a child receives a sticker for picking up toys)

4. Negative reinforcement occurs when something unpleasant or negative is discontinued when the organism makes a particular response. (example: an inmate is released from prison for good behavior)

5. Reinforcement, both positive and negative, increases the probability of a response. Punishment decreases the likelihood of a response.

Reinforcement Schedules: Continuous reinforcement is presented for each response.

Intermittent: Reinforcement is not provided for each correct response. Intermittent reinforcement can be in an interval or ratio form.

1. Variable-ratio: Reinforcement is presented so that it averages a number of correct responses. A random assignment is made, such as one out of every four as an average.

2. Fixed-ratio: Reinforcement is presented after a set number of correct responses, such as every third correct response.

3. Variable Interval: Reinforcement is presented so that it averages a time interval, such as an average of one reinforcement every seven minutes.

4. Fixed-Interval: Reinforcement is presented at the end of every set period, such as, after every seven minutes, but the response must be correct.

Operant Techniques: Operant techniques have been developed by various theorists and are 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 would 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 would 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 therapy. The therapist is a motivator.

3. Shaping: Reinforcing new behavior that approximates desired behavior. The 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 by the client.

6. Token Economies: Used for groups. This economy is based on 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 practices 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 to eliminate the behavior. A technique for aversive training is time out. The design of a timeout is isolation or inactivity or a behavior in question. This technique may be applied for temper tantrums such as secluding a child displaying acting out behaviors to his/her room for a brief amount of time.

Question 3-20:

John's parents are trying to teach him to pick up his toys. They decide first to reward him when he walks near the pile of toys. This is an example of?

   a. modeling.
   b. self-management.
   c. negative reinforcement.
   d. shaping.

Answer: d. shaping.

Question 3-21:

An employee is congratulated twice in one week by his boss but is not congratulated again for a month. Which one of the following reinforcement schedules does this follow?

    a. variable-ratio

    b. fixed-interval

    c. variable-interval

    d. fixed-ratio

Answer: c. variable-interval

JOHN B. WATSON

Watson, the father of behaviorism, believed that the mind of an infant is a tabula rasa or a "blank slate." He also believed that human development occurred due to the learned associations between stimuli and responses. To Watson, development was a continual process, rather than one that 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. The famous Watson-Raynor experiment Little Albert, conditioned fear and then deconditioned or eradicated fear.

JOSEPH WOLPE

Joseph Wolpe developed systematic desensitization to treat phobias and fears. 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, the 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. Reciprocal inhibition 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 the neural capacity to respond to stimuli. These responses form the basis for learning.

EDWARD L. THORNDIKE

Thorndike believed that all learning consisted of associative bonds between situations and responses (Byrnes, 2001, 2008). Thorndike introduced the terms Law of Exercise and Law of Effect, better known today as operant conditioning. His primary position was as an associationist. The basic understanding of 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 involves sets or attitudes imposed by culture, predisposing an individual to react in a certain way.
3. Prepotency of Elements – Individuals can respond to certain prepotent (significant) elements in a situation and ignore the irrelevant ones.
4. Response by Analogy - In a new situation, an individual will transfer responses from other situations.
5. Associative Shifting - It is possible to shift a response from one stimulus to another.

If learning is to take place a lot of repetition is recommended plus rewards should follow correct responses. Thorndike also believed that related subjects should be separated in time (Bryne, 2001).

EDWARD L. GUTHRIE

One-Shot Learning: Guthrie thought that everything was learning and that it took only one pairing (LeFrancois, 1982). The first pairing determines the strength of a bond. 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 applied each method to a 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 enhance 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 is to pair stimuli together in time and space. When stimuli are paired together they are learned. Postremity refers to remembering the last thing learned.

    Example: A child comes home and drops his coat on the floor and wants to go to his room to play a game on his computer. Have the son put his coat back on and go back out and come back in again. Putting his coat back on and going back outside to walk back in and put his coat on the coat rack is incompatible with going to his room to play a game. This repeated practice is similar to withdrawing a positive.

JOHN DOLLARD AND NEAL MILLER

Dollard and Miller (cited in Shaffer, 1985) thought neurosis developed as a result of experience. Much of their explanation for this understanding evolved from their involvement in Hullian learning. The development of neurosis or learning occurs when a child's behavior is changed as a result of his or her experiences. As the child develops, the child forms a collection of habits that cause the child to respond to various stimuli with the appropriate social responses, which in turn reduce a primary or secondary drive.

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

The four fundamental factors that are essential for all learning are:

1. drive or motivation
2. cue or stimulus
3. response
4. reinforcement

Terminology

Habit: The stable aspects of one's character and the building blocks of the personality.

Primary drives: Unlearned motives, such as thirst and hunger.

Secondary drives: Learned motives not present at birth, such as the need for parental approval.

Primary reinforcers: Unlearned reinforcers, such as food and sex.

Secondary reinforcers: Learned reinforcers, such as money.

Pathology

Neurosis is the result of conflict produced by two or more strong drives leading to incompatible responses.

Therapy

Therapy is a learning situation in which neurotic responses are extinguished and better, normal responses are learned.

The following are elements of therapeutic learning:

1. the lifting of repression
2. transference relationship
3. learning to label
4. learning to discriminate.

The desired outcome is the restoration of the higher mental processes. These processes require verbal and other cue-producing responses and thus depend on the removal of repression and labeling.

Six Conflict Behavior Assumptions

1. Tendency to approach the goal increases with nearness to the goal.
2. Tendency to avoid a feared goal increased 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 the drive.
5. Response tendency depends upon some reinforced trials.
6. When two responses are in conflict, the stronger will occur.

Types of Conflicts

Approach-Approach Conflict: Two positive choices exist, but the 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 and a Sponge Bob video for his birthday, and he likes them equally well.

Approach-Avoidance Conflict: A conflict where the approach is something the person wants but is afraid of getting punished or receiving a negative reaction.

Example: A young man wants to date the homecoming queen but is afraid of being rejected by her and in the presence of others.

Avoidance-Avoidance Conflict: The 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 (Dollard & Miller, 1950).

Techniques and Methodology

Permissiveness: The therapist is warm, friendly, understanding, and not shocked by what he or she hears.

Free Association: The client is encouraged to report everything that comes into his/her mind, immediately and without reservations.

Rewards for Talking: The therapist gives full attention, accepts what the client says, understands and remembers what the client has said, calmly faces important revelations, of which the client is ashamed or anxious, and does not cross-question or make certain pronouncements.

Handling the Transference: The therapist attempts to overcome transference-induced reactions by the following:

1. interpretation of silence
2. pointing out that avoidance is an escape and urging the client to resume work
3. refraining from inferring that the transference reactions are purposely produced by the client
4. identifying transference responses and finding out how they arose
5. handling these reactions without anger or irritation

Labeling

1. The client may discover or create the new verbal unit, under the compulsion of free association.
2. The therapist may selectively strengthen the client's responses that he/she thinks are important without contributing his or her ideas.
3. The client may rehearse responses provided by the therapist as interpretation.

Teaching Discrimination:

1. The therapist calls attention to problem areas to evoke new discriminations by failing to understand the client.
2. The therapist may discourage individual responses by labeling them as false or doubtful.
3. The therapist points out similarities between similar sets of stimuli.
4. The therapist points out the difference between the past and the present.

A counselor identifies and assesses the personal and environmental events that shape decisions at critical points (choice points). These learning experiences are of three types:

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

2. Associative: Past affective neutral stimulus associated with an emotional stimulus results in the affective stimuli strengthened.

3. Vicarious: The individual learns by observing others.

The individual learns to apply a wide range of skills, involving work standards, work values, work habits, and perceptual habits that become modified by experiences and feedback. These interactions will bring about certain consequences based upon self-observation generalizations, task approach skills, and world generalization (Dollard & Miller, 1950).

Question 3-22:
A person is afraid to receive a flu shot because it is painful. She is also fearful of getting the flu. Which of Dollard and Miller's conflicts is she facing?

    a. approach-approach

    b. avoidance-avoidance

    c. annoyance-avoidance

    d. approach-avoidance

Answer: b. avoidance-avoidance

ALBERT BANDURA

Albert Bandura, a social learning theorist, claims a significant amount of behavior is learned through modeling and observing others. The 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 new 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. Bandura's theory, Linear-Interactionist Social-Cognitive Theory, and is 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 significant 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 of similar sex, age, race, and attitudes. Other features 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 learning, coping model. The model can use graduated modeling procedures, give instructions and rules, and can allow the observer to summarize. Kanfer and Goldstein (1991) recommend rehearsing the presentation and to minimize distracting stimuli.

Question 3-23:
If modeling were used to teach adolescents how to say "no" to drugs, which would make the most useful model?

    a. teacher
    b. coach who the children all respect
    c. teenager who uses drugs
    d. older teenager who does not use drugs

Answer: d. older teenager who does not use drugs. The model would be closest in age and attitude to the observers. Also, the teens are likely to look up to an older teenager. The fact that he or she is not known to use drugs would make the youth appear more competent.

JULIAN B. ROTTER

Rotter describes his social learning theory as expectancy reinforcement of developed constructs (Patterson, 1966).

The basis of Learning: Learning situations are inextricably fused with needs requiring satisfaction through mediation by others. Attribute influences stem from the work of Lewin, Adler, Kantor, Thorndike, Hull and Tolman.

Basic Concepts:

1. Behavior Potential-the likelihood of a behavior occurring in a given situation.
2. Expectancy-individual's subjective probability estimate that behavior will attain reinforcement.
3. Reinforcement Value-degree of preference for a reinforcement.

Pathology: Pathology is avoided behavior because of some previously experienced appropriate punishment and learned inappropriate ways to attain satisfaction. A maladjusted person has expectancy that maladjusted behavior will lead to greater gratification than would constructive or adjustive response.

Therapy: Lowering expectancy that behavior will lead to gratification and increasing the expectancy that alternate behaviors will be gratifying.

Methodology:

1. Direct reinforcement.
2. Place a client into a situation where he can observe another 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 the client is capable of looking for and trying out alternative behaviors.

Nature of Man: Man is physiological. Psychological needs are learned about drives defined as physiological.

Cognitive Theories

The cognitive theorists believe that there is a strong biological basis for development. Children have a strong need to explore their surroundings and adapt to their environment actively. Their cognitive abilities will largely determine personality development.

JEAN PIAGET

Structural patterns of thought change as children mature and interact with their environment. Piaget worked with these changes that occur in the child's mode of thought. He believed there were sequential periods in the growth or maturing of an individual's ability to think, gain knowledge, and develop an awareness of one's self and the environment. Piaget's research and theory explanation was with 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 actions. Furthermore, Piaget indicated that this dynamic interplay between an individual and the environment is the foundation of all knowledge and intelligence. Piaget defined and described development as an adaptation.

Adaptation is the most important process in intellectual functioning including two processes, assimilation and accommodation. (LeFrancois, 1982).

Assimilation: The process of taking in new information and interpreting it in such a way 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 learn for dealing with 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 an 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 permanence in infants under a year-old causes infants to not understand that when a toy is out of sight, it still exists.
    b. Symbolic substitution-The child learns that mental symbols can replace physical actions. Example: language
2. Preoperational Stage (2-7 years)-When the child can imagine doing something; there is movement into this stage. During this stage, the child develops the capacity to employ symbols, especially language. Symbols enable the child to deal with things in another time and place.

Egocentrism occurs in this stage meaning that children four or five years of age consider their point of view to be the only possible one. They are not able to put themselves in another's place. The child will break and change rules many times. At this stage, the child can think in the past.

Piaget listed four limitations of this stage. The four are:
    a. strong ties to perception, similarity, and spatial relations. That is, the dog is a cat; the dog is a duck, etc.
    b. unidimensional-think only of one aspect at a time. Example: conservation—centration as opposed to decentration in which the child can consider multiple pieces of information simultaneously(Broderick & Blewitt, 2006)
    c. irreversible—what is done cannot be undone. If you pull the tape out, it cannot be retracted.
    d. distinguishing between reality and fantasy. The difficulty reveals itself when children talk about their dreams and people as real people.

Question 3-24:
A couple has been referred to the school counselor because their first-grade boy has some imaginary friends. Their friends implied that the boy may be developmentally delayed. They have a son about the same age who gave this up some time ago. They thought the couple should check for autism spectrum because the child tells others that he has friends, gives them names and that he sees them at night in his dreams. The counselor asked the couple for more child activity information which appeared to be normal for his age. The counselor decides the child is about to emerge into which of Piaget's stages?

    a. Sensory
    b. Preoperational
    c. Concrete Operational

d. Formal Operational

Answer: c. Concrete operational. Piaget believed that the four limitations of the preoperational stage often disappear as the child enters the concrete operational stage. Children at this stage do not confuse reality and fantasy. Other learning researchers disagree with Piaget's reality-fantasy time and believe the child often reaches this as early as four or five (Bryne, 2001).

3. Stage of Concrete Operations (7-11 years) - Beginning of rational activity and mastery of logical operations. The young person will adhere to the rules in a rigid way.

   a. Classes, Seriating, Number, Conservation - At approximately age 7, children begin to understand that a liquid or a solid still contains the same amount of material, no matter how it is shaped.

4. Stage of Formal Operations (11 years and above) - Begins dealing with abstractions and can engage in hypothetical reasoning based on logic. The rules will change now by mutual consent.

Question 3-25:

In which of Piaget's stages of development does the child achieve object permanency?

a. Sensorimotor

b. Preoperational

c. Concrete Operational

d. Formal Operational

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

Question 3-26:

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

a. Sensorimotor

b. Preoperational

c. Concrete Operational

d. Formal Operational

Answer: c. Concrete Operational. A schema serves four functions. Schema functions are to categorize, remember, comprehend, and problem solve (Byrne, 2001).

Question 3-27:

A classroom teacher requested the school counselor to test a second-grade child to determine if the child is academically developmentally delayed, normal development, and academically advanced. The counselor indicated he lacked training for a comprehensive assessment but would test to determine if a referral was appropriate. The counselor asked the child, as one part of several short test items, to name the number next from the following: 21, 23, 26, 30, _____. The counselor was testing for which one of Piaget's concepts?

a. conservation

b. seriation

c. centration

d. number

Answer: b. seriation. Seriation can be in the form of weight, length, color and use numbers or objects.

LEV VYGOTSKY: MIND

A relatively 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 mental functioning explain his concept of cognitive development in speech, thought, and learning. An important concept is an 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 is 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. Before that time the child might describe a concept by one or two of the criteria for that concept. An example might be a blanket as soft or soft and light. Modeling and self-regulation are critical to the guiding process from dependent to independent learning.

Vygotsky's theory is known for five cognitive functions: language, thinking, perception, attention, and memory. Self-regulation is the language function of informative speech (external speech), egocentric speech (external speech), and inner speech (speech to self).

Higher order thinking is from lower forms of thought to higher forms. Vygotsky's definition of higher forms of thought is when there is a shift of control from the environment to the individual. That is from other-regulated to self-regulation. Secondly, the child has conscious access to the activity under learning and has a social origin. Third, symbols or signs now mediate the cognitive activity (Wertsch, 1985).

Zone of Proximal Development: The "distance between a child's actual developmental level, as determined by independent problem-solving, and the higher level of potential development, as determined by problem solving under the guidance of an adult guidance…" (Valsiner, 1998, p. 36). The zone is the difference between what the child can achieve with guidance and what he can achieve through individual effort.

Scaffolding: a process where the child can move from the point of difficulty in learning to where, with help (teacher), he/she can eventually achieve the task independently. The intent is to provide just enough guidance where the child can learn independently. Instruction should be just ahead of where the child's current learning is at present. Instruction should be in three phases; 1) teacher models skill with verbal instructions for the 'why' of doing something, 2) child imitates what instructor does with the verbal instructions, and 3) teacher is to "fade" or withdraw slowly from the instructional concept (Palinesar & Brown, 1984).

It is Vygotsky's belief that social and cultural processes shape children. That is, any cultural experience is experienced from two processes. The first is interpsychological, a social exchange with others and the second is intrapsychological, an inner speech within the child .

Question 3-28:
According to Vygotsky the primary tool to progress developmentally is:

a. physical activity

b. speech

c. social engagements

d. zone of proximal distancing

Answer: b. speech

Question 3-29:

Which one of two concepts does Vygotsky consider important as the guiding process in development from dependent to independent learning?

a. modeling

b. practice

c. centration

d. control

Answer: a. modeling. The other tool is self-regulation

Language Acquisition

Language acquisition is explained primarily through three different theories: learning, nativist, and interactionist.

Learning a 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 right speech.

Nativists believes the child's biological capacities explain language acquisition. The language acquisition device (LAD) has universal features of language, and the child can 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. Certain skills such as perceptual, cognitive, motor, social, and emotional development are vital to language acquisition. Jerome Bruner's identified three stages of language acquisition.

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 go through a series of stages to reach a level of sophistication they reveal in adult verbal communication (Bruner, 1983). Bruner's theory is based upon the following modes:

1. Enactive mode: Motor behavior that is the movement of arms, legs, and body muscle in such a fashion to represent some object. This style is mainly physical. In frustration, a child will shake a fist as an attempt to get attention. The ultimate is in dance, in which all movement is symbolic.

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

3. Symbolic mode: The child starts to devise symbols, words, or gestures that stand for certain people, objects, or actions, but these symbols bear no resemblance to the real thing.

Problem Solving: Problem-solving is understood as higher ordered thinking and explained through two different methods, developmental and definitional (Byrne, 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 who has an awareness of cognitive activity followed by the cognitive awareness has a social origin, and will use symbols to solve the problem. Bloom relies on the knowledge taxonomy he developed (knowledge, comprehension, application, analysis, synthesis, and evaluation). The Novice-Expert teaches novice-experts to study problem-solving strategies of experts and compare to their own (novice). This theory has seven dimensions of expertise. These domains are:

1. Domain specificity-usually not transferable from one specialist area to another area.
2. Greater knowledge and experience
3. Meaningful perceptions-experts see the whole while novice see the parts
4. Reflective qualitative problem solving
5. Principled problem representation-understand in a deep way
6. Effective strategy construction
7. Post analysis speed and accuracy

Definitional Problem Solving Approaches: Sternberg and Resnick developed models that reflect the definitional approach to problem-solving.

Briefly, Sternberg's information processing approach has three clusters, metacognitive (problem definition, planning, and resources), performance (encoding, inferences, mapping), and knowledge acquisition (selective encoding, selective combination, and selective comparison).

The Ideal problem solver uses two domains, a set of problem-solving strategies and specific knowledge.

Resnick's approach focuses on higher order thinking that is not visible from any one point. She indicated there are many solutions (complex) and is effortful (mental energy).

The additional steps are to involve nuanced judgments, multiple criteria, uncertainty, self-regulation, and meaning.

The Actively Open-Minded approach has two components for higher order thinking, which are: competence and performance (Byrne, 2001). McMahon and McMahon outlined a four-stage model for problem-solving.

Stage 1: Preparation-understanding what the problem is and bringing together information that will help to solve the problem (McMahon & McMahon, 1986)

Stage 2: Incubation-letting the problem wait a while so possible solutions will occur to us

Stage 3: Illumination-the actual occurrence of the solution

Stage 4: Verification-the process of verifying that the solution chosen was the correct one

Obstacles to Problem-Solving:

1. Set-the tendency to solve new problems the way old ones were resolved.
2. Functional Fixedness-the tendency to see objects for their most obvious function and ignore possible alternatives

Question 3-30:
What do 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 them.

Answer: a. verify the solution. The problem-solver verifies that the solution chosen is correct.

Cognitive Therapies

The most common cognitive therapy approaches are Aaron Beck's Cognitive Therapy and Albert Ellis's Rational Emotive Therapy. Twenty other therapies are listed in Mahoney and Lyddon (1988). Some of these are:

1. Personal Construct Therapy - George Kelly
2. Logotherapy - Victor Frankl
3. Multimodal Therapy - Arnold Lazarus
4. Rational Behavior Training - Maxie Maultsby
5. Cognitive Behavior Modification - Donald Meichenbaum
6. Cognitive Developmental Therapy - Michael Mahoney

Problem-solving Therapy (Dobson, 1988)

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

Cognitive Restructuring (Dobson, 1988)

1. Rational Emotive Therapy - Albert Ellis

2. Cognitive Therapy - Aaron Beck

3. Self-Instructional Training - Donald Meichenbaum

4. Rational Behavior Therapy - Maxie Maultsby

Coping Skills (Dobson, 1988)

1. Anxiety Management Training - R. M. Suinn and B. Richardson

2. Stress Inoculation Training - Donald Meichenbaum

3. Systematic Rational Restructuring - M. Goldfried

Cognitive Change Procedures

Cormier and Cormier (1998) pointed out two significant assumptions of cognitive therapy. The first is that a person's thoughts and beliefs can contribute to maladaptive behavior. The other is that targeting the person's beliefs, attitudes, and ideas can change maladaptive behaviors. Two change methods are cognitive modeling and cognitive self-instructional training. The plan is to teach the client the procedure and rationale and finally for the client to self-initiate self-instruction as needed.

1. Cognitive Modeling:

    Counselors demonstrate to clients a cognitive change procedure in "what to say to themselves while performing a task" (Cormier & Cormier, 1998, p. 344).

    Steps:

    a. Counselor serves as the model and first performs the task while talking aloud to him/herself.
    b. Client performs the same task while the counselor instructs the client aloud.
    c. Client is instructed to perform the same task again while instructing himself/ herself.
    d. Client whispers instructions while performing the task.
    e. Client performs the tasks and instructs himself/herself covertly.

    Procedure:

    a. provide rationale
    b. cognitive modeling of the task and self-verbalization.
    c. client practice
    d. overt external guidance
    e. overt self-guidance
    f. faded overt self-guidance
    g. covert self-guidance
    h. homework and follow-up

2. Thought-stopping
    Thought-stopping was introduced by J. A. Bain but was developed by J. G. Taylor. The rationale is

to control unproductive or self-defeating thoughts and images by suppression or eliminating negative cognitions. Empirical evidence is limited.

Procedure:

a. Provide rationale

b. Counselor directs thought-stopping:

b1. Interruption: Counselor assumes control of the interruption (LOUD STOP). The client is instructed to verbalize all thoughts and images aloud.

b2. Second effort: Visual again, but this time does not talk loudly. Instead, uses the hand signal to inform: STOP.

c. Client directs thought-stopping: Client now assumes responsibility for interruption: LOUD STOP

d. Client-directs thought stopping: Covert Interruption Client stops thoughts covertly.

e. Shift to assertive, positive, or neutral views. Explain reasons for substituting positive thoughts. Different thoughts should be exercised so that saturation does not occur.

3. Cognitive Restructuring or Cognitive Replacement:

Focus on faulty reasoning and illogical or irrational inferences and beliefs

Goal: Alter irrational beliefs or negative self-statements

Clients: Socially anxious clients

Rationale: Self-talk can influence performance especially changing self-defeating thoughts or negative self-statements that cause emotional distress and reduce performance.

4. Reframing:

Modifies or restructures a client's perception or view of a problem

Procedure: Cormier and Cormier (1998) list six components of cognitive restructuring

Goal: Correct mistakes in encoding, identifying, and modifying client's perceptions

5. Stress Inoculation:

Stress inoculation is a method to teach physical and cognitive coping skills. A psychological protection set of skills that function the same way as medical inoculation, a prospective defense or set of skills to deal with future stressful situations. Resistance is enhanced by exposure to a stimulus strong enough to arouse defenses without being so powerful that it overcomes them. Meichenbaum (1993) pointed out that stress inoculation equips the client with knowledge, self-understanding, and coping skills.

Goal: Teach physical and cognitive coping skills, anger control
Procedure:
a. before: anticipate, prepare
b. during (very angry): confront self, lose control (cope)

     c.   after: encourage yourself

     d.   information on coping skills

     e.   acquisition and practice

Question 3-31:

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-stop

     d.   cognitive modeling

Answer: c. thought-stop

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 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.

ABRAHAM MASLOW

Maslow believed that people have an innate need for self-actualization. However, self-actualization cannot be met until other needs are fulfilled. These needs are arranged in a pyramid-shaped hierarchy (Maslow, 1954). No level can be achieved until the level below it has been achieved. The hierarchy is as follows:

1. Self-actualization

2. Esteem needs (confirmation)

3. Belongingness needs (love, be loved)

4. Safety needs (to feel secure in daily life)

5. Physiological needs (like food, warmth, rest)

Self-actualized people tend to be older. Most of the self-actualized people Maslow studied were over 60 years of age.

Social Psychology Theory

Social psychology is a combination of sociology and psychology and examines how individuals affect one another's behavior (Lambert, 1980). Social psychology is the study of personality, attitudes, motivations, and behaviors that are influenced by social groups (Merriam-Webster, 2014). Theory

principles provide stages of personality development, normal and abnormal behaviors associated with different developments and explore the relationships between social institutions, social groups, and individual behavior. Following are some of the prominent theories encountered in the field. Social psychology is the study of how people's thoughts, feelings, and behaviors are influenced by the actual, imagined, or implied the presence of them (Allport, 1985).

Hedonism is 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 inherently self-centered and pleasures seeking (Edwards, 1979).

Power is 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).

Social Exchange theory (Homans): derived from social learning theory and contends that interactions between people must be mutually reinforcing. Individuals seek to imitate "profitable" exchanges with others and try to eliminate "nonprofitable" exchanges with others (Albrecht, Thomas, & Chadwick, 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 behavior are high, the rewards should also be high. Adams (1965) called this "equity theory," proposing that a person seeks to maintain a balance between what he or she gives and receives and what others give and receive. If an exchange is imbalanced, pressure will build until equity is restored.

Cognitive-consistency theory principles explain the need to establish and maintain consistency in people's 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.

Dissonance theory states that two cognitions that are in disagreement produce tension within the person until that person changes one of those cognitions. The amount of stress experienced is a function of the degree of the dissonance. Dissonance is an uncomfortable state that an individual attempt to alleviate or change by bringing cognitions closer together (Festinger, 1957). Changing a behavior, changing the environment, or adding new cognitive information that will "outweigh" one of the dissonant cognitions can reduce dissonance. The individual will try to alter the cognitions to be more consistent (Dunn & Burclaw, 2012). Dissonance may be like Rogers's term for incongruence, an experience that is contradictory in perceptions about a person or his/her environment. Modification of the discomfort is a change in the physical situation, personal change, or denial or distorting the sensory or visceral experiences (Mayer & Cody, 1968).

OBJECTIVE 3C: PERSONALITY DEVELOPMENT

Objective 3 c. theories of normal and abnormal personality development (CACREP, 2015, P. 10)

Nature and Nurture study of human development consists of the genetic and environmental aspects of early life. Nurture focuses on the care given to children by their parents and environmental factors that include prenatal, parental, extended family, peers, and environment. The cultural life of the individual

includes the social life, cognitive-knowing, normative-acting and the emotion- feeling dimensions. Nature/nurture controversy may be outdated by the recent literature in explaining the development of a healthy personality.

Nature views development from genetic and inborn biological factors. Human behavior is learned and results in flexibility and adaptability. If there are "imperfections" in the genetic make-up behaviors, behavioral deviations from the norm are likely and interpreted as abnormal.

Kagan's research and beliefs focused on personality traits and biological influences beginning in early childhood (infancy) and those biological factors played a huge role in personality development. He referred to these influences as milestones and behaviors that were shaped by inborn temperament. Temperament is a pattern of stable behavioral and emotional reactions that appear early in life (first two years of life) and influenced in part by genetic endowments (Kagan, 1994).

There are many definitions for normal versus abnormal personality development. A common social finding reported that the most critical factor in self-esteem is physical appearance (Erol & Orth, 2011). Individuals with high self-esteem tend to be emotionally stable, extraverted, conscientious, agreeable, and open to experience (Robins, Hendin, & Trzesniewski, 2001).

Each developmental theory attempts to define or illustrate that normal and abnormal behavior is a result of successful or unsuccessful resolving of conflicts at specific times during development.

Personality development from the psychoanalytic perspective attributes healthy development takes places when a person has successfully moved through the psycho-sexual stages and when there is a balance of the psychic energies of the id, ego, and superego. An unsuccessful personality development is an enduring pattern of inner experiences and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, and leads to distress or impairment (APA, 2013, p. 645). Some of the behavioral issues across 10 personality disorders include distrust, suspiciousness, detachment, discomfort with close relationships, disregard of rights of others, instability in interpersonal relationships, grandiosity, social inhibition, feelings of inadequacy, self-image, lack of empathy, submissive and clinging behaviors, preoccupations with orderliness, perfectionism, and control, violation of other's rights, and physiological effects of a medical condition (APA, 2013).

Freud believed that play was the cornerstone of the linkage with sublimation in career choice along with the psychosexual stages. Parten's (1932) established the importance of normalized play that resulted in six types of play with each an orderly progression to stages five and six in which the child learns to share, take turns, work and play with others shown to be a higher degree of success later in life.

Mary Ainsworth researching jointly with John Bowlby developed the theory of relationship attachment styles between the infant and parent and predicted that early attachment was the foundation for personality development. Security theory was the basis of her understanding in formulating attachment theory. Attachment theory does indicate that early behaviors are subject to change. However, those that do not change develop a pattern of social, psychological, and interpersonal conflict behaviors where some behavioral patterns become deviant from the social norms of society. Attachment theory stemmed from object relations theories where the actual quality of the infant-parent relationship becomes the shaping influence on the developing child's personality. Bowlby and Lovinger reported that children with secure attachments are less vulnerable to stress, are more resilient, and when

meeting stressful events rely upon earlier internal models of feelings of nurturing that are sustained into adulthood and influence the future conflict event. Additional findings for attachment styles report that anxious/resistant attachments increase the probability for anxiety disorders and avoidant attachment enhances the likelihood of conduct problems. Ainsworth predicted the probability of pathological symptoms would surface for the disorganized attachment and later reveal dissociative symptoms and possibly borderline personality symptoms (Sroufe & Siegel, 2011). Social competencies in adulthood are developed during early years and from the internal models of conflict styles to resolve disputes (Corcoran & Mallinckrodt, 2000). Rahim (1983) described five types: (a) dominating, (2) avoiding, (3) obliging, (4) integrating, and (5) compromising. The five types involve concern for self and others. Compromise may take place at the midpoint of self and others.

The definition of a biopsychosocial model is normal physical maturation during a period based on meeting critical tasks of learning to walk, talk and behave according to societal expectations. Not meeting these tasks slows development for age-related peers resulting in difficulty in achieving goals. Physical maturation, personal resources, and pressures of society are a combination of bio, psycho, and socio components (physical, cognitive, and psychosocial).

If personality is altered by an unsafe and insecure environment from infancy to adulthood, there is a lack of attunement, and the person has not developed a positive set of beliefs about the self and others and has a lower level of trust. The conflict appears to be at the root of a personality style in which the person resorts to an attachment style or conflict resolution style rooted in early infancy. The resolution style does not necessarily limit other interpretations for normal and abnormal personality. Resiliency skills may reflect the child's ability to respond to stresses and setbacks of life.

OBJECTIVE 3D: Addiction

Objective 3 d. theories of etiology of addictions and addictive behaviors (CACREP, 2015, p. 10)

Alcohol & Addiction

The alcohol user drinks excessively with the intention of getting "high" or drunk (Burnett, 1979). The alcoholic addict, on the other hand, has a compulsion to drink more and more once drinking has begun. With the addict, there is a loss of control. Although not all abusers become addicts, the counselor should be aware of the early signs of addiction when dealing with abusers. No one knows exactly at what point an abuser will cross the line into addiction. The counselor should also keep in mind that a maximum of 10% of alcohol users become addicts (Burnett, 1979).

Psychologically, alcohol abuse often results from a need to experience power. Physiologically, alcohol creates an illusion of power in the abuser. The alcoholic seeks a magical and immediate sense of power from alcohol as opposed to acquiring legitimate social power through goal-directed behaviors (Burnett, 1979).

An addiction occurs when the alcoholic or drug addict becomes obsessive, compulsive, and unable to control drinking, despite its adverse consequences (Washton & Boundy, 1989). The addiction has psychological and physiological components. Alcoholism must be viewed holistically as a psychosomatic

social disease with interpersonal and intrapsychic components as well as physical 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 domestic violence (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.

RISK FACTORS: ADOLESCENTS

Screening clients using voluntary self-reports for problematic substance involvement with alcohol or drugs are questionable, especially for adolescents (Smith, 2011; Winters, 2004).   Powell and Newgent (2016) reported that the Substance Abuse Subtle Screening Inventory-Adolescent 2 (SASSi-A2) for ages 12 to 18 is a screening instrument that asks indirect questions to gather information regarding amount and severity of involvement. They caution interviewers to be wary of underreporting and using a single source for assessing risk. Powell (2013) developed the Juvenile Addiction Risk Rating (JARR) utilizing a psychosocial approach for risk factors that focuses on multiple sources for characteristics and circumstances that reveal the progression toward substance involvement. These multiple sources include:

1. history of substance abuse services.
2. mental health history.
3. the family history of addiction.
4. the strength of family relationships.
5. peer selection.
6. school-related difficulties.
7. aggression and violence.
8. juvenile delinquency.
9. attitude toward substance use.
10. extent of substance use.

Recovery and Relapse

Recovery and relapse prevention treatment programs have been from two approaches. Early treatment programs focused on denial as prominent and the Twelve Step Plan program. Recent programs focus on strength approaches and view denial as healthy. One such model, Harm Reduction, is designed

to alleviate the social, legal, and medical problems associated with the unmanageable aspects of addiction. The harm-reduction emphasis is to limit the harm that may result from infectious diseases, violence, criminal activity, and early death. At the same, time the approach does not necessarily attempt to cure the addiction (Nadelmann, McNeely, & Drucker, 1997). Another strength-based approach by Rapp (1998) suggested that there are six components to recovery. These are:

1. identity as a human being
2. need for personal control or choice
3. need for achievement
4. need for purpose
5. need for hope
6. the 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 (1998) stated that negative emotions such as anger, anxiety, depression, and boredom accompany or promote the return to the addiction.

Models for Addiction

Several addiction models include temperance, spiritual, sociocultural, social learning, cognitive, biological, psychological, dispositional disease, general systems, public health, and biopsychosocial (Peterson et al., 2003).

The moral, psychological, family, disease, biological, sociocultural and multi-causal models help explain the causes of substance use and addiction (Capuzzi & Stauffer, 2012; Fisher & Harrison, 2013).

Moral Model: Puts forth the idea that addiction is not biologically determined, rather individuals inherently know right and wrong and mostly offers punishment therefore, a consequence.

Psychological Model: A mind-emotions concept where people crave alcohol and other mind-altering drugs.

Cognitive-behavioral Model: This model suggests that pleasure is the source and motivation and reinforcers constitute involvement with substances.

Psychodynamic Model: An ego deficiency, inadequate parenting, attachment disorders, hostility, and homosexuality (Capuzzi & Stauffer, 2012).

Family Model: Family members are important in assisting the client to become sober.

Disease Model: A model where the disease is progressive along with symptoms for each stage (prodromal, middle, crucial, chronic).

Biological Model: A predisposition of dependence on drugs (medical model).

Sociocultural Model: Based on sociocultural systems and understanding the social phenomena that surround the substance use.

Harm Reduction Model: The underlying assumptions for harm reduction are: a) alternative to the moral/criminal and disease model, b) abstinence is ideal but accepts alternative for reduced harm effects of use, not use itself, c) grassroots advocacy and not federally driven, d) meeting the person where they are, and e) a compassionate, pragmatic approach focus is daily living and not moralistic idealism (Marlatt & Witkiewitz, 2002).

Multi-causal Model: A combination of different models of addiction. Two examples are the syndrome model (Shaffer, Laplante, LaBrie, Kidman, Donato, & Stanton, 2004) and integral model (Amodia, Cano & Eliason, 2005). The Syndrome model includes addictions of eating, gambling, sexual behaviors, shopping, and substance abuse. This model includes three shared experiences that have intersecting variables (experiences and consequences, psychosocial antecedents, and neurobiological antecedents).

Assessment and Treatment

There are several approaches to assessing for addiction to include strength-based characteristics, other disorders, prior treatment, red flags, a motivation for change, type of addictive preference(s), family involvement as well as participation in substances, spirituality, coping skills and peer relationships. Assessment for screening and diagnosis can include standardized instruments such as the Substance Abuse Subtle Screening Inventory (SASSI-3), Michigan Alcoholism Screen Test (MAST), and The Cage. The MMPI-2 has three scales of importance: MacAndrew Alcoholism Scale-Revised (MAC-R), Addiction Potential Scale (APS) and Addiction Acknowledgment Scale (AAS).

Evidence-based practices are the treatments of choice. The National Registry of Evidence-based Programs and Practices (NREPP; http://www.nrepp.samhsa.gove) listed 96 intervention programs for abuse prevention and treatment. Cited as evidence-based treatments include cognitive-behavioral, contingency management, solution-focused, and interventions programs. Interventions have not been found to be helpful. Harm Reduction has a strong emphasis on prevention with an outcome of reducing the harmful effects of the addiction and substance (Marlett, 1998). Emphasis is more on the harmful effect rather than the actual substance. One example of the harm reduction concept was the needle exchange program that offered clean syringes during the increase of HIV/AIDS.

Guidelines for Counseling

Discover whether the client is in control of his or her drinking by taking a drinking history in a nonjudgmental manner. Get specific, objective information.

1. Once the client has decided he or she is an alcoholic (which may require several progressively confronting interviews including family members, employers, etc.), refer the client to AA or a hospital alcoholism treatment center.

2. Refer the family to Al-Anon and Al-Ateen.

3. Once sobriety is established through 6-12 months of membership in AA, individual counseling may resume with the goal of understanding the underlying issues of alcoholism. It is imperative that the client maintains active participation in AA simultaneously. Burnett (1979) contends that until abstinence is achieved that counseling will not be effective. At the same time, however, as Washton and Boundy (1989) pointed out, the drug itself is not the complete problem. Therefore, getting off the drug is not the whole solution.

4. The goal of counseling is to help the client shift from a passive-dependent approach to a more active, problem-solving, self-reliant, goal-oriented approach. The counselor should help alcoholics to own the split-off, rejected parts of themselves that they've masked through drinking. Assertiveness training may be particularly helpful for the recovering alcoholic as he or she learns to achieve power through instrumental behaviors (Burnett, 1979). The key is to build a healthier, nonaddictive lifestyle (Washton & Boundy, 1989).

5. The recovery process must be holistic and multidisciplinary, involving family counseling, psychotherapy, medical supervision, a spiritual program, and personal development of non-chemical coping skills. The goal is recovery through understanding and healing the internal need for a mood-changing chemical (Washton & Boundy, 1989).

Addictive Drugs (other than alcohol)

Any drug that results in the development of a tolerance effect and withdrawal symptoms is considered addictive (Burnett, 1979). The Drug Awareness Warning Network (DAWN) reported, in a 2011 survey, the illicit drugs identified in emergency room episodes were in rank order cocaine and marijuana followed by heroin, marijuana, amphetamines, methamphetamine, MDMA, GHB, Flunitrazepam, Ketamine, LSD, and PCP (DAWN, 2011).

Todd and Harp (2017) reported according to the Center for Disease Control and Prevention that 91 people die every day from opioid abuse. Since 1999 approximately 200,000 Americans have died because of abusing opioids. Meyers (2017) reported that in a single day in West Virginia in one community (Huntington) 26 people overdosed on opioid abuse and that 26 were revived because of naloxone, an antidote. Opioids include prescription pain relievers and illegal drug heroine. Also, once a person is addicted to pain killers the individual is likely to turn to heroine mixed with fentanyl, a stronger opioid. CDC data revealed that during 2015, 33,000 Americans died from opioid overdoes. Counselors during client history assessment should be alert to risk for opioid addiction because of trauma, mental illness, family relations broken or struggling and for other substance abuse.

The drugs with the highest dependence potential are heroin, crack cocaine, morphine, and opium (DAWN, 2011; Ray & Kisir, 2002).

Stimulants are often referred to as uppers and include many drugs. Addicts who use stimulants experience a feeling of less fatigue, increased alertness, and mood elevation. Behaviors associated with stimulant withdrawal tend to be a drug craving, irritability, depression, anxiety, apathy, and attempts or thoughts of suicide. Some drugs included under stimulants are:

1. nicotine.
2. amphetamines or methamphetamines ("uppers" or "speed").

3. cocaine/crack (produces the same effect as amphetamines but for a shorter duration of time).

Other substances often abused: glue, stimulants (caffeine, nicotine), LSD, PCP, ecstasy, peyote, hallucinogens, marijuana, mescaline.

Depressants are often called downers. Alcohol is the most widely used depressant. Barbiturates constitute another depressant group.

Hogan, Gabrielsen, Luna, and Grothaus (2003) suggested that certain factors point toward involvement in drugs. Counselors should be cognizant of the risk factors associated with substance use. Risk factors in the community, family, school, and within the individual are noticeable signs of possible involvement in drugs. Risk factors for the community are availability, favorable attitudes toward drug use, and mobility. Family risk factors include a 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 a school. Individual risk factors are alienation, rebelliousness, friends who are involved in problem behavior, and favorable attitudes toward problem behavior.

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, and 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 feelings so that there is less need to escape reality.

4. Marshall all resources to support the client's efforts. Utilize peer counseling, 12-step programs, support groups, family therapy, community programs to meet legitimate dependency needs and which encourage through the development of trusting relationships.

5. Counselors treating opioid addiction use a strengths-based approach focusing on wellness (Todd & Harp, 2017).

Question 3-32:

The treatment of choice for substance use addiction is:

a. peer counseling and support groups.

b. a 12-step program such as AA.

c. family and individual therapy simultaneously.

d. to wait until a support system is developed.

Answer: b. a 12-step program such as A.A. Most addicts readily respond to treatment programs, which include AA meetings.

Question 3-33:

What treatment would be recommended if a counselor was practicing harm reduction with a client experiencing an alcohol use disorder?

    a. Adlerian and supportive therapy

    b. CBT and Solution-focused

    c. Psychodynamic and Object Relations

    d. Person-centered and Reality Choice theory

Answer: b. CBT and Solution-focused. CBT and Solution-focused therapy are brief with a low threshold.

OBJECTIVE 3E: Neuroscience, Biological, & Physiological Factors

Objective 3e. biological, neurological, and physiological factors that affect human development, functioning, and behavior (CACREP, 2015, p. 10)

It has become increasing more important that counselors develop an understanding of neurobiological behavior regarding the nature and needs of persons at all developmental levels. Understanding neurobiological behavior involves brain chemistry and effects regarding human growth and development. Understanding the development and implications when issues arise cuts across all eight objectives of this unit. Neurobiological behavior is defined as "the relationship among brain anatomy, function, biochemistry, learning, and behavior" (CACREP, 2009, p. 61). This form of feedback is essential in recognizing, monitoring, and training clients to self-regulate in those areas where brain waves and chemistry is of such importance to improved health. For interested readers, a comprehensive article written by Meyers and Young (2012) provides an extensive coverage of biofeedback, neuroscience feedback and potential uses in counseling.

Ivey and Zalaquett (2010) reported that measurable structural changes occur in client brains as a result of cognitive and interpersonal therapy. Neuroscience terms include neuroplasticity, neurogenesis, attention and focus, and understanding emotions are central understanding how the brain can change. The impact of stress has profound effects that include:

    a. impulsivity.

    b. short-sightedness.

    c. aggressive behavior.

    d. depression.

    e. alcohol and drug use.

    f. learning disorders.

    g. stress-related diseases (p. 108).

The stress response includes increased heart rate, respiratory rate, and strengthened muscle tone each of which has an impact on judgment, planning, decision-making, and a sense of self.

Darwin was the first to suggest that emotions such as anger and fear have an innate neural understanding of the mind-body connections (Ross, Homan, & Buck, 1994). Heilman, Bowers, and

Valenstein (1985) reported that a neuroscience relationship exists between the right brain and primary emotions. As a result, neuroscience feedback is based on this relationship. The smart vagus nerve consists of the active processes of attention, motion, emotion, and communication. For readers interested in learning about the relationship among emotions, attachment, communication, and self-regulation read Porges (2011), *The Polyvagal Theory*.

The function of neuroscience feedback is to allow clients to monitor and make changes to brain wave patterns that assist in self-regulation and symptom reduction. Different emotions and disorders can be identified by changes in alpha, beta, and theta waves. If clients learn to regulate brain waves, it will improve autonomic regulation, promote brain competencies, help remediate brain-based disorders, and improve underlying conditions (Arns, Ridder, Strehl, Breteler, & Coenen, 2009). Another positive outcome is there have been no side-effects reported.

Learning how the brain works regarding neuronal transmission and the blood-brain barrier clarifies understanding how medication and drugs alter the chemistry of the brain and neural receptor activity and changes. The impact of the counselor and intervention strategies is to educate clients regarding the linkage of issues and normal functioning. Thus, the client can become aware of and understand the bridge of experiences and the issue. Jencius (2014) pointed out the research of others that there are mirror neurons. These neurons fire whether the person is in action or observing. If this activity is present, whether in activity or observing the implications for intervention during the therapy hour is enhanced and suggestive of new techniques. Jencius likens the mirror neurons to empathy.

For research purposes findings and knowledge acquisition Henirich, Gevensleben, and Strehl (2007, p. 54) described wavelength during sleep as delta (1-4 cp), drowsing or daydreaming takes place as delta (less than 4 Hz), theta (4-7 cps, 4-8 Hz), alpha waves (8-12 cycles per minute, 8-13 Hz) as brain idling and ready for action, beta waves (13-21 cycles per minute, 13-30 Hz) thinking, focusing and sustaining action and high beta waves (20-32) with hyperactivity and anxiety (p.22).

Research findings:

1. Low-frequency brain waves are associated with relaxation, meditation and trainability (Othmer, Pollock & Miller, 2005)
2. Too little alpha in right hemisphere correlates with social withdrawal and depression
3. Too much beta in the right hemisphere is correlated with mania (Soutar & Longo, 2010, p. 70).
4. High beta wave frequency was found with OCD, sleep disorders, ADHD, anxiety, depression, and learning disorders (Demos, 2005)
5. Alcohol abusers have lower levels of alpha and theta waves and extra beta waves (Peniston & Kulkowsky, 1989)
6. When beta waves reach a range of 20-32 cps, hyperactivity and anxiety are often associated.
7. Most ADHD children have slow theta wave activity (Loo & Barkley, 2005)

Counseling Implications

Ivey, Ivey, Zalaquett, and Wuirk (2009) pointed out that there is a relationship between biological and psychological functioning that has implications for counseling. These implications are:

1. the brain can change and remodel itself.

2. the brain can build new pathways.

3. counseling skills such as attending are measurable with brain imaging; empathy can be identified and measured.

4. each person's emotions fire in different parts of the brain.

5. training in the frontal cortex will promote strengths and wellness.

Question 3-34:

Biofeedback and neuroscience feedback have identified a relationship that exists between biological and psychological functioning and can be measured. Two relationships that can be measured are?

    a.   anger and confrontation

    b.   rescuing and empowerment

    c.   attending skills and empathy

    d.   frustration and fear

Answer: c. attending skills and empathy

OBJECTIVE 3F: Environmental Factors

Objective 3 f. systemic and environmental factors that affect human development, functioning, and behavior (CACREP, 2015, p. 11)

Systematic and environmental factors that influence human development and functioning have been pointed out in several units. Documented in the literature are behaviors for adults and children experiencing oppression in the form of biases regarding race, religion, gender, and cultural factors. Behavioral results have been worker dissatisfaction, physical and psychological illnesses, suicide, aggression, social isolation, and a lack of fairness in life pursuits.

The Fragile Families and Child Wellbeing Study (FFCWS) was a cohort study of interviews with 9-year old children and their parents that emphasized children's behavior problems and personal functioning as a result of the impact of environmental factors. The FFCWS study conducted during 2007-2010 in 15 states and 20 cities included a population of 4,898 births, sample of 3,311 between 1998 and 2001 (Schneider, Waldfogel, & Brooks-Gunn, 2015). The sample contained 52% male, and 21% of mothers were White, 50% Black, 26% Hispanic, and 3% another race/ethnicity and follow-up surveys were conducted at ages of 1, 3, 4, and 9 years of age (Census 2000 Population Statistics, 2011). The authors focused on the Great Recession and resulting turn of events such as the decline in gross domestic product, increases in national unemployment, news coverage of home foreclosures, decline in consumer confidence, decline in national Consumer Sentiment Index (CSI), perceptions of personal finances and state of the economy as shock factors in development and functioning.

The study included hypotheses derived from data such as warmth, psychological aggression, depression, household income, and unemployment. Data was gathered through instruments, in-home visits, interviews, and national databases. Four hypotheses (paraphrased) include:

a. worsening consumer confidence was associated with an increase in child behavior problems

b. the strong link between economic uncertainty and outcomes for boys and girls, more likely boys to experience behavior problems

c. single mothers are more likely, due to economic hardship and uncertainty, to have children who may experience behavior problems

d. children's difficulty and behavior problems may be due to the mother's increased harsh parenting practices, reduced warmth, and increased depressive symptoms and may partially mediate those associations (p. 1618).

The impact factors included internalizing (aggression) and externalizing (anxiety and depression), alcohol and drug use, and vandalism. Schneider, Waldfogel, and Brooks-Gunn (2015) cited 11 research reports for the Great Recession regarding effects of children and family relationships.

The FFCWS Great Depression aggregate shock results indicated that there was evidence for:

a. Boys displayed more externalizing and internalizing behaviors as the Consumer Sentiment Index (CSI) worsened. Boys self-reported vandalism and use of drugs and alcohol (not girls).

b. Boys living with single mothers may be at risk during economic downturns and experience an increased instability or lack of support faced by families and as a result change in parenting

c. Unemployment was not found to be a factor in child behaviors

d. Child well-being may be associated with the Great Recession.

The systemic and environmental impact is evident in the workstations often with debilitating effects for diverse workers. Needs assessment addressed different variables that have negatively impacted the lives of clients. Management style and the work environment (72%) and personal life changes (42%) have resulted in increased anxiety, exhaustion, discontent, depression, sleep issues, social avoidance, troubled relationships, hospitalization, physical illness, alcohol abuse, suicide, and violence (Dooley, 2003). Also, Murphey and Shillingford (2012) reported the unemployed male experienced sadness, increased anger, antisocial and narcissistic behaviors and conflicts with loved ones, lower self-esteem, shame, isolation, and psychiatric disorders. African American women experienced disturbed affect, reduced cognitive functioning, personal strain, and lower levels of satisfaction because of stress, lack of advancement and work mobility, and psychological disturbances (Norman & Tang, 2016).

OBJECTIVE 3G – Disasters, Crises, Trauma

Objective 3 g. effects of the crisis, disasters, and trauma of diverse individuals across the lifespan (CACREP, 2015, p. 11).

Developmental Crises

A developmental crisis occurs if a change or transition is too extreme for the coping mechanism of an individual. The crisis may be physical, mental, social, or environmental. A coping mechanism that may be lacking is a skill deficit, overload in demand (stress) and a transition out of sync with societal expectations. An assessment is the first step regarding the person's perception of the crisis. The counselor gathers

symptom data in the form of behavior, affective, somatic, interpersonal and cognitive. An example may be the use of Erikson's psychosocial stages regarding resolving the crisis at that stage. A crisis can be developmental, situational, existential, and ecosystemic. James (2008) outlined four intervention models to be the equilibrium (Caplan, 1961), cognitive (Ellis, 1962), psychosocial transition (Dorn, 1986), and contextual-ecological (Myer & Moore, 2006).

Response to a crisis is to provide support and aid in the form of assistance to the victims. The ecological model explains the cultural and social contexts of a crisis in the larger system. The three elements of the theory are layers of a crisis, reciprocal effect, and time factor. Layers refer to the nearness to the crisis and reactions that are moderated by perception and meaning. Reciprocal effect involves the interactions among the primary and secondary relationships and the degree of change as a result of the crisis. Time includes understanding the amount of time that has passed since the crisis and special occasions such as the anniversary after an event such as the 9-11 tragedy. Myer and Moore (2006) calculate the impact as a function of proximity, reaction, relationship, and change divided by time.

Erikson believed that his first two psychosocial stages transcend all of the stages. That is if, positive social development took place than the individual's needs will be met. Secondly, when attitudes toward self and others merge together, one develops a balance between positive and negative feelings and a successful resolution takes place if the positive outweighs the negative.

Trauma

Trauma is assessed as post-traumatic stress disorder (PTSD) when criteria are assessed and met for the DSM-5. However, symptoms may be repressed and observed years later. Abusive behaviors referred to as bullying may be a trauma. Many people who witness bullying may suffer a trauma. Bullying is not harmless, minor, or developmentally appropriate behavior rather there is long-lasting psychological and physiological stress. Bystander witnessing to repetitive acts of abuse as well as victims of ill-treatment generates feelings of isolation, humiliation, hopelessness, helplessness, and ineffectiveness (Hazler, 1996; Hazler, Miller, Carney, and Green, 2001). Also, resultant behaviors may include feelings of revengefulness and suicidal thoughts (Carney, 2000). Bullying comprises three characteristics: (a) an adverse action that harms someone, (b) an imbalance of power, and (c) repetition over time (Janson, Carney, and Hazler, 2009; Monks & Smith, 2006). Bullying typically occurs between the 5-8 grade levels and situational factors such as race and emotional or intellectual abilities have been cited. Janson et al. (2009) in a study of 586 adults reported that the abused who apparently recalled the event experienced psychological trauma at a level of distress. Participants indicated they experienced sadness and fear, anger and emotional pain, helplessness, and feelings of being physically ill. Intervention and prevention for bystanders start with understanding the level of trauma. Factors to consider in responding include: (a) type of witnessed abuse, (b) relationship to the abuse victim and perpetrator, (c) intensity, frequency, and duration of witnessed abuse, and (d) bystander's emotional state (depression, anxiety, and anger). Treatment for the four factors across cultural contexts include narrative and play therapy.

Disasters

Trends for disaster preparedness and response involve medical and psychological training for victims, administrators and service providers for the increasing numbers of disasters. Disasters throughout the

world have focused the attention on national and international figures for immediate responses. During and after trauma first responder efforts have been rescuing and aftercare for victims of earthquakes, mudslides, tornadoes, typhoons, hurricanes, tsunamis, and disasters resulting from human causation. Large-scale disasters such as the Asian tsunami and Hurricane Katrina (Fernando & Herbert, 2011), garment factory collapse in Bangladesh killing 100, Hurricane Andrew, and 9-11 have accounted for the serious loss of life and significant life adjustments for those survivors. The sustained stress and decision-making during life and death decisions such as those taking place during the Katrina hospital patient evacuation resulted in desperate actions (Fink, 2013). These have become global concerns ranging from the mudslides in Oso, Washington, Japanese power reactor spills, New York City Sandy flooding, multiple tornadoes striking a community, hurricane in Haiti, typhoon in the Philippines, Twin Towers, Fukushima nuclear disaster in 2011, and loss of lives in the thousands at several of these sites.

These disasters have called upon local, state, and federal relief efforts for locating living and dead victims, notifying and reconnecting family members, housing, food, medical assistance, debriefing and psychological support in the form of counseling. In the past agencies' responses have been by the American Red Cross and federal organizations such as FEMA, military presence for civil order, evacuations, needed supplies, and international assistance.

Physical and psychological recovery efforts for many reach beyond the time of the disaster. In fact, for some the prevailing thought is to wait and observe before attempting debriefing and or restorative efforts (documentation lacks effectiveness studies for debriefing). At risk victims are those who do not respond immediately and who may lack coping skills, resources, and family and community connections for assistance. The trauma of surviving the disaster, experiencing horrific deaths of loved ones and others, having language difficulties in communicating needs, experiencing physical harm, witnessed homes destroyed, seeing a breakdown in civil obedience has shaken the internal self of survivors.

Fernando and Herbert (2011) interviewed and counseled victims in two different disasters and found commonalities across the experiences. Some of these commonalities had to do with surviving, and others centered on the trauma. These authors site several other authors who have researched factors that are important to survive a disaster. The accumulated research identifies post trauma processing of the catastrophe by the survivor. During and immediately after a disaster certain behaviors and responses take precedence such as physical safety, food, lodging, and the basic needs of life. Medical practices have found the best opportunities for healing are at the time of the insult. If a client can process the event soon after the disaster or trauma, initiated changes for a quicker recovery are improved. That is not to indicate that counseling practices later are not helpful, as they are. A second survival factor is the ability of the person to have the necessary stamina (resiliency) to confront the trauma along with the subsequent losses sustained by the disaster survivor. The secondary trauma or injury may be regarding a home, work, finances and social support. There is no single pathway for victims to process the trauma as many variables are to be considered such as age, gender, and type of disaster, intensity and severity of personal loss, ethnic diversity, support systems and previous personal experiences with trauma. Psychological first aid offers support, reassurance, comforting and calm communication, and a physical presence. The emotional well-being through psychological first aid includes basic human responses of comforting and consoling. Mary Trentini, a parent of a child in the Newtown shooting, stated that what she recalls was "there was one person who was just kind, she just came and sat with me and held on" (Aleccia, 2013).

Coping during and after a disaster is reliant upon past understanding of processing skills. A combined approach with problem-oriented (solving a problem) and emotional-oriented (reducing negative components) set of skills is essential for coping (Carver & Scheirer, 1994; Carver, Scheirer, & Weintraub, 1989). Disasters are experienced and often perceived by survivors as larger than the person thus feelings are magnified and frustrations quickly multiply resulting in feelings of fear and hopelessness. Survivors experience a series of emotions ranging from an inability to meet what is before them, to resume their life, and that life will never be what it was before the disaster. Victims feel entirely in the care of relief workers, first responders, medical and psychological personnel to make available pathways to stabilize a resemblance of normalcy and to resume their lives. Roysicar, Thorn, and Thomas (2008) in a PowerPoint presentation (slide 18) identified internal and external coping mechanisms. Internal characteristics were humor, optimism, intelligence and creativity, high levels of self-esteem, internal locus of control, empathy, and hardiness. External components included an absence of additional life stressors, strong social and family support network, education, employment, and material resources, health and property insurance. Two other support resiliency elements were noted by Fernando and Herbert, that of religion and hopefulness for the future.

Ryan and Deci (2000) utilized the term disaster agency which is the ability of the victim to possess the internal stability (stamina) to address the trauma. This stamina appears to be a trait in which the person confronts his or her purpose in life and strives to embrace survival (persistent strength, resourcefulness, and surviving will).

Responding skills regarding large-scale disasters require triaging, immediate assessment and planning for the relief actions for the service provider as needed. SAMHSA published TAP 34: Disaster Planning Handbook for Behavioral Health Treatment Programs (Substance abuse and mental health services administration, 2013).

Professionals, volunteers, and first responders provide frontline services to those encountering disasters. Most, who experience a disaster, whether as a victim or a responder, will have a psychological, physical, cognitive and emotional response to the event (American Medical Association, 2005). Associated with a disaster are psychological distress, severe depression, somatic symptoms, posttraumatic stress disorder (PTSD), acute stress reaction, and changes in the amount and type of substance use (Cedra, Tracy, & Galea, 2011). The well-being of service workers necessitates being vigilant about self-care. Factors that impinge on self-care include burnout, compassion fatigue, and vicarious trauma. Ehrenreich and Elliott (2004) compiled a list of stressors from reports by participants who responded to disasters. This list included:

a. long hours in treacherous conditions.
b. an excessive amount of work.
c. separation from family.
d. a lack of privacy, constant immersion in fear and danger.
e. a lack of appreciation.
f. the sense of helplessness.
g. overwhelming guilt for having food, clothing, shelter, or other things that the disaster population lacks.

In summary, psychological first aid administered by first responders offers support, reassurance, comfort and calm communication and a physical presence. Responders are trained to recognize saliency skills as a positive coping skill to a disaster. Those with coping skills will, in time, rebound with efforts to right the situation to the best of their abilities assuming the necessary resources are available. Those whose coping skills of resiliency are deficient will need more immediate assistance for safety, food, housing, medication, and psychological services in adjustment.

Stress

Dr. Hans Selye (1956), a medical researcher, was one of the first pioneers to study and write about 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. The alarm reaction is the body's response to an attack on its system. The physical response includes blood is concentrated, pupils dilate, breathing becomes faster, and the heart rate increases (Matheny & Riordan, 1992).

Stage 2: Stage of resistance. This stage of adaptation is resistance as blood is dumped into the bloodstream to combat the stressor.

Stage 3: Stage of exhaustion. Systems appear similar to the stage of alarm reaction. A sort of premature aging due to wear and tear on the body occurs.

Selye also coined the word "eustress" which is "healthy stress." He theorized that the body would undergo less wear and tear when it is under a moderate amount of stress and pressure than when it is inactive (Matheny & Riordan, 1992). Distress is an unpleasant or disease-producing stress. Later Selye added hyperstress and hypostress, an over-and-under stress reaction. The hypostress person lacks self-realization.

The diathesis-stress model explains psychopathology results from an interaction of a predisposition to a psychological disorder and experiencing stressful events. Some therapists point to this explanation for depression.

1. Coping with Stress

    A response to stress is primary prevention and 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 to cope 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 modify the environment to make it less stressful.

An example of an instrumental intervention is changing some aspect of the workplace to reduce stress.

2. The Effects of Stress

Continued stress weakens the immune system and 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 an extended period, though, the organism will begin to wear down.

3. Stress and Personality

According to Matheny and Riordan (1992), there are three personality types that induce the stress response more often and at a detrimental level.

   a. The Anxious Reactive Personality: This type of person overreacts to stressful experiences and, as his/her arousal level increases, he/she reacts anxiously to his/her symptoms.

   b. Coronary-Prone Personality: Friedman and Rosenman (1981) identified 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 suggested that 60% of Americans are Type A. Friedman and Rosenman (1974) refer to Type A as the hurried syndrome, and these individuals tend to be prone to stress-related illnesses. Type B people 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 people 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: The disease-prone 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 a disease.

4. Other Names and Terms Associated with Stress

   a. Walter Cannon (1929)-The body sets off adjustments to change and disruption. Holmes and Rahe (1967) developed the Social Readjustment Rating Scale that is comprised of life events that are rated according to the amount of stress they produce. A total score of 300 or more indicates the likelihood of depression or illness in the coming 24 months (McMahon & McMahon, 1986).

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

      Learned Helplessness 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 stress caused by unpredictability and uncontrollability. Helplessness is a condition that occurs when events are perceived as uncontrollable (Seligman, 1975).

The primary element of helplessness is based on 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 lead to 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 does not act when events are controllable.

Question 3-35:

The General Adaptation Syndrome was developed by:

    a. Seligman.

    b. Selye.

    c. Simpkin.

    d. Holmes and Rahe.

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

OBJECTIVE 3H: DIFFERECING ABILITIES

Objective 3 h. a general framework for understanding differing abilities and strategies for differentiated interventions (CACREP, 2015, p. 11)

Exceptional Abilities

Children and adults differ from one another physically and intellectually as well as in applying learning attributes as some can act with what they have learned while others need to repeat and practice. Exceptional people differ from the norm and need individualized programs. Exceptional individuals can be those who have difficulties in physical abilities and learning while those of superior qualities also require special needs. People with exceptional abilities either excel or are lacking in characteristics of cognition, affect, intuitive ideas, physical and social skills. Terms such as impairment, disability, and handicap do not have the same meaning. Impairment is the loss or reduced function of a body part. A disability exists when impairment limits the person. A person is not handicapped unless a disability leads to educational, personal, social, vocational, or other problems.

Characteristics for cognition can include a quantity of information, advanced comprehension, ability to generalize, use abstracts, see unique and diverse relationships, generate original ideas and interests, know the intensity of interest/commitment and has goals, language development, and determine the appropriate approach to self and others. Characteristics of affect are humor, sense of justice, sensitivity to others, heightened self-awareness, emotional depth and intensity, high expectations, internal locus of control and, need for consistency. Intuitive characteristics consist of the ability to predict outcomes, interest in the future, and creative and intuitive knowledge. Societal characteristics include interest in social problems, ability to conceptualize, and leadership skills. Hollingworth (1942) in studying the highly gifted children indicated that they are early in talking, reading, imagination, and practice extreme precision.

Categories found to be common with exceptional individuals might be an intellectual disability, learning disabilities, emotional and behavioral disorders, autism spectrum, communication disorders, hearing impairment, visual impairment, physical and health impairments, traumatic brain injury, multiple disabilities, and giftedness and special talents. Heward (2010) reported that special education in some form is required.

Differentiation of exceptional abilities is the task of a qualified psychometric or school psychologist with an experienced background.

The Rehabilitation Act of 1973 Section 504 and The Americans with Disabilities Act of 1990 (1991) protect the rights of individuals with exceptional abilities. Public Law 94-142 allows for assessment and individualized programs of remediation.

OBJECTIVE 3I: Ethics and Cultural Strategies for Resiliency and Wellness

Objective 3i is the awareness of ethical and culturally relevant strategies for promoting resilience and optimum development and well-being across the lifespan (CACREP, 2015, p. 11)

Wellness and Prevention

Wozny (2012) devoted an article to promoting leisure wellness in counseling. The implications for this unit of study include wellness from a prevention approach for the counselor and the client. Of immense importance is the direct effect of emotional states on immunity and illness. The ACA 2014 Code of Ethics in Section F.8.c. emphasizes self-growth, an expected component of the counselor-in-training. Also, the code specifies remediation regarding impairment (C.2.g.) and for personal concerns (F.8.d.).

Self-care in the form of assessment and implementation of effective strategies to maintain a healthy lifestyle are encouraged. The result of not doing so increases the risk of fatigue, burnout and eventual impairment for the counselor. For clients, the same exist but also includes health issues, relationship conflicts, and personal psychological risks. Review unit one for definitions of serious and casual leisure perspective and resiliency. That same unit highlights Myers, Sweeney, and Witmer's (2000) wheel of wellness and suggestions for treatment planning. The concept underlying wellness is prevention and alternative methods of intervention and remediation when working with clients. An overarching goal for clients is to move from a dependent position in life to one of independence. The charting for wellness includes an assessment and planning for spirituality, self-direction, sense of worth, realistic beliefs, emotional awareness, problem-solving and creativity, sense of humor, nutrition, exercise, self-care, stress management, cultural identity, work, leisure, friendship, and love. One or more of these categories is a part of a large majority of counseling cases.

Remley and Herlihy (2010) approached the topic of early prevention and prevention from a wellness perspective. The philosophical and practical belief system in responding to societal client needs by counselors is the belief in prevention-oriented efforts to identify the risk factors, protective factors, and precursors of psychological issues. Counselors endorse the mental health beliefs in assisting clients through the client's emotional issues within the wellness model of mental health. The belief is that

problems are developmental; prevention is superior to remediation interventions, and to empower clients to resolve their problems (pp. 19-20). Prevention strategies are primary (awareness and teaching preventive techniques), secondary (intervene the issue or symptoms), and tertiary, reducing the effects (Gibson & Mitchell, 2008).

The Institute of Medicine (IOM) in 1994 regarding prevention focused on precursors of dysfunction and health risk factors and protective factors (Heller, 1996). The first task was to define prevention. The committee studied and described prevention as interventions that occur before the initial onset of a clinically diagnosed disorder (Munoz, Mrazek, & Haggerty, 1996). The second step was to define intervention types to be universal preventive (entire population at risk), selective preventive (individuals or subgroup whose risk of developing a mental disorder is significant) and indicated preventive interventions (high risk).

Risk factors are characteristics, variables, or hazards, that if present, increase the likelihood of a disorder. Protective factors are those factors that will lessen or reduce a person's predisposition to a dysfunctional outcome (Rutter, 1985). The IOM commissioned five disorders for prevention study regarding the risk and protective factors. The disorders are conduct disorder, depressive disorder, alcohol abuse and dependence, schizophrenia, and Alzheimer's disease.

Resiliency-Individual, Couple, Cultural, Family and Community

Resiliency is the "ability to cope in the face of adversity" (Ward, 2003, p. 17). Fink-Samnick (2009) defined professional resiliency as a "commitment to achieving balance between occupational stressors and life challenges while fostering professional values and career sustainability" (p. 13). Lambert and Lawson (2013) found in their study of professional counselors that they experienced burnout and compassion comparable to that of the general survivors of Hurricanes Katrina and Rita. They found that counselors who volunteered and were personally affected by the hurricane had higher levels of posttraumatic growth than did counselors who volunteered and were not affected by the disasters.

Resiliency as a strength-based factor has been a research topic in family dynamics, children, women, burnout, stress, and trauma studies. Jean Baker Miller in her relational cultural model investigated and defined compassion fatigue regarding the characteristic resiliency. Her researched focus was relational resiliency as growing in a relationship and being able to move forward despite setbacks (Miller, 1976; Miller & Stiver, 1997). McCubbin and McCubbin's (1996) family model emphasized a resiliency model for family stress, adjustment, and adaptation. Stamina is a characteristic of resiliency. Osborn (2004) identified seven key salutary variables for stamina: selectivity (S), temporal sensitivity (T), accountability (A), management (M), inquisitiveness (I), negotiation (N), and acknowledging agency (A). Relational resiliency is a movement to a mutually empowering, growth-fostering connection in the face of adverse conditions, traumatic experiences, and alienating sociocultural pressures and the ability to connect, reconnect, and resist disconnection. The movement toward empathic mutuality is at the core of relational resilience (Jordan, 2004).

Fernando and Herbert (2011) researched recovery variables for women who were survivors of the Asian tsunami and Hurricane Katrina. Their research pointed out the importance of internal and external resources that existed for the 14 women in the study. Internal resources involved optimism, creativity, humor, high levels of self-efficacy and self-esteem, internal locus of control, empathy, and cognitive

hardiness. External resources included strong social and family support and network, education, employment and material resources (Roysircar, Thorn, & Thomas, 2008). The core factors for the women in the tsunami and Katrina disasters found religiosity, hopefulness, church and worship, self-agency (sense of self), stamina, social support, and feelings of belonging (Fernando & Herbert).

Individual characteristics of resiliency

1. self-attitudes (healthy self-relationships, goals, self-discipline, flexibility, a sense of purpose)
2. social attitudes (social responsibility, tolerance, ability to forgive, gratitude, morality)
3. skills (communication, sense of humor, insight, problem solving, critical thinking, planning)
4. noble abilities (faith, wisdom, creativity, dreams, hope, goal of highest good, courage)

Resiliency is a process that sustains individuals through change and includes:

1. the process that draws upon characteristics, abilities, and skills.
2. capacity possessed by all people.
3. the inner strength that does not change while we are being changed.
4. the internal song that anchors us within ourselves, linked to self-familiarizing activity, belief, or other self-soothing behavior.
5. innate dignity in spite of powerlessness.
6. moving forward, moving inward and moving upward. Crisis workers use resiliency to strengthen the human spirit of clients.

Optimal Development

Theories for facilitating optimal development and wellness over the life span include those methods that will enhance the likelihood of achieving satisfaction into adulthood. Lifespan development is about change and having an optimal development, being able to part with some order of development and assume new roles, becoming cognizant of critical timing issues during the lifespan, and being aware of cause-and-effect relationships (Siegelman & Shaffer, 1991). Theories describing optimal development would include creating a successful lifestyle of play, school, and work. Theories of personality and well-being, work and financial stability, achievement, generativity, empowering relationships, meaning in life, coping strategies to meet the stressors in life, mindfulness, and self-compassion all contribute to optimal development.

Unit 3 – Terms

ADDICTION:
Addiction is often defined by four criteria: (1) preoccupation with the substance or activity, (2) withdrawal signs after not engaging with activity or substance, (3) increased tolerance for the substance or activity in order to receive the same effect, (4) continued use of the substance or involvement with the substance or activity despite negative consequences (Buck & Amos, 2000).

ADDICTION MODELS:

Addiction models include moral, psychological, cognitive-behavioral, learning, psychodynamic, personality theory, family, disease, biological, genetic, sociocultural, and multicausal

CENTRATION:

The ability to concentrate on one thing at a time. A concept Piaget found to exist in the Preoperational Stage. A child can focus on only one element of an action or thought; e.g. only one car when viewing cars and different models.

COHORT EFFECT:

The fact of being born at a particular time and growing up in a particular historical context (Siegelman & Shaffer, 1995, p. 16).

COMPASSION FATIGUE:

Compassion fatigue refers to "vicarious traumatization" (Figley, 1995). It is the emotional residue or strain of exposure to working with those suffering from the consequences of traumatic events (hurricanes, floods, earthquakes, bombings). The process of compassion fatigue involves exposure to suffering, empathic ability, and concern, leading to empathic response, detachment, sense of satisfaction, resulting in residual compassion stress, with prolonged exposure to suffering, traumatic memories, and life demands resulting in compassion fatigue.

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 on dominant ideas or beliefs and is consumed with them, never to let them go.

DEVELOPMENTAL NORM:

The average age of mastery for specific developments such as locomotion, puberty, speaking, learning volume, and other unique aspects of human growth.

EQUILIBRATION:

A term coined by Piaget for when a schema becomes more mature.

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 occurs when reassurance is received from pleasant stimulation.

HARM REDUCTION:

Harm reduction is a philosophical method for those suffering from alcoholism that 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.

HEDONISM:

Hedonism is 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. Behavior is essentially self-centered and pleasures seeking (Edwards, 1979).

HIERARCHICAL:

Maslow's hierarchy of needs is 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 destiny, he/she is internally controlled. If the individual feels that others control his/her life, then he/she is externally controlled (Rotter, 1975).

JAMES LANGE:

An emotional response comes after a 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 the emotion of fear reaction first, emotion second (McMahon & McMahon, 1986).

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 for 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.

MATURITY:

Maturation is a natural 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). A mature individual is a realistic individual with a rational sense of values and an underlying meaning to life that is maintained with integrity. The person has achieved a state of harmony between self and social groups.

McCLELLAND, DAVID:

A motivation theorist who put forth the idea that people are driven by a desire to achieve (Nach), to be recognized (Naffil), or to be successful (Nsu).

NEUROSCIENCE:

Heinrich, Gevensleben, and Strehl (2007) defined neuroscience and neurofeedback as monitoring and changing brain wave patterns that lead to other changes in behavior, a sense of and ability to self-regulate.

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). These actions are 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.

RESILIENCY:

Resiliency is a process that sustains individuals through change and includes self-attitudes, social attitudes, skills, and noble attitudes. Resiliency is the ability to cope in the face of adversity.

SCHACHTER COGNITIVE THEORY:

Emotional responses involve physiological excitement, but the person feeling it cognitively labels the emotion felt. We believe whatever we call it (McMahon & McMahon, 1986).

SCHEMA:

A schema is an organized pattern of thought or action that is used to understand experiences. Piaget viewed schemas as cognitive structures (Siegelman & Shaffer, 1995).

SOCIAL EXCHANGE THEORY:

Social Exchange theory (Homans) is derived from social learning theory and contends that interactions between people must be mutually reinforcing. Individuals seek to imitate "profitable" exchanges with others and strive to eliminate "nonprofitable" exchanges with others (Albrecht et al., 1980).

Questions

Question 3-36:

Larry, a student in the tenth grade, stated that he had a conflict. He must make a decision between going out for basketball or wrestling. He likes both sports and is equally good at them. This approach is an example of what type of conflict?

    a. approach-approach
    b. attribution
    c. autonomy versus dependence
    d. bipolar disparity

Answer: a. approach-approach

Question 3-37:

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

    a. preconventional

b. conventional

c. postconventional

d. formal operative

Answer: a. preconventional

Question 3-38:

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 an obvious sense without considering its possible uses.

d. the process of holding a visual image in immediate memory.

Answer: b. where thought processes are represented by physical acts.

Question 3-39:

Erik Erikson has proposed a stage for middle age that has been modified by Roger Gould and Robert Peck. These authors agreed that a fundamental conflict is to be resolved at this stage. The conflict is:

a. intimacy vs. isolation.

b. initiative vs. guilt.

c. industry vs. inferiority.

d. generativity vs. stagnation.

Answer: d. generativity vs. stagnation.

Question 3-40:

A teacher believes the best way to reinforce learning is to provide a reward after every third response for which a student gives a correct answer. This is an example of which reinforcement schedule?

a. fixed interval

b. variable interval

c. fixed ratio

d. variable ratio

Answer: c. fixed ratio

Question 3-41:

In 1952, Hans Eysenck reported that nonpsychotic adults recovered without any treatment at all. This recovery was because of:

a. empathy.

b. the placebo effect.

c. anticipation of cure.

d. spontaneous remission.

Answer: c. anticipation of cure.

Question 3-42:

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

    a. schemata

    b. reification

    c. equilibration

    d. conservation

Answer: c. equilibration.

Question 3-43:

Which one of the following is considered a developmental theme or deficit for those who experience an eating disorder?

    a. sibling rivalry

    b. avoid femininity

    c. over embrace femininity

    d. lack separation and differentiation

    e. exhibit younger styles of reasoning

    f. desire to remain a child

Answer: a. sibling rivalry. It is possible that NBCC will question material regarding symptoms for the more common disorders. This question is not typical of questions in the past, but in anticipating the 2016 standards it is possible questions of this nature may be in the exam. However, there will not be six answers.

Unit 3 - References

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UNIT 4 - Career Development

Goals and Objectives

Counseling individuals for career development throughout the life span requires knowledge of the world of work, techniques of assessment, vocational theory, special programs, and occupational resources. Counselors who assist clients with career exploration and decision-making must put lifestyle and career development theory to practice. It would be helpful to become familiar with the following information:

1. six to eight prominent vocational theories
2. major resource materials
3. commonly utilized assessment devices (interest, values, and aptitude)
4. career issues for all age groups
5. special needs for a diverse population.

The sample questions in this unit are designed to elicit recall of specific facts as well as to test the application of information for specific concerns at different age levels. The materials included in this unit are not intended to be a thorough presentation of the subject matter. Rather, the topics introduced are viewed in light of how familiar you are with the entire area of career counseling. If you are more knowledgeable than the brief presentation in this manual, continue to the next unit. There are approximately 25 to 26 questions devoted to career development content of which 21 count toward the final score for Career Development.

CACREP Objectives

CACREP 2016 objectives for Career Development are abbreviated and for a full review of the objectives download the standards from www.cacrep.org (CACREP, 2015, p.11). Example questions follow the listed objectives.

a. career developmental theories and decision-making models

b. approaches for conceptualizing for work, mental well-being, relationships, and life roles

c. processes for identifying career, avocational, educational, occupational, and labor market information, resources, technology, and information system

d. approaches for assessing conditions of the work environment

e. strategies for assessing abilities, interests, values, and personality for career development

f. strategies for career development program planning, organization, implementation, administration, and evaluation

g. strategies for advocating for diverse client's career and employment opportunities

h. strategies for facilitating client skill development for a career, and educational and life-work planning and management

i. methods of identifying and using assessment tools and techniques relevant to career planning and decision-making

j. ethical and culturally relevant strategies for addressing career development

Question 4-1: (Objective A.)
Career-Infused Career Counselling (CICC) emphasizes social, economic, and political forces that shape career development. CICC is a theory:

a. based on a work culture of a constant work role

b. on a principle that work is a lifetime one career

c. of social justice and advocacy

d. reinforcing work and a constant work role

Answer: c. social justice and advocacy

Question 4-2: (Objective A.)
The concept of career maturity is of primary importance to the theory of:

a. decision-making.

b. structural-interactive.

c. career development assessment and counseling.

d. trait-factor.

Answer: c. career development assessment and counseling. Career development assessment and counseling (C-DAC), is the final name change for Donald Super's theory previously identified as life span-life space.

Question 4-3: (Objective A.)

What instrument would Structural Interactive Theory employ to assess for congruence in a person-environment fit?

    a. Kuder Preference Inventory

    b. Holland Occupational Code

    c. Strong Interest Inventory

    d. Beck Anxiety Inventory.

Answer: c. Strong Interest Inventory

Question 4-4: (Objective B.)

Persons of diversity often encounter hindering (negative) factors in the work environment. A result of these hindering factors has been:

    a. gender grouping.

    b. racial grouping.

    c. isolation and cultural assumptions.

    d. job changes.

Answer: c. isolation and cultural assumptions

Question 4-5: (Objective B.)

All of the following guide the counselor in developing competencies in meeting social justice except:

    a. awareness of the counselor's cultural identity.

    b. establishing a fair practice handout.

    c. awareness of the client's cultural identity.

    d. establishing a cultural effective alliance with the client.

Answer: b. establish a fair practice handout

Question 4-6: (Objective B.)

Research reports indicated that the most helpful influences in securing, maintaining and achieving satisfaction in the work environment are all of the following except:

    a. support from family and friends

    b. personal attitudes

    c. internal framework and boundaries

    d. supervisor is of the same gender

Answer: d. supervisor is of the same gender. There were four influences, and the fourth one was self-care (Butterfield et al., 2010).

Question 4-7: (Objective B.)

Barriers for the unemployed worker in a job search include all of the following except:

    a. self-confidence.

    b. negative career thinking.

    c. lack of decision-making skills.

    d. transportation.

Answer: d. transportation

Question 4-8: (Objective C.)

State labor departments use which world of work classification system?

    a. Holland Occupational Classification

    b. Standard Occupational Classification

    c. Dictionary of Occupational Titles

    d. Standard Industrial Classification

Answer: c. Dictionary of Occupational Titles

Question 4-9: (Objective C.)

The National Occupational Information Coordinating Committee (NOICC) was formed in 1976 to provide:

    a. state career information systems.

    b. up-to-date job listings in each state.

    c. assistance for displaced workers.

    d. store user information.

Answer: a. state career information systems.

Question 4-10: (Objective C)

Considered to be the largest job growth projection for the years 2012-2024 is:

    a. health related occupations.

    b. computer related occupations.

    c. production occupations.

    d. energy occupations.

Answer: a. health related occupations (23%), computer (16.4%), production (-3.1%)

Question 4-11: (Objective D)

The American Counseling Association conducted a survey to assess the well-being of professional counselors. The results reflected an overwhelming number of counselors who experienced stress at work and impairment that was symptomatic of:

    a. exhaustion, incompetence, devaluing clients, and deterioration in their personal life.

    b. role conflicts.

    c. an economy that did not integrate cultural values.

    d. a stagnate economy and reduced worker compensation.

Answer: a. exhaustion, incompetence, devaluing clients, and deterioration in their personal life.

Question 4-12: (Objective D.)

Worker dissatisfaction in adjustment and a sense of well-being on the job are found to be hindered by all of the following factors except:

    a. compensation.

    b. management style.

    c. work environment.

    d. personal life issues.

Answer: a. compensation

Question 4-13: (Objective E.)

The Armed Services train military personnel for a war environment. Veterans experience which of the following when attempting to re-integrate into the U.S. employment setting:

    a. military training is an advantage for employment settings

    b. a set of rules and language that is a different work value system

    c. communication issues with the civilian worker

    d. inability to acquire their past employment before commitment service.

Answer: b. a set of rules and language that is a different work value system

Question 4-14: (Objective F.)

One of the several steps in designing and implementing a career development program is to write measurable objectives. Writing measurable objectives is important because:

    a. the objectives set up the target population for services.

    b. these are the means for the creation of a budget.

    c. they are purposeful in hiring the correct counselor for the correct position.

    d. the objectives determine the content and evaluation of the services.

Answer: d. the objectives determine the content and evaluation of the services.

Question 4-15: (Objective G.)

A technique that will assist a career counselor in understanding the relationship between family background, cultural prescriptions and career and life planning is the:

    a. Psychodrama.

    b. Genogram.

    c. Johari Window.

    d. Karpman Triangle.

Answer: b. Genogram.

Question 4-16: (Objective G.)

Career assistance in the early history of the field of counseling and guidance was focused on job placement. At the present time, in a global economy, placement and planning the focus for diverse clients is:

a. a singular placement.

b. a match with commerce, industry, and professions based on college training.

c. based on a developmental perspective.

d. based on economic need.

Answer: c. based on a developmental perspective.

Question 4-17 (Objective H.)

In preparing for a job search Leuty and Hansen's (2011) Cross-Battery includes two instruments to conduct a comprehensive assessment that includes scales for the environment, competence, status, autonomy, organizational culture, and relationships. This assessment is measuring:

a. work values

b. career thoughts

c. work personality traits

d. worker engagement

Answer: a. work values. The Minnesota Importance Questionnaire (MIQ) is considered the most comprehensive assessment of work values that includes the environment, competence, status, autonomy, organizational culture, and relationships. Life Values Inventory (LVI) assesses the client's values and how they relate to life roles. Leuty and Hansen's Cross-Battery included the Minnesota Importance Questionnaire (MIQ) and Super's Developmental Work Personality Scale (DWPS). The DWPS measures behaviors, role models, and tasks while the MIQ is considered the most comprehensive assessment of work composed of those scales in the question above (4-17).

Question 4:18: (Objective H.)

Which of the following will assist the counselor in assessing for positive emotion, good health, ability to mobilize resources, and cross over engagement skills for life planning and management?

a. Beck Anxiety Inventory

b. Oldenburg Burnout Inventory

c. Computer Educational and Career Exploration System (ECES)

d. O*Net

Answer: b. Oldenburg Burnout Inventory

Question 4-19: (Objective I.)

Computer resources for career planning and decision-making use a cross-walking tool to:

a. move from one database to another database.

b. move from one workstation to another workstation.

c. switch career lines with a comparable skill set.

d. provide interpretations without counselor involvement.

Answer: a. move from one database to another data base.

Question 4-20: (Objective J.)

Cyber counselors and cyber clients are confronted with issues not as likely or apparent as in face-to-face counseling. One of these issues has to do with:

    a. training.

    b. a secure environment.

    c. payment.

    d. homework.

Answer: b. a secure environment

Question 4-21: (Objective J.)

An ethical dilemma might likely occur when counselors use the Internet to:

    a. deliver occupational information.

    b. provide on-line databases for purposes of occupational options.

    c. provide on-line searches.

    d. provide counseling on-line.

Answer: d. provide counseling on-line.

Harris-Bowlsbey-Dikel and Sampson (1998) provided four guidelines in which the Internet can be utilized to provide career services to clients. Ethical issues are evident for each of the four including provider qualification, uses and limitations and no false emails.

Terms

The following list of terms is provided to promote vocabulary knowledge (a brief definition is located at the end of the chapter).

Burnout	Differential Aptitude Test
Career Awareness	Differentiation
Career Guidance	Disability
Career-infused Career Counseling (CICC)	DISCOVERDOT
Career Lattice	Holland's HOC
Career Maturity	Interest
Career Pattern Study	Leisure
CASVE Cycle	MAPS
Congruency	NOICC
Consistency	Obsolescence
CORE-OM	OCCUPATIONAL ASPIRATION MODEL (OAM)
Crystallization	OOH
Cyclical Counseling	O*Net

P x E Fit	Shadowing
RIASEC	SOC
Role Salience	Transition
Rust Out	

Introduction

One reference to career development in the 2014 Code of Ethics is for the counselor educator to provide students an awareness of career advising for job opportunities (F.8.b.; ACA, 2014). Many of the constructs such as respect, relationship, informed consent, client rights, releases, confidentiality, assessment, record keeping, technology, Internet counseling, electronic transmissions, employment, social media, research, competence, supervision, diversity and cultural specifics, instrumentation pertinent for guidance, counseling and psychotherapy are the same for each of the eight units in this study manual.

A review of the lifestyle and career research revealed that there is a resurgent interest in viewing individuals regarding 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 rated as "impaired" (Valliant, 1977). The Northcutt Studies in the early 70s indicated that 40% of the American adult population was coping inadequately with typical life problems (Knowles, 1977). The 1980s witnessed Americans in one or more phases of career transition. The 1990s 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 normally released numbers of skilled and experienced workers into the unemployment pool. These individuals, as well as high school and college graduates, were seeking jobs, information on occupational fields, analysis of career possibilities, training programs, job-skill training, and counseling. The 2000s witnessed a depressed economy, a resurgent of 15 years of war, environmental disaster, terrorism, unemployment, advances in technology, and a wider separation between the poor and wealthy.

One outcome of the reports summarized above has been a resurgent interest in research regarding all aspects of work in the individual's developmental lifecycle. The major contributions of a few researchers are organized below for review.

George Valliant (1977) in studying 300 Harvard graduates concluded that no single event greatly influenced the process of midlife adjustment. Long-term relationships and recurrent events in adult development are of greater importance than isolated traumatic events.

Daniel Levinson's (1978) in The *Seasons of A Man's Life* concluded that the term life cycle is better adapted to the course of one's development and is composed of four overlapping cycles: Childhood (0-20), Early Adulthood (17-45), Middle Adulthood (40-65), and Adulthood (60+).

Gail Sheehy (1976) described adult development in *Passages*. Passages are the transitional periods and the difficult times for adults. Sheehy's Life Stages are: Pulling up Roots 18-22, Trying Twenties 22-29, Catching thirty 30, Rooting and Extending 30s, Deadline Decade 34-45, and Renewal and Resignation (mid-40s).

Thomas and Kuh (1982) provided an understanding of Robert Gould's transformations in growth and change in the early adult years. They suggested the basic recurring developmental task is to rid oneself of major false assumptions to reach maturity. Gould theorized the task of development was a confrontation between childhood consciousness and adult reality. The person was to identify and reject wrong perceptions or myths of an inaccurate concept of reality. A second confrontation was between doing something right and doing the same as done in childhood. Gould's theory is composed of six periods covering the ages of 16-60. Each stage progresses through tasks during a period. Gould's periods, task and myths are (Gould, 1978):

Period	Task	Myth
22-28	Leaving parents' world	Always belong
28-24	I'm nobody's baby (independent of parents, career commitment, marriage, doing what is right	Doing things same way as parents
35-45	Opening up to what's inside	Life is simple and controllable
34-45	Mid-life	No evil or death in world
45-53	"Die is cast" (sympathy & affection)	We are whoever we are
53-60	Later middle & old age	

The History of Vocational Guidance: An Overview

Brewer (1942), described the development of guidance with a list of democratic ideals, labor divisions, technological growth, and the development of vocational education as major factors. The history of vocational guidance in the United States before 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 on 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 significant 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 individual differences and believed that these differences should be studied systematically.

1896: LIGHTNER WITNER: Opened first psychological clinic and was interested in learning disabilities. A student, Morris Viteles, developed the "clinical approach" in vocational and moral guidance.

1907: JESSE DAVIS: Grand Rapids, Michigan. He was a counselor for the 11th grade and conducted class period on "vocational and moral guidance."

1908: CLIFFORD BEERS: Mental Health. Wrote the book, *A Mind that Found Itself.*

1909: FRANK PARSONS: Wrote a unique book, *Choosing a Vocation.* The Minnesota Employment Stabilization Research Institute (1930) recognized his work. He established Vocations Bureau in Boston and advocated a three-step procedure for guidance culminating in true reasoning and is considered the Father of Guidance.

1910: BOSTON: First National Conference on Vocational Guidance.

1911: Vocational Guidance Newsletter: First American journal devoted to vocational guidance and 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 significant 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 and was the forerunner to APGA.

1917: Several psychologists were appointed to government positions to determine if psychology could assist in the war effort (Bingham, Yerkes, Otis, Scott, Thorndike, etc.). Developed at this time included instruments such as the Otis IQ and the Army Alpha/Beta.

1918: JAMES BURT MINER: Developed the first interest questionnaire at Carnegie Institute of Technology. Bruce Moore conducted research with graduate engineers, and Karl Cowdery applied a differential weighting system to interest item responses.

1925: HARRY KITSON: He was a pioneer in the training of counselors for vocational counseling, which became a specialized field.

1927: E. K. Strong's Vocational Interest Blank (SVIB) appeared in 1927.

1931: DONALD PATTERSON: Directed the Minnesota Employment Stabilization Research Institute and studied factors in unemployment. Data derived from aptitude batteries, interviews, and occupational ability patterns (OAP) contributed to a vocational diagnosis.

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 that 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 were condensed into one volume and added many more occupations

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. Aptitude interest provided the definition for career choice. 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

OBJECTIVE 4A: Vocational Theories: An Introduction

Objective 4a. theories and models of career development, counseling, and decision-making (CACREP, 2015, p. 11)

Each vocational theory, irrespective of 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 (Rounds, Shubachs, Dawis, & Lofquist, 1978), and safety, altruism, comfort, achievement, aggrandizement, and autonomy (Lofquist, & Dawis, 1978).

Work adjustment theory focuses on 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 environments change. Lofquist and Dawis

(1978) described one aspect of their theory of work adjustment as the individual possessing a personality style. These styles are:

1. Activeness: act on their environment to increase correspondence
2. Reactiveness: change work personality to increase correspondence
3. Celerity: speed with which the person acts to increase correspondence (quickly/slowly)
4. Flexibility: tolerance for "discorrespondence"

Classifications and Definitions

Since the early 1960s, there has been an effort to classify and predict how individuals will select a satisfying job and career.

Trait-and-Factor or Actuarial: Emphasis 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 period for development and career choice.

a. E. Ginzberg
b. Donald Super
c. Tiedeman and O'Hara
d. Robert Havighurst

Psychodynamic: The 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. Theorist includes 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 on the writer. Some author-theorists such as John Holland could appear under the psychological framework and yet appear under a personality structure. Newer formations about career theory are emerging such as systems theory, constructivism, and methods for diverse populations (military, race, gender, foreigners) with different work values and in need of contextual counseling. Young, Valach, ,and Collin's (1996) contextual theory emphasized a structured, action theory holistic perspective involving goal setting that is an exological consideration of micro, macro, and exo-systems in planning for smaller action steps to decrease anxiety.

Newer theories in career development 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, 1996), career guidance from a social cognitive perspective (Lent, D, & Hackett, 1996), values-based, holistic model of career and life-role choices and satisfaction (Brown, 1995, 1996, 2015), and contextual (Brown, Brooks, & Associates, 1996).

 Another approach to career counseling is Cochran's Narrative Career Counseling (Cochran, 1997). A 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 with 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 (Krumboltz, 1979; Super,

1990), inactive-unstructured (Tiedeman), inactive-structured (Roe, Parsons), and active-structured (Holland).

Career-infused career counselling (CICC; Arthur & Collins, 2010; Collins & Arthur, 2010) is a current theory of social justice and advocacy. The overarching principle is that the counselor is aware of and consistent in acquiring knowledge that social, economic, and political forces do shape career development. An accepting diverse workplace will create an atmosphere where all aspects of the culture are open, and employees may appropriately express their spirituality, political affiliations, sexual orientation, disabilities, gender, ethnic background, age, socioeconomic status, and who they are without fear of discrimination. Adverse effects of conflict, poor work performance, isolation, social divisions, and dissatisfaction are well documented in the literature when diversity is not accepted.

The evolution of CICC, a reflective theory of practice, has principles that require a fundamental understanding that culture and career issues shift over time. Challenged are the past work ideas because questions have arisen regarding desired results for people of diversity. Previous theories based on a work culture of a work role for a lifetime in one career path are not constant but are always changing (Fouad, 2007). A prevailing social issue, particularly for a dominant culture, is that those in non-dominant positions are unable to exert appropriate power and privilege in self-care for work needs. The oppressed do not experience work and work-related opportunities like others, rather experience racism, sexism, ageism, marginalization and religiously biased forms of discrimination in preparation, training, hiring, promotions and work-related performance (evaluations). Butterfield, Borgen, Amondson, and Friebach (2010) conducted an exploratory study in what helps and hinders workers and found that the environment, organizations, and management style do not prepare workers for change, an ability to meet change, to maintain an even keel in the face of change, and as a result experience difficulty handling change when thrust upon them.

CICC emphases principles for self-awareness, awareness of the cultures of other people, and an awareness of the influences of culture on the working alliance. The first principle relates to diversity for individuals outside the dominant culture because of ethnicity, gender, religion, marginalization, abilities, sexual orientation, age, and for some social class as second-class status. Those with more than one non-dominant identity have experienced multiple issues, and difficulties are engaging, establishing, positioning, and advancing in work-related roles within those communities, organizations, and social systems. Once a person of a diversity culture is in the work organization hindering factors set the stage for detachment and feelings of exhaustion due to isolation and non-integration that promotes discrimination and cultural assumptions playing a dominant role. A principle receiving more attention for counselors, managers, and organizational personnel is the concept that past theories may have become obsolete because of a shift in work constancy and those cultural assumptions are not challenged. Those theories were based on assumptions that are consistent with Western values such as individualism and autonomy, work role, affluence, and progression. Finally, these theories based on past theory values have little meaning when compared to values of a collective nature in a work world that is constantly changing (Arthur & Popadiuk, 2010).

Three domains guide the counselor in meeting competencies of social justice. The first is an increasing awareness of his/her cultural identity. The second domain is an awareness of the client's cultural identities. The third domain is to establish an effective culturally working alliance with clients. Selecting interventions with an understanding of systemic and social influences are intended to

empower the client to go beyond adapting and coping with barriers but also for adjustment and acceptance in the work environment (Arthur & Collins, 2010; Arthur & Collins, 2011).

Vocational Theories
Trait-and-Factor

FRANK PARSONS

Pope and Sveinsdottir (2005) researched the personal and occupational life of Frank Parsons and noted that Parsons worked in at least nine occupational jobs. Frank Parsons was the first to outline the process involved in choosing a career. His efforts initiated the vocational guidance movement (Gladding, 1992, 1996). Parsons was active during the times of the Social Reform Movement and Settlement Houses. Parsons was a trained engineer, mill worker, teacher, dean, lawyer, as well as a volunteer who worked with immigrants and young people seeking jobs. Parsons utilized "True Reasoning" in vocational guidance. He advocated a three-step model:

1. Assessment: a clear understanding of your aptitudes, abilities, resources, and limitations
2. Occupational requirement and conditions of success: (dis)advantages, compensation, opportunities, and prospects
3. Decision-making: true reasoning of the above two

Parsons' three-step model was based on psychometric methods by which aptitudes, interests, and various other characteristics could be measured. Parsons appreciated the contributions of psychometric techniques but recognized that instruments in existence were not very sophisticated. He relied upon the case study of social work to secure information about the person. A second influence combined his second and third stages, that is, providing occupational information and counseling through a direct, advice-giving approach. He wrote *Choosing a Vocation* and included material from the work of Hugo Munsterberg, who was developing tests for measuring the abilities of men in various jobs. By 1939, three lines of thinking regarding vocational guidance emerged:

1. The importance of personality dynamics in vocational choice and adjustment was in conjunction with the rising interest in psychotherapy.
2. A developmental view of human growth.
3. A concern for the meaning of work.

Parsons counseled for "character analysis." He paid careful attention to physical attributes, non-verbal behaviors, and the ability to speak. He believed in giving homework as a part of educating the individual about oneself and the world of work. Frank Parsons is considered the father of vocational guidance.

E. G. WILLIAMSON

The Trait-and-Factor Theory assumes that man has a variety of capacities that form an organizational pattern which could 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 theory focus is with dislocated men and women evolved 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 on an empirical base of definition and statistically predictable variables. The theory is atomistic and analytical. The trait-and-factor foundation was a differential diagnosis, that is, a process of ferreting out assets and liabilities to make a prognosis or prediction for future jobs. This theory was durable. It evolved from early studies of individual differences and psychometric techniques and emphasized self-understanding, realistic planning, and decision-making skills. The process is rationalistic and represents a cognitive model.

1. Synthesis: collate and summarize using case study and test profiles
2. Diagnosis: describe outstanding character problems, comparing profiles with education and occupational ability profiles and determining causes of problems. Williamson developed a method for counseling individuals, and at the same time developed four categories for diagnosing:
   a. No Choice: The client is unable to state a choice.
   b. Uncertain Choice: The client has chosen a career and can verbalize the title but expresses doubt.
   c. The discrepancy between interest and aptitude/ abilities and fields. Three discrepancies:
      1) interest more than aptitude
      2) interest less than the ability
      3) interests and abilities the same but in different fields.
   d. Unwise choice: Disagreement between abilities and interests and requirements of the occupation
3. Prognosis: judging consequences and probabilities of adjustment
4. Counseling: advising a client what to do to effect the desired adjustment
   a. Analysis:
      1) collect data about attitudes
      2) interests
      3) family background knowledge
      4) educational progress
      5) aptitudes
5. Follow-up: repeat above steps

Relationship: is one of teacher/student

Stages:

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

Trait and factor theory 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:

a. According to Weinrach (1979), this theory suggested that people are rational beings. Questioned was the heavy reliance on the cognitive side to the exclusion of affective processes.

b. The belief that an occupational choice is a single event and that a particular type of person is in each specific type job and that there is a single goal. This single concept idea changed with the work of Donald Super, John Holland and P x E Fit (Herr & Cramer, 1992).

c. The theory was largely unreliable. The agreement in diagnosing was very low, rarely above 50%, and the categories were not independent and exclusive.

d. 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.

e. That everyone had a single career goal was questioned.

f. There was not an 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 notion 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) used different dimensions to describe the structure of the work personality and the work environment. TWA advocates a correspondence between work abilities and workability requirements as predictive of worker competence.

Question 4-22:

Frank Parsons' three-step model of career counseling relied heavily on:

a. psychometrics for analysis.

b. goal-setting.

c. the self-actualization process.

d. character analysis.

Answer: d. character analysis. Parsons relied heavily on the case study process of social work to secure information regarding the true character of a person. This information enabled Parsons to gain a clear understanding of an individual's aptitudes and abilities. Parsons recognized that psychometric techniques in existence were not sophisticated, he therefore, relied on "character analysis."

P x E Fit

The P x E Fit system developed by Dawis, Dohm, Lofquist, Chartrand, and Drue (1987) described the person-environment interaction of Work Theory of Adjustment (TWA) dimensions, levels of work abilities, and values. The components of each are:

1. Ability Dimension:
   a. Perceptual—perception and interpretation of stimuli
   b. Cognitive—storing, processing, and transforming
   c. Motor—manual, dexterity
2. Values and Occupational Reinforcers:
   a. Internal—achievement, autonomy, status
   b. Social—altruism
   c. Environment—comfortable and safe work conditions
3. Levels:
   a. High
   b. Moderate
   c. Insignificant

Stages of P x E Fit:

1. Diagnostic Appraisal: Clients seek an appraisal because
   a. career indecision
   b. they desire confirmation for a tentative career choice
   c. hope to improve their work satisfaction

   The counselor will:
   a. differentiate the presenting problem
   b. set priorities among goals
   c. assess current resources and stressors
2. Counseling Process: The process is to facilitate career decision-making, planning, and adjusting through the acquisition of problem-solving skills (Rounds & Tracey, 1990).
   a. Information Processing:
      1) encoding—perceive information and appraise its meaning
      2) goal setting—establish concrete, realistic goals and organize them in sequence
      3) develop a plan and alternate solutions, multiple avenues and considerations of pattern matching consequences

           4)   acting—implementation

3. Counseling Outcomes:

    a. client—stated goals

    b. the process being learned through counseling

4. Approaches to Counseling:

    a. counselor style-supportive

    b. directive teacher style

Decision Theorists

The key ingredient of decision theory is the process of decision-making. A career goal of decision theory is to choose a career or occupation that will maximize gains and minimize losses. The decision is based on what the individual decides is a 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 suggested that an individual needs both a prediction and a valuing system to decide. Gelatt advocated a prescription model and intuition valued. The process includes a purpose, identifying choices, predicting possible outcomes, and estimating likely results. Relooping or the step of investigatory decision for reentry is important when indecision exists (Gelatt, 1962). Decisions are based on information and the more information a person has, the clearer are the risks involved. Gelatt does not indicate that this will reduce the chance, 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 the framework that will allow the client to interact with change and ambiguity. Also, 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:

    a. Information about alternative action

    b. Information about possible outcomes

    c. Information about probabilities linking activities to outcomes

    d. Information about preferences for the various outcomes (Herr, Cramer, & Niles, 2004).

Decide:

    Data, Evaluation, Counseling, In, Decision-Making, Effectiveness.

In summary, Gelatt stated 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 advocated for the use of subjective data in the uncertainty of making a choice.

MILLER-TIEDMAN, TIEDMAN, and O'HARA - (Decision Theorists with a developmental emphasis)

Miller-Tiedeman and Tiedeman traced the history of the present decision theory to Tiedeman and O'Hara's study of Super's self-concept theory. Rejecting aspects of that theory they elected to utilize Erikson's theory of ego development as the cornerstone for making decisions. Their theory is one of how people decide, not what they decide. Since 1971 the theory has shifted to life is career that is guided by inner knowledge. This framework includes living in the moment, beyond a lifetime, living by inner guidance, and life is as it has always been (Miller-Tiedeman & Tiedeman, 1990). An essential difference in this model and the previous one is the use of literature outside of the career field such as decision-making, self-organizing theory, and quantum mechanics.

Decision-Making

Miller-Tiedeman, Tiedeman, and O'Hara's primary principle of their theory is the linkage of personality and individual responsibility.

Theory

Constructs of ego personality provide the core components of career development. Career development is the process of creating a vocational identity through differentiation and integration of the personality as one encounters the work in living (Tiedeman & O'Hara, 1963). The developing self becomes more differentiated and comprehensive. This development includes situational, social, and biological factors. Decision-making involves anticipation (formulation of choice), implementation, and adjustment. Tiedeman and O'Hara studied the relationship between aptitude, interest, social class, and values (the Ginzberg model) and the development of a vocational self-concept (Super). This ego self, an entity that is always expanding or contracting at choice points when critical decisions take place, occurs 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:

a. successively more refined and complex differentiations of the person's attitude toward oneself and his/her environment.
b. searching for integration at more and more comprehensive levels of identity and acceptance of the new self.
c. differentiation and integration are occurring about persons, things, and ideas.

Components of Decision-Making

Osipow (1983) listed three components for career decision-making:

a. Ego identity is a continuous differentiation based on experience.

b. Differentiation is based upon problem-solving.

c. 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:

a. disorganized thinking about an occupational field

b. evaluative process

c. decision (preliminary)

d. refractory period (expresses doubt)

e. induction into groups

f. integration (resolves conflicts of individuality)

Differentiation occurs in the process of considering a choice. It is a matter of separating experiences, whereas integration is structuring the experiences into a more comprehensive whole. Tiedeman indicated 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 to create larger wholes of them.

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 followed by a clearer distinction among fields by considering information. The person begins to make judgments regarding the advantages, disadvantages, and relative values. This process brings about some preliminary decision-making and is followed by a refractory period, a time when the person expresses doubt.

2. Implementation or Accommodation:

   a. Induction (self-participates)

   b. Reformation (abandons self for group purpose)

   c. Reintegration (group and self)

The individual is inducted into a group where he/she identifies closely with the purposes of the group. Later the person questions these purposes and may try to change the group. This is followed by integration, a process whereby the person resolves the conflicts of individuality with the group's demands and can integrate the two. Balance brings about an achievement 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.

a. Personally authoritative reality is an act, thought, behavior, or direction the individual feels is right for him/her and endorses one's feelings.

b. Common reality is what others say is right for you.

Miller-Tiedeman and Tiedeman (1990) utilized a cube to illustrate their model of decision-making. Three levels interact with each other and form a series of 27 possible combinations of acting on a problem.

1. The first is the problem condition composed of:
   a. problem forming
   b. problem solving
   c. solution using

2. The second is psychological states of:
   a. accommodation
   b. clarification
   c. exploration

3. The third is self-comprehension composed of:
   a. doing with awareness
   b. doing
   c. learning about

Their pyramidal model of decision-making comprehension is made up of four levels:

Level 1: Learning about the problem (forming)
   a. define problem
   b. exploration
   c. collect information
   d. crystallization
   e. choice

Level 2: Problem-solving (doing)
   a. initiating, beginning to act

Level 3: Solution using (doing)
   a. carrying out

Level 4: Solution reviewing (doing with awareness)
   a. thinks about

Miller-Tiedeman and Tiedeman's 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:

a. Loevinger, Wessler, and Redmore's model of ego development
b. Grave's values development model
c. Miller-Tiedeman and Niemi's decision-making strategies

The client's problem may be of the following types:

a. a lack of awareness regarding one's personal reality
b. one's personal reality is overwhelmed by the common reality
c. one's decision-making style is ineffective
d. one's ego identity is not fully developed in the areas of autonomy and acceptance of responsibility for directing one's life
e. lack of awareness of, or skill in, using a decision-making process

Information Systems for Vocational Systems (ISVS) is the computer software program for this theory.

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

Question 4-23:
All of the following are components of Trait and Factor Theory except:

a. decision-making skills
b. understanding the process of career choice
c. self-awareness
d. testing

Answer: b. understanding the process of career choice

The Developmental Career Theorists

GINZBERG, GINSBURG, AXELRAD, and HERMA
(economist, psychiatrist, sociologist, and psychologist)

This group was the first to approach a theory of occupational choice from a developmental standpoint. They reviewed the "accident theory" and "impulse theory" and found both 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. Also, 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 decision-making process occurred during a 6 to 10-year period beginning at age 11 and ending at age 17. The process was open-ended and moved through stages. In counseling an individual, the assessment was critical in determining the process of decision-making. They developed a set of questions that covered the person, reality, and key people. The person questions revolved around interests, goals, values, and time perspectives. Reality questions involved the social and economic influences of the family, from desired income to marriage. Key people or significant others were individuals who exerted pressure or had influence in the involved choice.

Key Points:

1. They believed there were four variables important in vocational choice (Osipow, 1983):

    a. reality factors
    b. emotional factors
    c. educational process
    d. individual values

2. The choice was an irreversible process of periods and a series of compromises (later changed).

3. The 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 extending to young adult)

    a. FANTASY: Play gradually becomes work-oriented and reflects initial preferences for certain kinds of activities (before age 11)

        a. change from play to work orientation (function to pleasure)
        b. frustrated by a sense of inadequacy and impotence
        c. ignore reality, abilities, potentials, and time perspective (Osipow, 1983).

    b. TENTATIVE: 4 stages (11-17): Tentative choices.

        a. interest (11-12)
        b. capacity (abilities 13-14)
        c. value (clearer perceptions of occupational styles 15-16)
        d. transition choices to responsibility (17)

        Behaviors:

        a. need to identify a career direction/likes-dislikes, intrinsic enjoyment
        b. father's identification (interest stage)
        c. evaluate the ability to perform well in the area of interest (capacity stage)
        d. service to society, different lifestyle, giving to others, begin to look for a way to use skills (value stage)

     e.   need to make immediate, concrete, and realistic decisions (transition stage)

  c. REALISTIC: Choices are made and a compromise between reality and personal factors occurs.

     a.   Exploration: college entrance, narrows career choice to two or three possibilities but in a stage of ambivalence and indecisiveness

     b.   Crystallization: commitment to a specific career field

     c.   Specification: selects a job or professional training (takes steps to implement)

     Behaviors:

     a.   narrows goal and vocational flexibility increased ambiguity

     b.   selection of a path from alternatives (exploration stage)

     c.   a clear idea of what to avoid, decisions are firm, and commitment grows (crystallization stage)

     d.   specification (specification stage)

7. Two basic personality types:

  a. work-oriented

  b. pleasure-oriented

DONALD SUPER: Life Span-Life Space

Super was intent on the idea of stages and tasks for a lifespan 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 the implementation and process in a developing self-concept. 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 was renamed the SEGMENTAL THEORY. The concepts of the Segmental Theory unified a 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:

a. Carl Rogers and Self-Concept Theory and Bordin's Projection of Self-Concept in stereotype

b. Developmental Psychology: Charlotte Buehler and her distinct stages with life tasks that vary according to the stage

By 1974 new influences had an impact on Super's evolving theory. Some of these are (Super, 1990):

1. Career Theory
   a. Differential Psychology: work and occupation
   b. intelligence and aptitude testing
   c. 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 (1990) propositions began at 10 in number and, as the theory evolved, grew to 12 and finally to 14 and the following statements represent the 14.

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 individuals and occupational variance.
4. Self-concept changes with time and matures along with time and experiences and becomes more stable from adolescence to maturity.
5. A series of life stages (maxicycle) represent a change of growth, exploration, establishment, maintenance, and decline and each stage has subdivisions.
6. The parental socioeconomic level, mental ability, education, skills, personal characteristics, and career maturity influence and create a pattern.
7. Success in coping with demands depends upon READINESS. A person is mature if able to successfully complete the stage and tasks of the previous stage.
8. Self-concept is a hypothetical construct and is operationally defined.
9. The developing self-concept in each of the stages for maturity is a process guided by personal characteristics, and reality testing.
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 level 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.

A maxicycle is a progression through the stages during one's lifetime (birth, growth, exploration, establishment, maintenance, decline, and death). The process of change occurs throughout the MAXICYCLE and any given life-career stage depends on the readiness to cope

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 becomes established when a person combines his/her life roles involving 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 can cope with the demands of the previous stage and tasks. The coping ability includes both cognitive and affective responses.

Super believed the process of maturity development begins with curiosity (exploratory behaviors) and leads to key dimensions (autonomy) and eventually to problem-solving.

SELF-CONCEPT: For the most part self-concept development is similar to Holland's in that the occupational selection is the choice of a role and setting in which the person can 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 the components of 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):

a. self-esteem
b. stability
c. clarity
d. abstraction
e. refinement
f. certainty

Four major elements of his approach are:

1. Vocational development: One of several human growth dimensions. Examples include ego, intellectual, moral, which can be broken down into stages. Each stage has its distinct characteristics.
2. Vocational maturity: For each age, maturity is noted when the individual can cope with the specific tasks.
3. Translating the self-concept into a vocational self-concept is a reflection of the occupational self-concept.

4. Career Pattern: This evolves as the person becomes aware of the information and personal meanings attached to the information.

Stages

Growth Stage: 0-14, self-concept-identification with important people and including needs, fantasies, interests, capacities, social participation, and reality testing:

1. Fantasy substage: 4-10, role playing
2. Interest substage:11-12, likes role playing
3. Capacity substage:13-14, abilities are prominent

Exploration Stage: self-examination and exploration (15-24):

1. Tentative substage:15-17, tentative choices
2. Transition substage:18-21, enters world of work, implements self-concept in school
3. Trial substage: 22-24, beginning job

Establishment Stage: 22-44, permanent place

1. Trial substage:25-30, change may be made
2. Stabilization substage:31-44, develop a secure place

Maintenance Stage: 45-64, building

Decline Stage: 65-plus, mental and physical decline

1. Declaration substage: 65-70, part-time job

Tasks: Society presents the individual with time and age-appropriate behaviors to be accomplished. These are biological, educational, and vocational in nature.

Readiness: Readiness is determined by one's cognitive and affective development. The Career Development Inventory (CDI) tests readiness through two affective components of career planning and career exploration/curiosity and three cognitive components. The cognitive components include 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 on work (Jepsen, 1991).

Career Decisions: Super saw 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 involved orientation to vocational choice, information, planning, consistency of preferences, crystallization of

traits, and wisdom of vocational preferences. Super's findings revealed a lack of readiness to decide on a particular direction or occupation.

Realism: The degree to which there is an agreement between ability and preference, interest and preference, interests and fantasy preference, the level of interest and preference, and the socioeconomic accessibility.

Super attempted in 1974 to illustrate his theory through another change in the name of the theory to Life-Career Rainbow. The change reflected and emphasized life space and lifespan. 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 figure of the Archway. The latitudinal dimension is role saliency, while the longitudinal dimension includes traits and career maturity.

Techniques and Instruments: Career Maturity Inventory (CMI), Career Development Inventory (CDI), and Salience Inventory

Counseling Applied

Cyclical Counseling: Cycling and recycling of developmental tasks through life span.

1. Appraising what life stage in which the individual is presently residing is based on the Person-Environment Interactive Model.
2. Assess vocational maturity of the individual.
3. Assess the person's self-concept or role saliency.
4. Expand experiences to experiment and implement self-concept. Teach decision-making for career maturity.
5. Recycle through previous stages.

Language

1. Psychtalk: Language individual uses to think about self
2. Octalk: Both verbal and nonverbal expressions of occupational interests
3. Incorporation: Incorporation is the degree to which occupational selection an individual makes is congruent with self-concept

JOHN CRITES (Maturity)

Vocational Development Project

As a member of the Career Pattern Study, John Crites developed a psychodynamic-oriented diagnostic system, Career Maturity Inventory, to use in career counseling. This was the first objective taxonomy for the classification of problems in career decision-making. Two scales of the instrument are completed and tested: attitude and competence. Comprehensive Career Counseling (Crites, 1981) contains elements of career development, life stages, organizational climate, and environmental influence. The basic premise is that all aspects of life functioning are interrelated.

Major Concepts:

1. Diagnosis

    Differentials—(using Crite's taxonomy) differential: What are the problems? (antecedents and contingencies)

    Dynamics—What are the causes of the problems?

    Decisional—How are the problems being addressed?

2. Process—establish collaborative relationship, communicate the parameters of the problem

3. Outcomes—career choice, acquisition of decision-making skills, and enhanced general adjustment

Sociological Emphases

Sociologists take a different perspective when studying man and the world of work. Emphasis is placed on institutions and the market forces that include formal and informal rules, and the supply and demand of workers and products. Tausky (1984) provided a list of topics most often involved in decisions regarding work. These are: status, occupational structure, labor unions, collective bargaining, power and authority, work-leisure, socialization at work, mobility, work groups, satisfaction, and rewards. Most of these topics fall within social structure, structural factors, and job structure.

Social Learning Theory for Careers

The foundation for social learning theory approach to career development stems from the work of Albert 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 individual 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 (associate past affective neutral stimulus with an emotional stimulus and the behavior will strengthen the behavior).

3. Vicarious: Observing others.

Components/Beliefs: Mitchell and Krumboltz (1990) listed four elements to their career theory:

1. Inherited Traits: Individuals are born with special abilities which are further developed through interaction with the environment. These traits are gender, race, physical appearance, motor-intellectual abilities, and perceptual skills.

2. Environmental Climates: The individual does not control environmental conditions. These environmental conditions have to do with the job market, training options, opportunities, social policies, family resources, role models, social climate, and technological development.

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) believed the individual will learn to apply under a full range of skills, attitudes involving work standards, work values, work habits, and perceptual patterns that are modified by his/her experiences and feedback. The individual will perform observations and an assessment of himself/ herself by his/her standards along with attitudes and skills of others. From the interaction of the above four components inevitable 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 on his/her life experiences. Skills of Self-Observation include tasks, interests, and values

   a. S-O About Task Efficacy: the individual estimates what are the skills they have to do task.

   b. S-O About Interests: an intermediate step which links first learning with choices and action and often a summary of past experiences.

   c. S-O About Personal Values: attitudes about the worth of an event or experience. These result from an associative 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 explain 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: Reinforcing someone positively for involvement in an activity results in a preference expressed and further strengthened if done by a valued person.

Negative Influences: If a person has been punished it is less likely a preference is expressed. Examples are poor models, low grades.

There are several systems that reflect a behavioral approach and when cognitive restructuring schemes are appropriate.

Instrumentation:

a. Career Beliefs Inventory
b. Career Decision Anxiety Scale
c. Career Decision Inventory
d. Structured Assessment
e. Dysfunctional Thought Record
f. Vocational Exploratory Behavior Inventory

Individual-Organizational Interaction

Hall (1990) described Edgar Schein's view as a sociological perspective traced through a person's movement in an organization. Schematically, Schein illustrated 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.

a. Socialization—organization influences (changes) the person
b. Innovation—person influences the organization

Through the individual's life cycle his/her integrative approach reinforces three dimensions. These are (as cited in Zunker, 2006, 2014):

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 described a life cycle of career development for organizations. These stages are (as cited in Zunker, 2014):

a. Entry—preliminary choice, dream anticipating socialization, facing realities
b. Socialization—reality of the organization, resistance to change, learning how to work, relating to a boss, develop identity
c. 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).

a. self-perceived talents and abilities

b. self-perceived motives and needs

c. self-perceived attitudes and values

Hall (1990) listed five types of anchors:

1. autonomy—large organizations

2. creativity—entrepreneurial activity

3. functional competence—professional specialization

4. security—stable setting

5. general management—corporate ladder

Late career—mentor, balance, retiring

Question 4-24:

Donald Super defined 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 an exploration task?

a. fantasy

b. beginning stabilization

c. interest

d. crystallization

Answer: d. crystallization. Crystallization is a task performed during the exploratory stage and is a process period of time during which the client formulates a goal through awareness of resources, contingencies, interests, values, and planning for an occupation.

Psychodynamic Emphasis

Bordin's Psychodynamic Model

Edward Bordin's psychodynamic model of career counseling has its foundation in psychoanalytic theory with techniques from Trait and Factor and Client-Centered approaches (Crites, 1981). Bordin (1990) modified his early work with Nachman and Segal. Freud was uncertain about the importance of work. He viewed work as needed by society but it was a painful activity, something to be tolerated. His basic belief was that man was unreliable. The pleasure and reality principles of giving up the child was necessary to establish a responsible person. The first six years of life, instinctual gratification, and the defense mechanisms of sublimation and identification are important. Sublimation is the linkage between job satisfaction and psychosexual development, instinctual behavior, resolution of infantile conflicts and similar needs (Osipow, 1983). Osipow interpreted 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

a. Career choice involves the client's internal needs (i.e., gratification, protection from anxiety).
b. 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 the client's self-exploration with the client serving as an active participant in selection.

Other Key Concepts

a. Spontaneity: Elements of self-expression and self-realization are major forces in differentiating work from play.

b. Compulsion: The internalization of external pressures. As an adult, this becomes conscience, duty, and expectations.

c. Work and Play: Work and play are fused through compulsion and effort from one's developmental history.

d. Early experiences with parents provide a balance of pressures from other's authority.

e. As the individual searches for a fit between self and work a string of decisions follow which changes work into a vocation.

f. Satisfaction comes from recognizing that every talent is needed in work.

g. 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) pointed 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 evolves from features of one's mother and father.

Counseling Steps

1. Exploratory Interview: The exploratory interview requires one to listen for wishes and views of the client's self-realization. Bordin (1990) listed three questions:

    a. "What of yourself are you seeking to realize?"

    b. "What is making the decision difficult?"

    c. "Just how are you thinking about yourself and your decision?" (p. 137)

2. Testing

3. Test interpretation

4. Planning

Psychological Emphasis

ANNE ROE

Anne Roe (1956) began her graduate training in 1926 at the University of Denver and received her Ph.D. in 1933 from Columbia University. A graduate student spurred her interest in careers as he enlisted her efforts to determine the meaning and accuracy in admissions testing for dental school. She worked as a clinical psychologist even though her training was in experimental psychology. While employed at Yale University she studied famous painters. The actual interviews became the most important part of her study. Until that time, she was interested in intelligence and projective techniques. In her early studies she used a five-category Taussig Scale to classify occupations. Later, she shifted to the Minnesota Classification of eight-groups. Shortly thereafter she wrote a three-year grant that was funded and extended her previous study of painters to include biologists, physicists, and social scientists (64 total).

Two sets of findings focused her attention on early family relations and the use of imagery. Roe's (1956, 1979) findings regarding early family relations revealed:

a. Biologists—Lack close ties, 7 of 20 lost parents at early age.

b. Physicists—Very few speak or give an indication of closeness to fathers as children.

c. Physical Scientists—All respected fathers, yet many have rebelled and little evidence of closeness.

d. 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 Sigelman helped her with the parent-child interactions. While at Harvard, Roe 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 & Sigelman, 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 the outcome of career choice. Her theory centers on where the child is in the emotional scheme of the family. Peterson, Sampson, and Reardon (1991) provided descriptors to Roe's parenting styles. These descriptors are a protective (child-centered), demanding (high expectations and strict obedience), rejecting (child inferior and unaccepted), neglecting (little attention, neither positive nor negative), casual (parents tend own needs first), and loving (set limits and guide). Roe (1979) interpreted 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 influenced the occupational level.

Theory: Anne Roe offered 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. Behaviors in which drives first find satisfaction later are expressed as dominant drives. Those drives most often frustrated will later become dominant motivators. One of the earliest differentiations is the orientation of attention between person and nonperson occupations.

1. A child who is loved and approved of but who is not the focus of intense interpersonal relationships will focus his/her attention on objects in the environment. He/she may develop object-orientation (nonperson) of interest in mechanical and scientific fields.

2. If a child is involved in an intense interpersonal relationship (positive/ negative), he/she may concentrate on 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 or failed relationship of father.

4. A child who becomes focused on himself/herself and not others through over-concern or even special abilities may select the arts and entertainment field.

Groups: Anne Roe displayed her groups with a circle. Groups form a relationship between early childhood developmental factors and occupational choice. The center of the circle differentiates between warm/cold atmospheres (Roe, 1979).

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 in extreme protecting and demanding homes 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 & Sigelman, 1964; Tolbert, 1980).

Propositions

Brown, Brooks, and Associates, (1990) provided 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. Control behaviors acquired through individual experiences evolve from a pattern of an interaction of interests, attitudes, and personality variables. 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 primary determiner of interests.

5. The intensity of needs, satisfied or frustrated, determine the motivation to reach a final goal.

PROCESS: Early orientation of an individual is related to later decisions.

a. Interview—Maslow's Hierarchy

b. Assessment—Family Attitudes—use of instruments

c. 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 levels 5-8 are a nonperson-oriented occupation.

Structural Interactive

John Holland's theory on careers has undergone five modifications. Much of his early work in counseling centered on the use of the Strong Vocational Interest Blank. He focused on the kind of work a person selects rather than the level of work. As mentioned in the P x E Fit, Trait-and-Factor Theory, and Work Adjustment Theory, the core of Holland's theory rests on the dynamic of an interaction between an individual's personality patterns with an environmental pattern. He believed that most difficulties in vocational decision-making fall into:

a. vocational identity
b. lack of job information
c. personal or environmental barriers

Vocational interests according to Holland are one component of personality yet work choices provide a description of the person's personality (Holland, 1985). John Holland was a vocational counselor and developed his theory from:

a. observations of broad classes of interests, traits, and behaviors
b. Darley's occupational stereotypes
c. Guilford's six types: mechanical, scientific, social welfare, clerical, business, and esthetic
d. Adler, Fromm, Jung, Sheldon, Spranger, Gordon and Welsh type analogies
e. assessing environment came from Linton's idea that the force of the environment is transmitted through people. Environmental data transmission helped with the development of the Environmental Assessment Test (EAT).
f. type development evolved from Staat's theory of social behaviorism

The principles and dynamics that underlie structural interaction are:

a. choice of vocation is an expression of personality
b. interest inventories are personality inventories
c. vocational stereotypes have reliable and significant psychological and sociological meanings
d. members of a vocation have similar personalities and similar histories of personal development
e. individuals in vocational groups have similar personalities and will respond to situations and conflicts in similar ways
f. satisfaction depends on the congruence between one's personality and the environment

Propositions

John Holland (1985) proposes four primary working assumptions to his theory. The personality and environmental descriptions are based upon a typology.

Primary Assumptions

Most individuals can be typed or classified as one of six personality types. These six personality types are:

1. realistic
2. investigative
3. artistic
4. social
5. enterprising
6. conventional

A type is a product of the interaction of cultural and personal forces including:

a. peers
b. biological hereditary
c. parents
d. social class
e. culture
f. physical environment

From this interactive experience, a person learns or develops a preference for a particular activity that becomes stronger with time. The development of these interests and competencies become a personal disposition of thinking, perceiving, and acting in particular ways. There are a possible 720 combinations of the six types (RIASEC).

There are six environments. They are the same types as personality types:

1. realistic
2. investigative
3. artistic
4. social
5. enterprising
6. conventional

These six types hang together (people of this type) and create an environment.

Occupational choice begins at an early age (with a predisposition) and a search for an environment (like type) that will allow him/her to express himself/herself fully. That is, to express his/her attitudes, skills, values, accomplishments, and abilities. The interaction between the personality and environment determine the behavior predisposition for a chosen work typology.

Secondary Assumptions (Concepts)

Holland (1985) used concepts to bridge the theory application to interpretation of the typologies. These are:

1. CONSISTENCY: This is the degree of relatedness between stereotype codes as arranged on the hexagonal model. If the codes are adjacent to one another, they are more alike in characteristic traits and tend to blend with one another. Relatedness (adjacent) is described by Holland as high, medium and low. High relatedness has adjacent codes (such as RI on the hexagon), while medium has one code between the two adjacent codes (such as RSI), while low has two or more codes between the two adjacent codes (such as RSEI). Assessment always begins with the first code of one's stereotype. Consistency can be applied for both personality and environment propositions or stereotypes.

2. CONGRUENCY: This concept relates to the fit concept of locating a person of a particular personality type (stereotype) in a similar environmental type. If the type is identical to the work environment, there is congruency. This fit (personality code and environmental code) 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 RI code.

3. DIFFERENTIATION: This term defines how well defined the type is for the person. A person can be a pure type (primarily one code or 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. The estimate is to promote a clear and stable picture of one's goals, interests, and abilities.

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) described 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. John Holland's book provides a thorough understanding of each type, however, a few adjectives selected from pages 19-23 include:

REALISTIC: asocial, conforming, natural, persistent, hardheaded 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 data

Process

The counseling process includes interviewing, assessing, and interpreting 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:

a. Strong Interest Inventory (SII)
b. Career Assessment Interest Inventory (CAI)
c. Self-Directed Search (SDS)
d. 16 PF
e. Environmental Assessment Technique (EAT)
f. Vocational Exploration and Insight Kit (VEIK)
g. My Vocation Situation (MVS)
h. SCA-CV is a computerized package including the MVS, congruence, level, consistency degree, identity, and differentiation.

Research and Limitations

There are over 450 articles published on the various revisions of the Holland Occupational Scales and Interactive Theory. 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 a bias of being sexist may exist. There is little to no support or foundation for how types are developed.

Composite Theory

ROBERT HOPPOCK

Hoppock's theory is best known as a need theory with heavy emphasis on the occupational information. His basic view is that individuals select occupations to meet their needs. To decide, he advocates that environmental information is critical. His theoretical foundation has ten propositions.

Question 4-25:
John Holland's classification system (HOC) is used to stereotype individuals, occupations, and environments according to code. Which of the following three letters illustrates the highest level of consistency?

a. RSE
b. RSC
c. SEC
d. IEC

Answer: c. SEC. Use the hexagon to determine order (adjacency)

Question 4-26:

Who incorporated Maslow's eight levels of needs into a two-level approach to understanding career selection?

    a. Donald Super

    b. Donald Patterson

    c. Edward Bordin

    d. Anne Roe

Answer: d. Anne Roe. Anne Roe utilized Maslow's hierarchy of needs in developing her theory of personality and career choice.

Question 4-27:

Tiedeman and O'Hara believed that individuals process through seven steps in career development and decision-making. According to these decision-making career theorists an individual who begins to see patterns, connections, or can order relevant information about a career decision would be at which step of this process?

    a. exploration

    b. crystallization

    c. choice

    d. clarification

Answer: b. crystallization

Question 4-28:

An individual assessed by the Strong Interest Inventory as high on the personality stereotype I (Investigative), would best fit in which work environment?

    a. business

    b. political

    c. scientific

    d. conventional

Answer: c. scientific

Career Theories for Women

While there is no established theory of career development for women, there has been some theory construction. It would be helpful to understand societal trends, career patterns for women, sex role stereotyping, gender role socialization, self-concept development of women, women in the workforce, and obstacles to women's development.

Fitzgerald and Betz (1983, 1994) and Fitzgerald and Weitzman (1992) cited several factors that affect career choice for women. Some of these are:

    a. societal sex—role stereotypes-different life roles and personality characteristics

    b. occupational sex stereotypes—normative view of male and female occupation appropriateness

c. socioeconomic status—SES and educational level

d. race—black women, for example, have been more disadvantaged than white

e. environment—family background, marriage, children, role models, education, and career counseling

f. 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 in the work world. 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.

Fitzgerald and Weitzman (1992) and Gray (1980) reported some 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:

a. the husband's job was considered the primary one

b. the husband's self-esteem was threatened

c. attitudes of neighbors, colleagues, and parents

d. views of married professionals

e. incompatibility of qualities of wife-mother and mother-worker

f. 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) pointed out those existing theories are inadequate. Career theories have evolved from the initial research that was based on 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)

a. stable homemaking—marry after high school and no work experience

b. conventional—work outside of the home until marriage

c. double track—combine work and home duties

d. stable working—work through the life span

e. interrupted—return to work soon after the children are raised

f. unstable—repeated cycle of home and work

g. multiple trail—unstable work history

Ginzberg (1966) Three Life Styles

1. traditional—homemaker oriented

2. transitional—more emphasis upon home than the job

3. innovative—equal emphasis to job and home

Zytowski (1969) Three Patterns

1. mild vocational

2. moderate vocational

3. unusual vocational

Brooks (1990) offered a brief introduction to three different approaches to career development for women. A summary of that work follows:

Hackett and Betz's Self-Efficacy Theory

Hackett and Betz (1981) believed 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 suggested 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 beliefs a person has in his/her ability to perform a feat. The ability to perform a feat will then determine:

a. if behavior will be initiated

b. the degree of effort expended

c. how long this will be maintained

d. how they handle obstacles

Bandura (1977) indicated 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 competent

Gottfredson's Model of Occupational Aspirations

A summary of Gottfredson's (1983) propositions includes:

a. occupations are differentiated along sex-type, the level of work, and field of work

b. people select jobs based upon his/her self-concept and how much energy he/she wants to put forth

c. the elements of a self-concept are: gender, social class, intelligence, interests, values, and abilities

d. the four stages of cognitive development:

1. Orientation to size and power —being an adult (3-5)

2. Orientation to sex role —gender self-concept (6-8)

3. Orientation to social evaluation—social class and intelligence (9-13)

4. Orientation to internal unique self —reinforcement, values, traits, attitudes, and interests (14+)

5. As a person progresses through these stages, he/she accepts and rejects occupations according to suitableness. Gottfredson refers to this as the Zone of Acceptable. He/she will:

   a. first, reject occupations unsuitable for gender.

   b. second, reject occupations unsuitable for social class and ability level.

   c. third, reject occupations unsuitable for personal interests and values.

6. Job self-compatibility and accessibility to jobs become job preferences involving obstacles and opportunities.

7. Jobs are not always available. Therefore, a compromise is necessary and in so doing women:

   a. first sacrifice interests

   b. second sacrifice prestige

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. the kind of work that will satisfy needs

   b. the type of work that is accessible

   c. if the person can perform the work

3. Sex-role socialization: An individual is rewarded and reinforced for gender-differentiated behavior. The person internalizes social norms and values regarding appropriate self-role.

4. The structure of opportunity: Social changes alter the opportunity and interaction with the sex-role socialization process and the opportunity.

Narrative Counseling

Cochran (1997) developed a seven "episodes" model for narrative counseling. The seven episodes are elaborating a career problem, composing a life history, founding a future narrative, enacting a role, constructing reality, changing a life structure, and enacting a role. This process is for the client to tell a story of his/her past and future and eventually crystallize a decision.

Social and Economic Approaches

1. Accident Theory-external factors affect such as chance factors and to benefit from accident theory the individual relies on self-efficacy.

2. Status Attainment Theory-the role that achievement and social status influence occupational choice. A graphing process referred to as path analysis and the family receives a significant amount of attention.

3. Human Capital Theory-the focus of this theory is the individual's attention and energies given to education and training with the outcome earnings.

4. Dual-economy Theory-the focus of this theory was two-fold and takes the perspective that employers view the work world from a monopolistic or oligopolistic market. The dual or two-fold was composed of a primary and secondary market with primary paying higher rewards and secondary less.

OBJECTIVE 4 B: Life Roles

Conceptualization approaches between work, mental well-being, relationships, and other life roles (CACREP, 2015, p. 11)

The interaction of a person's life roles and experiences in the work environment has a positive and adverse impact on the well-being of workers.

The impact of burnout and wellness affects self-care regarding optimal development for positive health. The American Counseling Association (ACA, 2010) conducted a survey to assess the well-being of professional counselors and the results suggested that 75.7% of mental health workers reported that impaired mental health professionals are a threat to the profession and that 63.5% reported knowing an impaired colleague (Lee, Ho Cho, Kissinger, & Ogle, 2010; Puig, et al., 2012). The Counselor Burnout Inventory (CBI; Lee et al., 2007) assesses for exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life.

Rehfuss and Gambrell (2014) in a study consisting of three female counselors employed in ACA specialty areas identified eight career themes and variables that were necessary for successful management of career direction and advancement rather than to remain a lifetime in the first job or career. The themes and variables included:

a. managing family and career choices

b. the importance of mentors

c. overcoming career obstacles

d. parental support with experiences

e. integrating experiences with passion

f. overcoming personal life challenges

g. the sense of uniqueness

h. resourcefulness

The results of this study of three women suggested that a fluid movement within career development has led to a more internalized and consistent professional identity.

Military:

Contextual counseling for the military is of particular importance for the integration of personnel serving in the armed forces. The training veterans received based on a value set in language, set of rules, and rituals are most difficult to absorb into a societal reward system for work (Anestis & Green, 2015; Bryan & Morrel, 2011). Many returning veterans when integrating into the workforce experience feelings of disorientation, significant status change, and identity confusion (Coll, Weiss, & Yarvis, 2011). During military training, personnel are taught denial and emotional detachment as survival techniques for stress-related experiences in combat. These techniques are not reinforced in societal re-entry. Large numbers of returning veterans experience severe mental and physical issues during service that has been adjustment barriers for integrating into the workforce because of combat-related trauma (U.S. Army Medical Department Mental Health Advisory, 2008). From research findings, Rausch (2014) cited Tanielian and Jaycox (2008) report that 30% of returning veterans suffer PTSD, a mild traumatic brain injury or depression. Suicide rates for active and veterans are critically high. Zoroya (2016) reported a rise in rates for the seventh year in a row for active military, a rate much higher than the general population at 12.5%. In 2014 there were 273 suicides for active military personnel, 254 in 2013, 321 in 2012, and 145 in 2001 (V. A., 2016). In 2012, 28.6% of soldiers who died by suicide had reported the potential for death before the event (U.S. Department of Defense Suicide, 2012). During the years 2007-2014 active military records reported rates for seven mental diagnostic issues with respective percentages, mood disorders, (5.5%) adjustment disorder (8.3%), anxiety disorders (5.6%), personality disorders (.3%), substance disorders (1.9%), PTSD (3.1%), and psychoses (.2%). Also, sleep was a major issue in the range of 5% to 14% (Health of the Forces, 2016).

Combat fatigue, trauma, and deployment issues appear to contribute to the high incidents of suicide. The Veterans Administration reported that in 2014 there were 20 veteran suicides per day. The interpersonal-psychological theory of suicide is a current theory to assess for suicide regarding interpersonal needs and acquired capability (Gutierrez, Pease, Hernandez, Matarazzo, & Monteith, 2016).

Many who enlist in the service immediately upon graduation or after dropping out of school experience barriers of a lack of education, inability to obtain training, and unsuccessful personal adjustment (Brown, 2006, 2015). While in the service or upon discharge some veterans have experienced life-changing events and personal relationship issues such as marital and familial problems, anger management resulting in physical aggression, and suicidal thoughts and completed acts of suicide (Coll et al., 2011). Job placement and information service activities needed include job fairs, community integration programs and special efforts, vocational rehabilitation, employment services, and mental health availability.

Psychological and physical trauma have had an adverse impact for many veterans returning to the workforce. The inability to engage in a job search and a lack of vigor in a job have made it difficult for a smooth transition in the civilian world. Bakker and Demerouti (2008) characterize vigor to be of high levels of energy and mental resilience while working and dedication when one is strongly involved in one's work and experiencing a sense of significant enthusiasm and challenge (p. 209-210). Engagement can be measured using The Utrecht Work Engagement Scale (UWES) for vigor, dedication, and absorption (Schaufeli & Bakker, 2003). A second instrument is the Oldenburg Burnout Inventory (OLBI; Demerouti & Bakker, 2008). Engaged workers perform better because of positive emotions, good health, ability to mobilize resources, and engagement cross over,

OBJECTIVE 4C: INFORMATION SYSTEMS (Technology/Systems)

Objective 4 c. processes for identifying and using career, avocational, educational, occupational and labor market information resources, technology, and information (CACREP, 2015, P. 11).

The U.S. Department of Labor Statistics (USDLS, 2009-2010) is a primary source of information for career counselors to provide current data concerning job growth, salaries, worker requirements, and geographical locations for jobs, skills, and job losses. The largest occupational areas identified by the U.S. Bureau of Labor Statistics (USDLS, 2016b) for the 21st century were the computer related and professional and health-related occupations for health services, teaching, designing, diagnosing and treating illnesses (http://www.dol.gov/wb/ factsheets/hotjobs03.htm). Graves (2014) reported from the BLS the 20 fastest growing jobs in the next decade to be in healthcare, business, construction, and social services respectively.

Vocational and Career Resources

The following resources are located on the Internet and in hard copy in public and school libraries, offices for career counselors, rehabilitation, and occupational counselors and therapists. These resources can be accessed from elementary through adult years to acquire immediate information in job definitions, requirements, salary indicators, skill requirements, and academic, mechanical, or physical training and requirements. Each resource has a specialized set of information dependent upon the need.

Occupational Descriptions

1. O*Net is a database that was developed by the U.S. Department of Labor and is available at www.onetcenter.org. The O*Net has more than 1,100 occupations. This website has three assessment instruments, the O*Net Interest Profiler, the O*Net Ability Profiler, and the O*Net Work Importance Profiler.

2. Dictionary of Occupational Titles (DOT) lists some 20,000+ titles. The original work of two (2) volumes outlined specific jobs and worker characteristics were reduced to one volume. A coding system with a nine-digit number identifies each occupation (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 an 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 is 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 with that function.

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 an occupation from another occupation by increasing a multiple of four if it has the same six-digit number.

3. Occupational Outlook Handbook (OOH)—The OOH is published by the U.S. Department of Labor (2012) every two years and can be accessed through the Internet (www.bls/gov/oco). This handbook uses the same classification system as the DOT. It contains several pages of information and includes employment trends, working conditions, training, earnings, and projections for some 250 occupations (U.S. Department of Labor, 1996-1997). Even though there are a limited number of occupations within this reference book, those 250 jobs account for approximately seven out of eight jobs in the economy (Neukrug, 1999).

4. Occupational Outlook Quarterly. This literature contains information on new occupations, the job, youth, women, veterans, minority group members, labor market, and training opportunities and is available at www.bls.gov/opub/ooq/ooqghome,htm (Drummond & Ryan, 1995).

5. Other work information sources:
   a. Occupational Briefs
   b. Post-Secondary Information (Examples)
   c. College Blue Book
   d. American Universities & Colleges
   e. Career Employment Opportunity Directory
   f. Directory of Career Training and Development
   g. Directory of Corporate Affiliations
   h. Moody's Manuals
   i. Standard and Poor's Register of Corporations

6. Vocational, Trade, and Technical Schools (Examples)
   a. Lovejoy's Career & Vocational

7. U.S. Employment Services (Job Service)

8. National Level

9. Services: Employment
   a. CETA: Comprehensive Employment and Training Act—disadvantaged individuals and rate of unemployment determine 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.

Work Classification Systems

Several classification systems exist that organize and categorize work according to characteristics of the work, work setting, tasks, and personality. Herr, Cramer, and Niles (2004) outlined classification systems by industry, socioeconomic group, occupation, interests, field and level, enterprise, income, type of work, educational prerequisites, occupational duties, lifespan, rewards, and age. Also, work classification systems provided a method to interpret work information within the Dictionary of Occupational Titles, interest inventories, and the Standard Occupational Classification (SOC) in reporting information or research in federal and state department labor statistics.

1. Standard Occupational Classification (SOC). This system has 21 divisions, 14 major groups, minor groups, and unit groups.

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 consisting of Field (8) and Level (6). The field is divided into four-person and four non-person occupational orientations, while Level is based on 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 identify the status of an occupation. Status is determined by the perceived prestige about the amount of money, level of power, type of work, and degree of responsibility for social welfare, the amount of education, and other indices. This system is called National Opinion Research Center Scale of Occupational Prestige (NORC; Herr, Cramer, & Niles, 2004).

Unemployment

Reactions to job loss tend 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. Some 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.

a. Seasonal: includes occupational work associated with climatic conditions such as tourism, food production, construction, etc.

b. Cyclical: fluctuates with fiscal and monetary policy. Often controlled by consumer demands.

c. Frictional: time between completion of schooling/job and next involvement.

d. Structural: where differences exist between skills of those seeking jobs and what skills are required

Question 4-29:

The goals of occupational exploration and career planning are most characteristic of which developmental group?

a. elementary students

b. junior-high-school students

c. senior-high-school students

d. post-secondary students

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

Resources are of vital importance when counseling for career, avocational, educational, occupational, and market information. The labor market has an organized process of gathering data for the supply and demand of individuals who want and can work and the demand for workers.

1. Americans with Disabilities Act of 2008 (ADA, 2008). This act covers many aspects regarding the work role and diverse populations. Title III includes public accommodations (auxiliary aids and physical barriers), employment (hiring/promotion, and assistance if a person is unable to ask if a person has a disability. Individuals in a job search who have a double or triple minority status contact an ADA consultant for client fairness assistance.

2. FERPA and HIPAA. The Professional Orientation and Ethical Practice Unit provides a detailed explanation for the Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act (HIPAA, 2013).

3. Bureau of Labor Statistics (USDL, 2013) publications include monthly labor reviews, national longitudinal surveys, news, Occupational Outlook Handbook, Occupational Outlook Quarterly, magazines and journals, chartbooks, bulletins and reports, a catalog of publications, research papers, contacts, and help. http://www.bls.gov/news.elease/empsit.t06.htm

Niles and Harris-Bowlsbey (2013) suggested that counselors have three obligations in recommending and dispensing of data for career counseling. The first is to select high-quality print materials, computer-based systems, and websites. The second is to make available a user-friendly manner, and the third is to aid the client to process and make meaningful use of the information. The National Career Development Association (NCDA) provides guidelines for the career counselor (ncda.org).

Information systems such as computer resources are pertinent to career, avocational, educational and labor market needs. The development of information technology 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 extensive development of computer software in this area, career counselors

can more efficiently serve clients because the retrieval of career and educational information is now manageable (Drummond & Ryan, 1995).

While distinct 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 in the use of information technology applications as a component of the counseling service. Possible problems could arise if consideration is not provided in how to secure and distribute confidential information in computerized systems. The majority of computer software programs are designed to offer multiple databases, labor statics, and market information. Some programs appear to be theory-based, however, do not provide all items of assessment, and do not store user information. The fact that they do not store the information is one way to avoid issues of confidentiality with user information.

Drummond and Ryan (1995) and Niles and Bowlsbey (2002) provided a comparison of the pros and cons of computerized career guidance systems. A few of these advantages and disadvantages are summarized below.

Advantages

a. clients gain increased knowledge about themselves
b. clients develop more specific career plans as a result of using computerized career resources
c. clients learn more about career exploration resources
d. clients find the systems helpful, understandable, and enjoyable
e. the systems deliver the same services to all clients and are not subject to conscious or unconscious biases of the counselor
f. computers can administer test and inventory along with interpretation
g. database searches can be conducted
h. crosswalk is moving from one database to another
i. access to the information from a variety of sources
j. monitoring the progress of the user
k. delivering instruction
l. linking resources

Disadvantages

a. computer resources may be expensive
b. counselor intervention is needed to provide reinforcement, clarification, and support for career or lifestyle decisions
c. career counseling risks becoming mechanistic and dehumanizing
d. user anxiety with technology
e. using interpretation without counselor involvement (ethics code for the 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 to assist in educational needs, 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 based on Anne Roe's classification and provides the counselor-administrator support with the capability of local development for computer-assisted instruction.

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, and up-to-date occupational information and search capability for educational institutions.

6. GIS: Guidance Information System contains four data files and 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 developed by John Holland for data gathering.

11. NOICC: National Occupational Information Coordinating Committee. The NOICC is a federal interagency committee regarding occupational and market information and interfaces with State Occupational Information Coordinating Committees (SOICC). This combined system offers the Occupational Information Systems (OIS), Career Information Delivery Systems (CIDS), The National Career Development Guidelines (NOICC, 2000), Improved Career Decision Making (ICDM), and the Career Development Portfolio (NOICC Teacher's Guide to U.S. Department of Education, 2000, Archives).

Education Career Guidance

An effective career guidance program to be used throughout the client's school years and later life can be implemented using Havighurst's developmental stages. The stages have an established continuity and transition approach. The focus of the theory identifies specific tasks encountered during different time periods. Tasks and time periods are early infancy, 6-12, 12-18, 18-30, 30-60, and 60+.

There will be some overlap when equating Havighurst's developmental stages with age ranges to grade level for the elementary, middle school and high school years. Developmental tasks according to Havighurst (1972) for the middle childhood students are to:

a. achieve new and more sophisticated relations with peers
b. achieve emotional independence from parents and other adults
c. set vocational goals
d. prepare for marriage and family life
e. develop skills for civic competence
f. acquire a set of values and an ethical system as a guide to behaviors

The goal is to establish realistic goals and make plans for achieving these goals.

Career guidance involves all activities that seek to disseminate information about present and future vocational interests (Gladding, 1992, 1996, 2002). Many school-based guidance programs are based on the National Occupational Information Coordinating Committee (NOICC) competencies and indicators (2002, 2007). These competencies skills are based on self-knowledge, educational and occupational information, and career planning.

Career Guidance: Elementary Years. The focus during these years is on developmental experiences to:

a. become aware of choices
b. anticipate and plan for choices
c. take into consideration personal characteristics
d. foster self-awareness and utilize the school experience to explore and prepare for the future

Niles and Harris-Bowlsbey (2013) suggested that elementary school counselors use the standards established by the American School Counseling Association (ASCA).

Standard A: Contains descriptions and definitions for self-knowledge, self-skills, and self-feelings that indicate students will acquire the knowledge, skills, and feelings to investigate the world-of-work and make informed career decisions.

ASCA's competencies and indicator domains include academic, career, and personal/social development. Standard A will be highlighted to serve as an example except for career development. Standard A for academic indicates students will acquire the attitudes, knowledge, and skills that contribute to effective learning in school and across the life span. Within this domain are competency and indicator tasks. The competency for academic development is to improve academic self-concept, acquire skills for improving learning, and achieve school success.

Standard A for career development indicates that students will acquire the skills to investigate the world of work about knowledge of self and to make informed career decisions. Within Standard A the competencies are to develop career awareness (ten indices), and develop employment readiness (nine indices) (ASCA, 2004).

Standard B for career development indicates that students will employ strategies to achieve future career goals with success and satisfaction. Within Standard B the competencies contain career information (eight indices) and, identity and career goals (five indices).

Standard C for career development indicates that students will understand the relationship between personal qualities, education, training and the world of work. Within Standard C the competencies are to acquire knowledge to achieve career goals (seven indices) and to apply skills to achieve career goals (four indices).

Standard D is personal/social development whereby the student acquires the knowledge, attitudes and interpersonal skills to help them understand and respect self and others.

Focusing on these topics emphasizes the importance of a developing self-concept, how to interact with others effectively, personal responsibility, the relationship between work and learning, benefits of educational achievements, work habits, societal needs, decision-making, different occupations, changing female roles, and career planning (Zunker, 2006, 2014).

Counselor's Role

The counselor's role in the elementary years is one of counseling, coordinating, and consulting. Bailey and Stadt (1973) suggested 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, the world of work, planning one's time, application of decision-making skills, social relationship, and work attitudes and values.

Critical Development

Miller (1996) indicated that the significant development in the formative years is self-awareness. Thus, career guidance is to foster a "child's awareness of self, feelings of autonomy and control, need for planful behavior, and desire for exploration" (p. 350).

Career Guidance: Junior High School

1. The focus during this 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. 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.

    Havighurst's (1972) developmental stages for this age group include:

a. achieving new and more mature relationships with peers of both sexes
b. achieving a masculine or feminine role in society
c. accepting one's physique and using the body effectively
d. achieving emotional independence from parents and other adults
e. preparing for marriage and family life
f. preparing for an economic career
g. acquiring a set of values and an ethical system as a guide to behavior
h. desiring and achieving socially responsible behavior

2. Counselor's Role: Lefstein and Lipsitz (1986) indicated 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.

Career Guidance for High School

The American School Counseling Association content standards for high school for career development are as follows (American School Counselor Association, 2004):

The content standards provide the foundation for the acquisition of skills, attitudes, and knowledge enabling students to make a successful transition from school to the world of work and from job to job across the lifespan career. Standards are the same across elementary, middle school and high school except for the indices. For high school students, the indices are to:

a. develop skills to locate, evaluate and interpret information
b. learn about the variety of traditional and nontraditional occupations
c. develop an awareness of personal abilities, skills, interests, and motivations
d. learn how to interact and work cooperatively in teams
e. learn to make decisions
f. learn how to set goals
g. understand the importance of planning
h. pursue and develop competency in areas of interest
i. develop an avocational interest
j. learn to balance work and leisure time
k. acquire employability skills such as working in a team, problem-solving, and organizational skills
l. apply job readiness skills to seek employment opportunities
m. demonstrate knowledge about the changing workplace
n. learn about rights and responsibilities of employers and employees
o. learn to respect individual uniqueness in the workplace
p. learn how to write a resumé
q. develop a positive attitude toward work and learning

r.   understand the importance of responsibility, dependability, punctuality, integrity, and effort in the workplace

s.   utilize time and task management skills

Standard Five describes competencies and indices for employing strategies to achieve future success and satisfaction. Standard Six outlines an understanding of the relationship between personal qualities, education and training, and the world of work (American School Counselor Association, 2004). Career Goals: Wilson (1986) indicated 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). Career Guidance for Senior High: This period in the vocational career development of high-school students revolves around selecting vocational training, admission to college, major field selection, full-time employment, the option of military service, marriage, and apprenticeship training and involvement. The young person is about to separate from high school and about to face the reality of independence. This independence is approached by how he/she looks at the alternatives and implications of his/her decisions.

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, 2007). 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, 2014). Whereas elementary years goals are to become aware, and middle-school years are to understand, the senior-high years are a time to evaluate and interpret career development.

Career Guidance: Adult Development Career guidance in higher education and for adults is comprehensive. That is, individuals are counseled for the selection of a major field of study, self-assessment, understanding the world of work, decision-making, access to the world of work, and specific needs of special populations (Herr & Cramer, 1996).

Individuals change jobs for a variety of reasons. Career writers in the 1970s focused on crises and predisposing factors as each related to a job change. Levinson (1983) and Vaitenas and Weiner (1983) also discussed several reasons for career changes (as cited in Osipow, 1983):

1.   Levinson (1983) found middle-aged men change jobs due to:
    a.   anxiety over aging and death
    b.   questioning about the basis of their lives
    c.   need for affirmation of self by society through success in career
2.   Vaitenas and Weiner (as cited in Osipow, 1983) found several other reasons for career changes:
    a.   interest incongruity with the occupation
    b.   lack of consistency and differentiation of interests

c. fear of failure

    d. emotional problems

3. The unfulfilled worker is searching for autonomy, challenge, and meaning in work. He/she tends to experience:

    a. a change in needs and restructuring of goals

    b. recognized disparity between current work content and formulated goals

    c. recognized difference between self-perceived abilities and utilization of current work

    d. the sense 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 workforce remains interested in his/her skill and work areas but 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, 2014) pointed 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 suggested that two issues are important for counselors working with adults in transition. The first is the counselor's experiences with his/her past transitions or changes. The second concern is counseling when the counselor is in transition.

Question 4-30:

A librarian at a community college has managed to acquire 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 an accurate 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 utilized best by individuals without counselor intervention.

    d. DISCOVER and SIGI PLUS are considered viable tools in the career decision-making process.

Answer: c. DISCOVER and individuals without counselor intervention best utilize SIGI PLUS. A major disadvantage of all computerized career guidance systems is that clients may often 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

Traditional computerized career guidance programs such as DISCOVER, SIGI, and CHOICES are now extensively used in career counseling programs. A review of the literature indicates 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) pointed out that individuals use computerized career guidance to assist in making career and educational plans and to make confident career decisions. Hinkle (1992) suggested that a thorough search for the accountability of these computer-assisted career guidance packages (CACG) is critical. "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 can and cannot be used efficiently and recognize when the computer or the counselor may be more effective alone. Johnston, Buescher, and Heppner (1988) identified common issues with the wholesale use of CACG to be in the area of psychometrics, programming, technical service, and staffing.

Avocational Career Guidance

Leisure is a component of vocational and avocational wellness and 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 particular 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) identifies 725 different leisure activities classified in a three-level system. A later guide published in 1990, The Leisure Activities Finder identifies 760 leisure activities (Holmberg, Rosen, & Holland, 1990). Some advantages of leisure are the release of tension, attainment of a sense of freedom, feelings of pleasure, joy, satisfaction, or being creative or expressive of the self (Gunter & Gunter, 1980).

Leisure can serve several functions. Some of these are to help:

a.   people learn how to play their part in society
b.   people to achieve societal aims
c.   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. 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, or attending a play.
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, and travel. 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 during the life span.

OBJECTIVE 4D: Work Environment Conditions

Objective 4 d. Approaches for assessing the conditions of the work environment on client's life experiences (CACREP, 2015, P. 11).

In evaluating the conditions or impact of the workplace on the client's life experiences, it is important to understand intrinsic and extrinsic rewards and worker engagement. Internal rewards experienced and associated with one's work is a result of employee engagement, and the degree of vigor one has for the work role. Worker well-being is reflected in a positive, fulfilling, affective-motivational state that is the opposite of burnout and characterized by vigor, dedication, and absorption (Bakker & Dermerouti, 2008). These authors reported four reasons why engaged workers perform better than non-engaged workers. Workers that are engaged possess positive emotions, experiences better health, create their job and resources, and transfer their engagement to others. Schaufeli, Salanova, Gonzalez-Roma, and Bakker (2002) reported that a worker's well-being is the interactional environmental impact and sense of a job well done (skill performance) resulting in a positive, fulfilling, and work-related state of mind that is characterized by vigor, dedication, and absorption (p. 74). Work-related well-being is activation, ranging from exhaustion to vigor and the identification range is from cynicism to dedication. Burnout is the opposite of well-being, a combination of exhaustion and cynicism.

Factors associated with worker satisfaction include equal treatment, opportunities and positive interaction with co-workers. Butterfield et al. (2010) conducted an exploratory study to determine the influencing factors for "what helps and what hinders" workers in a social and contextual work environment. The study sample consisted of 45 individuals from 23 industries representing the fields of education, mental health, government, technology, management, recreation, natural resources, science and engineering, communications, transportation, and farming. The helping factors contained eight categories with two listed as hindering. The four most important helping categories included support from friends and family (80%), personal attitudes/traits/emotional set (76%), self-care (64%), and internal framework and boundaries (60%). The hindering categories included management style and work environment (71%) and personal life changes/issues (42%).

A breakdown of events and consequences for four helping categories and two hindering categories include:

a. Support from friends and family revealed that family and friends cared, helped, empathized, listened, validated, respected, and encouraged participants.

b. Personal attitudes/traits/emotional set included "being optimistic, insightful, confident, or responsible for their life." The participants reported that the consequences of these "attitudes produce good and bad days, keeping an even keel in the face of change, minimizing the risk of disaster, having increased energy to deal with change, and feeling purpose" (p. 150).

c. Self-care participants described "healthy, positive, growth and learning, self-affirming, and self-soothing activities such as exercise, enjoying living conditions, having pets, hobbies, educational

pursuits, and balancing work and social life." The outcomes or consequences include "balance or stability, stress reduction, new perspectives or options, increased patience, the ability to take on more work, and being connected to something other than work" (p. 15).

d. Internal framework and boundaries-participants described this category as dealing with change via an "internal framework, philosophy and approach to life that reflected a set of beliefs that were religious and spiritual, and personal and professional boundaries." The outcomes or consequences included "having job structure, increased confidence and freedom to make decisions, reduced worry and regret, and a sense of spiritual connection and trust that things work out" (p. 151).

e. In the hindering category of management style and work environment 71% of the participants mentioned hindering incidents of workplace-related items including "difficult for members to handle change well, when change is thrust upon them with no consultation, lack of proper training, managers not telling the truth, unfair compensation, budget and resources cuts, no management support, and poor job prospects." The outcome or consequences for the hindering influences include "exhaustion, discontent, decreased effectiveness on the job, self-doubt and the desire to escape" (p. 151).

In summary, support was mentioned in three helping categories emphasizing that the importance of the inter-relatedness of people in a social network was crucial. A hindering factor of responses regarding management reflected comments of not feeling valued or treated fairly, not kept informed of corporate decisions and changes affecting them that resulted in decreased productivity, exhaustion and detachment from the work and work community, and job burnout. These types of hindering factors are indicative of organizational injustice issues (Hosmer & Kiewitz, 2005).

Conducting a needs assessment is one approach to addressing different variables that have an impact on the lives of clients. Englert, Doczi, and Jackson (2014) identified a model for a needs-based assessment for profiling, assisting, and empowering job seekers.

Risk

A major component of career and life planning is a needs-based profiling tool to assess employed or unemployed worker satisfaction of work roles and in making job selections. The needs-based assessment (NBA) provides feedback to the client's willingness and capacity to find employment and availability of opportunities so that the person can manage a job search. Work capacity assessment provides client confidence feedback regarding skills, qualifications, and experiences in finding a job and work tasks. Willingness is the degree of motivation based upon how careful the person is in a job search taking into consideration self-reservations or risks and is a reflection of attitude. Labor market demand, opportunities, and specific client roles are integrated into the NBA three factors creating a risk-assessment for long-term unemployment (Englert et al., 2014).

Negative thinking

Another unemployment factor to consider is self-confidence in conducting a job search. Negative career thinking (career path or career direction) and lack of decision-making skills have been singled out as barriers. Bullock-Yowell et al. (2014) recommended the cognitive information processing approach (CIP; Sampson, Reardon, Peterson, & Lenz, 2004). The client examines self-knowledge and knowledge of

the world of work in a step-by-step approach reaching the execution cycle in the decision-making process. The Career Decision-Making Difficulties Questionnaire (CDDQ; Gati, Krausz, & Osipow, 1996; revised by Gati & Saka, 2001) identified themes of difficulties in career decision making. The Career Thoughts Inventory (CTI: Sampson, Peterson, Lenz, Reardon, & Saunders, 1996) identified negative career thoughts. All of these instruments can be helpful in sorting out conditions in client life experiences associated with the work environment's impact on choices and decisions.

Work Personality Traits

The Developmental Work Personality model illustrates that environmental structure as a foundation for developing a work personality is stimulated by learned behaviors in childhood and translated into adult work practices (O'Sullivan & Strauser, 2010). In essence, worker personality and worker engagement are two interrelated constructs that have a positive impact on satisfaction.

Workaholism is an addiction involving uncontrollable need or compulsion to work continuously. Symptoms are similar to alcoholism and are reality distortion, need to control, denial, anxiety, depression, withdrawal, irritability, and relationship problems (Spruell, 1987). These personality traits involving physical and emotional deficit tend to cut the individual off from others. Chamberlin and Zhang (2009) reported that physical health problems and lower levels of psychological well-being and self-acceptance are factors for workaholism.

Gati, Krausz, and Osipow (1996) reported three main types of difficulties in the decision-making process that include a lack of readiness, lack of information, and inconsistent information. Core self-evaluations consist of self-esteem, self-efficacy, tendency to have a negative cognitive and explanatory style, and locus of control (Judge, Locke, & Durham, 1997) and late social intelligence closely related to emotional intelligence (Di Fabio & Kenny, 2011). The Developmental Work Personality Scale (DWPS: Strauser & Keim, 2002; Strauser, O'Sullivan, & Kong, 2012) measured behaviors, role models, and tasks.

Judge, Bono, and Locke (2000) researched the mediating variables of self-evaluation, intrinsic job characteristics and job satisfaction. Core self-evaluations and job satisfaction are measured across traits of self-esteem, self-efficacy, a locus of control, and low neuroticism. One of three outcomes measured in middle adulthood revealed that core self-evaluations were linked to job satisfaction.

Work-Family-Life Roles

Dual career is a term coined by Rapoport and Rapoport (1978) whereby both spouses are pursuing an active career and family life. Counselors often confront clients with multiple issues, which are 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 (2006, 2014) identified counseling issues during the counselor-client hour to be child care, role conflict, geographic moves, competition, personal factors, relationship factors, and family-oriented work policies.

Dual role occurs when one of the two partners assumes two roles, that of house-family-children and an occupational job outside the home. There is a lack of male perspective in most studies relating to the dual-career families. Some authors subscribe to the idea of an identity tension line. This line identifies a point at which the individual feels uncomfortable in the sex-role socialization.

Family changes are ever changing as many families are experiencing the wait generation, young people waiting for jobs, difficulties with insurance, marriage, education financial debts, more women entering the professional ranks and in leadership positions and changing careers. Many family issues remain from past generations such as single-parent, extended families, childcare, poverty, and dual roles. Family relationships are often affected by expectations and intentions revolving around work and family. Issues can be role conflict, childcare, geographic moves, competition between partners, personal factors (attitudes, values, biases, finances, divorce, disabilities, work loss, trauma, i.e.), relationship issues, and work-related issues.

Work and Work Characteristics

Work has always been a significant activity in the daily life of man. Historically, from a food gatherer to a knowledge provider the work role has changed to meet the existing needs. Changes in work roles along with the innovations and expansion in technology have necessitated an increased need for many skill developments to do that job. As the worker has focused more on skill development, the interpersonal distance between the worker and the work arena has separated. Behaviors such as longevity in work, worker and company loyalties, hostility in the workplace, and commitment frequently appear in the guidance and counseling hour creating a need for assistance in bridging the gap between the worker and the employer. This support during the early years came in the form of guidance.

Individuals, young and old, often lack direction in locating a job, lack career exploration skills, and do not have the ability to assess potential career options. Career counseling is a process involving exploratory skills, values, development, needs assessment, goal identification, and the necessary skills to secure a job (interviewing skills, job specifics).

A variety of events gave rise to the concept and formation of guidance in the United States. Some of these important influences are:

a. philanthropy and humanitarian
b. religion
c. mental hygiene
d. social change
e. individualism
f. federal support
g. client-centered therapy

"Traditionally, work has an economic, psychological, and social perspective regarding the purpose and meaning of work" (Drummond & Ryan, 1995, p. 40). 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?

Herr, Cramer, and Niles (2004) provided various definitions and purposes of work from an economic, psychological, and social perspective. Economic goals tend to reflect a gratification of wants, acquisition of assets, security, liquid cash 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. 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 work ethic changes the meaning of work. To understand worker satisfaction and dissatisfaction, one has to consider the prevailing worker ethic, economics, technology, mobility, social class, ethnic background, and psychological factors. For the present, although dated, employee satisfaction is related to the level of prestige, autonomy, work group cohesiveness, job challenge, working conditions, wages, job security, upward mobility, the 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.

Many people who work are satisfied with their choice of careers. However, small percentages of individuals remain dissatisfied with work experiences or have patterns that lead to failure. Neff (1977) described work pathology regarding type. These types indicate people 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) listed some reasons for dismissal and work adjustment.

DISMISSAL	**ADJUSTMENT**
1. carelessness	1. punctuality
2. laziness	2. honesty
3. absence/tardiness	3. reliability
4. disloyalty	4. dependability
5. distraction	5. initiative
6. too little/much ambition	6. cooperation

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exploratory skills, values, development, needs assessment, goal identification, and the necessary skills to secure a job (interviewing skills, job specifics).

Variables to Consider in Career Guidance

Presently, career counselors 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 some changes. Some of these are Protestant ethic, craft ethic, entrepreneurial ethic, career ethic, and finally self-fulfillment ethic. Maccoby and Terzi (1981) identified the motivation to work behaviors for each work ethic as:

a.   Protestant ethics—labor as a religious imperative, for the greater glory of God, a moral obligation, work is first.

b.   Craft ethics—social obligation benefited the individual, as self-sufficiency and a desire for control of work standards—independence from entrepreneurs.

c.   Entrepreneurial ethics—came about during mass production, machines, free enterprise, and risk-taking.

d.   Career ethics—self-employment decreased, moving up the ladder, being loyal to the employer/business.

e.   Self-fulfillment ethic—orientation toward greater concerns for self-fulfillment, personal growth, enjoyment of work, and a life of leisure.

Stress at Work

Zunker (2006, 2014) compiled a list of stress sources for workers includes:

a.   Conditions of work—pace of work, hours, etc.

b.   Work itself—repetitious, overloaded, uninteresting

c.   Shift work—bodily function/family disturbances

d.   Supervision—close/no supervision, unclear job demands

e.   Wage and promotion—low pay

f.   Role ambiguity—lack of clarity

g.   Career development stressors—lack of job security, attainment, obsolescence

h.   Group stressors—no group cohesiveness or identity

i.   Organizational climate—impersonally structured

    j.   Organizational structure—bureaucratic/ autocratic

Motivation

Several theories attempt to explain what motivates individuals to work. Three of these theorists are:

1. Maslow: Need theory—individuals work to satisfy needs
2. Herzberg: Two Factor theory based on motivators and hygiene
    a. Motivators—recognition, achievement, responsibilities and work
    b. Hygienes—negative perceptions of company, extrinsic to job
3. McClelland: People work for one of three basic needs.
    a. NACH Need for achievement, intrinsic rewards, success as measured against some internalized standard of excellence
    b. NAFF Need for affiliation, close interpersonal relationship, and friendship
    c. NPOW Need for power, direct control or influence over others

Burnout

Herbert Freidenberger (1974) was the first to use the term burnout in relationship to work behavior. There is no conclusive evidence to suggest that burnout is a result of stress or a part of the developmental aspect of career theory. The term is derived from psychiatric patients who were burned out physically, emotionally, spiritually, interpersonally, and behaviorally to the point of exhaustion (Paine, 1982). Burnout is an "internal psychological experience involving feelings, attitudes, motives, and expectations" (Maslach, 1978; 1982, p. 29).

Definitions for "Burnout"

1. Freidenberger (1974) defined burnout 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) described 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 needs)
    b. strain due to an emotional response to anxiety and tension
    c. cope defensively by changing attitude to job commitment
3. Maslach (1978) viewed burnout as a loss of concern for people with whom one is working. Emotional exhaustion exists when the professional no longer has positive feelings, respect or empathy for clients.
4. Howard (1975) described burnout about individuals who are underemployed and who are in occupations do not make full use of their education and training, or who do not have enough pressure and challenge on the job.

5. Osborn (2004) described burnout as a process of physical and emotional depletion resulting from conditions at work or prolonged job stress (p. 319).

The two types of stressors that contribute to burnout are psychosocial and biogenic. Levels of burnout are a 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) outlined 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 adverse outcomes. If exhaustion lacks treatment, 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.

OBJECTIVE 4E: Assessing abilities, interests, values, personality

Objective 4e. strategies for assessing abilities, interests, values, personality and other factors that contribute to career development (CACREP, 2015, p. 11)

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 modeled after the social intake interview. He was interested in instrumentation, however, at the time these instruments were not refined. A proper assessment will stimulate, broaden, and provide a focus for career exploration, encourage an exploration of self about a career, and provide the necessary information to assist in conducting a choice.

Career assessment considers information from the family development (career tree), socio-economic levels, education, aspirations, work ethic, skill level, resources, special skills, personality, interests, and aptitude.

APTITUDE: Aptitudes measure specific skills, proficiencies or abilities as an index of measured skills and provides an indication of cognitive strengths and weaknesses. The commonly used batteries include:

a. GATB: General Aptitude Battery. This GATB was developed by the U. S. Department of Labor and predicts job performance in 100 specific occupations (Gregory, 1996). GATB results provided an occupational analysis profile (OAP) and matched across occupations for a job fit.
b. DAT: Differential Aptitude Test is the most commonly utilized in the high school setting.
c. FACT: Flanagan Aptitude Classification Test was developed from the Flanagan studies.

d. 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.

e. SAT: Scholastic Aptitude Test used for college acceptance and provides competition probabilities for selection purposes for the best choice. The SAT is considered a reliable measure for reasoning skills.

f. ACT: American College Entrance Examination. The ACT, similar to the SAT in purpose, also includes an interest inventory based on 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). Some interest inventories and authors are:

a. Clark Hull: Minnesota Vocational Interest Inventory

b. E. K. Strong: Strong Vocational Interest Blank and Strong Interest Inventory

c. G. F. Kuder: Kuder Preference, Occupational, and Vocational inventories

d. 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:

a. Myers-Briggs: Myers-Briggs Type Indicator

b. Raymond Cattell: 16 Personality Factor Questionnaire

c. A. Edwards: Edwards Personal Preference Schedule (EPPS). Based on 15 needs of Murray.

VALUES: Values inventories measure values associated with broader aspects of lifestyle. Assessment techniques are used to clarify skills, interests, expectations, and values. Values-based approaches broaden career exploration and then narrow vocational interests toward a career choice. Values-based instruments to assess work personality include the person-environment fit (P-E), Brown's Values-Based Approach and the Theory of Work Adjustment. Individual needs and vocational abilities combine the self and the environment. Work environment refers to the job requirements and reinforcement systems (VanVoorhis & Protivnak, 2012).

The Leuty and Hansen's Cross-Battery assesses work values with the Minnesota Importance Questionnaire (MIQ; Rounds, Dawis, Reardon, & Saunders, 1981) and Super's Work Values-Revised (SWV-R; Zytowski, 2006). The MIQ is considered the most comprehensive assessment of work values that include environment, competence, status, autonomy, organizational culture, and relationships. Life Values Inventory assesses the client's values and how they relate to life roles (Crace & Brown, 1996).

On-line resources in the form of assessments and resources include the Occupational Information Network (O*NET).

OBJECTIVE 4F: Career Development Program Planning

Objective 4f. strategies for development program planning, organizing, implementation, administration, and evaluation (CACREP, 2015, p. 11)

Workplace diversity

Developing a comprehensive systematic workplace diversity plan involves an endorsement and a commitment to structure a principled set of social justice guidelines that includes attitudes from the organizations, managers, and employees. Recognition for change, increased self-confidence, adequate financial commitment to the plan, education, and support from the community and family are factors for creating the atmosphere for implementation (Kleemann, 1994; Neault & Mondair, 2011). Soft diversity in the workplace is an approach focused on food and art while a hard focus is strong commitment to challenge the embedded elements of racism, sexism, ageism, and attitudes that maintain oppression (McBeath, 2008, p. 7). Reduced absenteeism, worker isolation, marginalization, and an increase in enjoyment, and satisfaction are outcome behaviors to suggest a successful plan for the person and the organization (Barrile, 2003).

Evaluating career guidance from an individual and program perspective utilizes the research designs relative to a formative or summative view. If the career program has a step-like design it is easier to formulate a plan for follow-up and evaluation. Niles and Harris-Bowlsbey's (2013) ten-step program includes:

1. define the target population and characteristics (high school, college, corporation, etc.)
2. determine the needs of the identified population
3. create measurable objectives to meet the needs
4. determine how to deliver the career planning services
5. determine the content of the program
6. determine the cost of the program
7. promote and explain services
8. promote and deliver the full-blown program of services
9. evaluate the program
10. revise the program as needed

How to determine and evaluate program needs easily could be two areas for the examination. These authors identify four ways to identify needs of a group. That is:

1. some information may already be available
2. a short questionnaire may be developed and administered and processed for a focus group
3. consultants may be hired
4. ask managers and administrators to identify problems that need solutions

If program objectives are written in a clear concise manner, the evaluation process will be much easier. The objectives are the content and evaluation of the services. Evaluation of services can include

both quantitative and qualitative findings and can be through asking questions of those who use the service. A pre-post questionnaire administered after a seminar or individual session provides for feedback. An experimental design using a control group is recognizable information.

Hansen (1996) developed an Integrative Life Planning (ILP) model that included career development, life transitions, gender-role socialization, and social change. The overarching integrated nature of the process is processing and decision-making regarding the impact of decisions that reflect changes in lifestyle and relationships. Decisions affect responsibility sharing regarding finances, child care, home environment, leadership roles, changes from traditional jobs to others not considered before and, along with these changes, subtle attitudes and prejudices (glass ceiling; Reskin & Pakavic, 1994). The glass ceiling is a transparent barrier for women in moving up in the corporate ladder (sex discrimination and harassment).

This programmatic outline targets middle school, high school, college and university, corporations, and job service offices. Working from a program design, the evaluation can pursue a macro-micro approach, that is, from an agency, a group or an individual.

An evaluation should consider the feasibility of a formative or summative data gathering that lends itself to analysis. If the assessment is for a program, assessment content and feedback can be secured from participants. A second step is to gather specific knowledge, skills, attitudes and behaviors of the individual or group. The data can be collected through feedback, questionnaires, and interviews or administering standardized instruments and structured interviews or observations. Follow-up studies can be a part of the overall evaluation plan. The final step is to decide on the proper analysis of the data.

OBJECTIVE 4G: EMPLOYMENT: Diversity

Objective 4g. strategies for advocating for diverse clients' career and educational development and employment opportunities in a global economy (CACREP, 2015, p. 11)

Advocating an employment strategy includes remaining abreast of "hot" spots for employment jobs and fields providing openings in the upcoming years. The United States Department of the Bureau of Labor Statistics (USBLS, 2016b) maintains an updated listing of job projections for the fastest-growing occupations from 2014 to 2024.

The 2014-2024 projection fastest-growing occupations and percent of change includes wind turbine service technicians (108%), occupational therapy assistants (42.7%), physical therapist assistants (40.6%), physical therapist aides (39%), home health aides (38.1%), commercial drivers (36.9%), nurse practitioners (35.2%), physical therapists (34%), statisticians (33%), occupational therapy aides (30.%), physicians assistants (30.4%), operations research analysts (30.2%), personal financial advisors (29.6%) and cartographers and photogrammetrists (29.3 %; USDLS, 2016b).

The Occupational Outlook Handbook listed 20 occupations with the highest job growth in percent to include: personal care aides (25.9%), registered nurses (16%), home health aides (38.1%), combined food preparation and serving workers (10.9%), retail salespersons (6.8%), nursing assistants (17.6%), customer service representatives (9.8%), cooks (restaurant, 14.3%), general and operations managers (7.1%),

medical assistants (23.5%), software developers (18.8%) and construction labors (12.7%) represent the first ten (United States Department of Labor, Bureau of Labor Statistics, 2016a, Table 6).

Growth projections for 22 different major occupational groups for the 2014-2024 decade include increases in healthcare support (23%), healthcare practitioners and technical occupations (16.4%), personal care and service occupations (13.2%), computer and mathematical (13.1%), community and social service occupations (10.5%) and percentage decreases in farming, fishing, and forestry occupations (-5.9%) and production occupations (-3.1%).

The culture and climate of work and changing status of work conditions have become the new norm. It is important to be aware that those preparing to work, considering a job change, have lost a job, or are unemployed may encounter barriers of class, status, oppression, and racism. The newer cultural norm is a parallel career trajectory, creating different pathways, retraining, and dealing with the negative factors for acceptance, satisfaction, and meaning of work (Maglio, Butterfield, & Borgen, 2005). Ronzio (2012) reported that past developmental career theories do not accommodate transitions. Clients expressing fearfulness, uncertainty and a lack of resiliency skills are current concerns for those in a temporary job, shifting work roles, and the unemployed as well as the underemployed.

Age, race, religion, lesbians, gay, and transgender, and those individuals from other countries, and disabilities in the status of employed or unemployed can identify as diverse clients. Individuals employed or unemployed face barriers in education, training, hiring practice, and in a promotion. Bullock-Yowell et al. (2012) conducted a study of 440 unemployed adults representing an age range of 17-54, an equal number of men and women, and ethnicity (primarily African Americans-48.5% and European Americans-47.3%, and a smaller number for Native American, Asian American, and Hispanic Americans). Unemployed workers when surveyed cited symptoms of anxiety, depression, sleeping issues, social avoidance, and troubled relationships. There are reports of severe consequences such as clinical depression, hospitalization, physical illness, alcohol abuse, suicide, and violence (Dooley, 2003).

Mental health responses target negative career thoughts by focusing on career decision-making, career development, and personality via principles of cognitive information processing (CIP) approach (Sampson, Reardon, Peterson, & Lenz, 2004). Bullock-Yowell et al. (2012) singled out career thinking, career decision-making, self-efficacy, and interests and compared responses of the unemployed with current research of college students. The conclusion stated that a distinct work culture coupled with the culture of individuals did share some similar work values, but there were some differences.

Murphy and Shillingford (2012) reported several studies citing adverse effects suffered by unemployed males that included:

a. sadness, increased anger, engaging in antisocial and narcissistic behaviors and conflict with loved ones (Rabinowitz & Cochran, 2008)

b. lower self-esteem, shame, isolation, and depression (Guindon & Smith, 2002)

c. increased depression, low self-esteem, decreased interpersonal communication (Funk & Werhun, 2011)

d. may experience spousal abuse, marital friction, psychiatric disorders, spousal depression and suicide, increase in relationship problems and interpersonal difficulties (Jarzombek, 2010)

e. restrictive emotionality in men (Wong, Pituch, & Rochlen, 2006)

Murphy and Shillingford developed a group modality and integrative approach with CBT and psychoeducation. The treatment of choice was CBT because of the emphasis on cognitive processes to change core beliefs, rumination and to understand the consequences of thought and feeling suppression. Psychoeducation goals included delivering information and through group discussion integrate the factual information with psychosocial support. The group format for weekly meetings included setting goals and objectives, social support, emotional responses, unrealistic gender expectations, communication skills, coping skills and relaxation, employment resources, and a termination session.

Ronzio (2012) cited issues for adult women in transition. The U.S. Labor Department statistics (2016) reported that over half of women were employed in education and health services, financial industries, leisure, and hospitality although under-represented in occupations related to agriculture, mining, construction, manufacturing, transportation, and utilities. In 2014, 6.1 % of women were unemployed down from 8.6 % in 2010 (USLD, 2016).

Factors to consider when counseling women should include the role of class and status, gender biases, unique cultural experiences, religious and cultural backgrounds, previous negative encounters involving discrimination (racial, ethnic, hiring, age), job loss, physical and mental health issues, work that is acceptable, psychological issues of the client, and family and relationship issues. Women have tended to develop relatedness to self, others, and the wider community (U.S. Department of Labor (2012).

Culture is defined as "the set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each, communicated from one generation to the next" (Matsumoto, 1996, p. 6). Zunker (2006) paraphrased the work of Matsumoto in describing work-related values that the counselor is to determine when conducting career counseling with clients. These are:

a. power distance
b. uncertainty avoidance
c. individualism/collectivism
d. masculinity

The dimensions are covered within other units of this manual except "uncertainty avoidance." Matsumoto's dimensions of uncertainty avoidance have to do with how different cultures deal with anxiety and stress.

Sue, Ivey, and Pederson (1996) provided some key points for counselors who offer career work with individuals of ethnic background. It is important to:

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

Issues of discrimination and a lack of access to work opportunities for individuals and groups representing a minority, disability, disenfranchisement, gender, especially women, age, and special needs are plentiful. Broad areas in which these opportunities have lacked support are in opportunities to contribute and to receive a satisfactory fulfillment in work, education, politics, culture, social influence,

skill development, and non-discrimination practices (biases). Although there are commonalities (universal) that cut across all oppressed individuals and groups, frequently the individual experiences them as both individual and group applied.

For some time, attention has focused on the national censure bureau description of minority groupings of African Americans, Asian Americans, Hispanic Americans and Native Americans although issues in multicultural work-related issues cover an even much broader scope of individuals and groups and can be said to exist for all oppressed people.

Cultural differences exist as noted in applying the concept of worldview to different groups such as individual or collectivism. Acculturation (beliefs, values, and behaviors of the white dominant and minority cultures) is not universal. Time orientation regarding promptness is viewed from different perspectives within and outside of groups. From that point of view language, place of birth, generation level, socioeconomic status, ethnic identity and ethnic group contacts are areas for counseling when issues arise. Hall (1971) defined time as polychromic and monochromic. Another problem may be that space and privacy are culturally determined and oriented (Zunker, 2014). A concluding comment is that much non-acceptance and misunderstanding may center from an acceptable behavior in one cultural group and not so in another. Hofstede (1984) studied work-related values in 50 countries, 20 different languages and at seven different occupational levels and identified cultural differences to exist. The differences are power distance, uncertainty avoidance, individualism/collectivism, and masculinity.

Title VII of the Civil Rights Act of 1964 and Title IX of the Educational Amendment of 1972 prohibit discrimination and provide protection by gender in employment, payment for work, educational opportunities and equal opportunity.

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

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

People of color, with disabilities, are mostly unemployed, have a lack of education, training, and job opportunities and have similar experiences in the work world when compared to the general population. However, the minority population meets additional barriers and stress levels and the impact of those stressors, and unmet needs have a tremendous impact on their lives.

The experiences of African-American women in addition to race discrimination and gender discrimination also face organizational cultures, policies and practices resulting in race-related and work stress. The effects of environmental injustice have had detrimental effects on their lives. Research summarized by Norman and Tang (2016) provided supporting results of the consequences of stress, lack of advancement and work mobility, and psychological disturbances to include:

a. high levels of psychological strain and low levels of satisfaction (Niles & Harris-Bowlsbey, 2013, 2017)

b. disturbed affect, impaired motor behavior, changes in cognition functioning, and physiological change (Lazarus & Folkman, 1984)

c. elevated stress levels because of restricted economic opportunities (U.S. Department of Labor, Women's Bureau, 2016)

d. role conflict and personal strain (Cook, Heppner, & O'Brien, 2005)

e. receive lower pay when compared to non-Hispanic, white women, and African- American men (Department of Commerce, 2011) and frequently move into food and clerical work even lowering their wages.

Hudson et al. (2016) in a qualitative study documented adverse experiences resulting from racial tension and stress for African American women that impacted their lives and continued for a lifetime.

Mentoring relationships for career and psychosocial orientation, career guidance, exposure/visibility within an organization were found to be helpful. Psychosocial mentoring provides modeling, counseling, acceptance, confirmation, and friendship and promotes confidence (Anderson, 2005). Same-race and with the same gender mentoring resulted in increased career self-efficacy, job involvement, and self-esteem (Catalyst, 2004; Sepand, 2015).

4H: PLANNING AND MANAGEMENT STRATEGIES

4h. strategies for facilitating client skill development for a career, educational, and life work planning and management (CACREP, 2015, p. 11)

Evaluating career guidance from an individual and program perspective utilizes the research designs regarding a formative or summative view. If the career program has a step-like design, it is easier to formulate a plan for follow-up and evaluation. Niles and Harris-Bowlsbey (2013) ten-step program is:

1. define the target population and its characteristics
2. determine the needs of the target population
3. write measurable objectives to meet needs
4. determine how to deliver the career planning services
5. determine the content of the program
6. determine the cost of the program
7. begin to promote and explain the services
8. start promoting and delivering the full-blown program of services
9. evaluate the program
10. revise the program as needed and reflected in the evaluation process

This program targets middle school, high school, college and university, corporations, and job service offices. The evaluation can pursue a macro-micro approach, that is, from an agency, a group or an individual when using a program design.

An evaluation should consider the feasibility of a formative or summative data gathering that lends itself to analysis. If the assessment is for a program, assessment content and feedback is secured from participants. A second step is to gather specific knowledge, skills, attitudes and behaviors of the individual or group. Data collection methods include participant feedback, questionnaires, and interviews or administering standardized instruments and structured interviews or observations. Follow-up studies can be a part of the overall evaluation plan. The final step is to decide on the proper analysis of the data.

4I: TECHNIQUES CAREER PLANNING AND DECISION-MAKING

Objective 4i. methods of identifying and using assessment tools and techniques relevant to career planning and decision making (CACREP, 2015, p. 11)

Globalization, economic policy changes, flexible labor practices, and advances in technology have drastically changed the nature of a career search and opportunities for employment. With the increasing use of social networking sites (SNS), the Internet has contributed to increased employment flexibility and employers are using SNS to recruit and hire employees. Decisions made by potential employees to avoid the use of SNS may result in a lack of up-to-date information and in extending their social network for personal sharing of work-related concerns. Long-term employment is in the past and changing work roles is standard. The change in a work context calls for careful attention to a boundaryless career and an ongoing need for possible transitions.

The Internet has become a resource to aid in decision-making and for designing and maintaining resources. The Internet pathways provide for immediate dissemination of information and interpersonal communication. Social media platforms have become intervention pathways for many seeking to mentor for work issues and advancement. Osborn, Dikel, and Sampson (2011) reported that the Internet has three primary uses of web-based resources that include: (a) assigning websites for clients to review, (b) conducting distance counseling sessions, and (c) supporting virtual career resource centers. The use of the Internet highways is heavily laden with caution and ethics.

Counselors are to screen clients when recommending social networks as a component of career guidance and information access and the ability to use the social networking sites as a self-help tool. The face-to-face relationship with a counselor is not a distant one. Skills are necessary to factor out fact from opinion. The authors refer to this skill as information literacy to decipher the complexity of their career choice and life issues and goals. Virtual career centers can be established and provide current resources and information. Social networking has become an important resource in career planning and job searching. The virtual centers can include links to additional resources for self-assessments, occupational information, and apprenticeships for all audiences. Neault and Saunders (2012) recommended that counselors use this resource when they match Internet-based resources to the clients' needs, capabilities, and career readiness.

 Some SNSs require a self-descriptive registration that includes name, gender, age, and occupation, contact information, pictures, interests, activities, preferences, skills, career goals, and affiliations. Previously this information was the bulk of one's curriculum vitae or resume that is now public domain for SNS. Another recommendation is to enhance the client's on-line profile with career-focused information including professional qualifications. Strehike (2010) reviewed websites and cautioned users that there

might be some risk regarding information on the SNS profile. Information that employers considered problematic include misrepresentation, criminal behavior, bad-mouthing previous employers, disclosing confidential information concerning previous work, posting information regarding drinking or drug use, displaying inappropriate photographs and using an unprofessional screen name (p. 44).

4J: ETHICAL AND CULTURAL STRATEGIES

4j. Ethical and culturally relevant strategies for addressing career development (CACREP, 2015, p. 11).

Social networking sites are a source for possible ethical violations and risks. Strehike (2010) identified three themes after reviewing 14 web-based articles. Three themes included: (a) user visibility, (b) self-presentation, and (c) network connections. Some of these SNSs are not safe (confidentiality) rather are viewed by many managers or employers before the person has met the interviewer (Strehike, 2010).

Unit 4 - Terms

BURNOUT:
Lowman (1993) considers burnout to be one of three patterns of over commitment. Over-commitment refers to an identification that is too intense with and involvement in the work role where psychological health is at risk. Ashforth and Lee (1990) indicated burnout is a three-dimensional construct composed of the psychological aspects of emotional exhaustion, depersonalization, and personal accomplishment. Leiter (1993) pointed out that not all experts agree emotional exhaustion is a factor in burnout but that it appears to be related more too 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-INFUSED CAREER COUNSELING (CICC)
CICC is a reflective theory that emphasizes social justice and advocacy. Social, economic, and political forces shape career development for an acceptance diversity workplace. Culture and career issues shift over time, and work roles are not constant (Arthur & Collins, 2008, 2010).

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 males 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. Five factors influencing maturity include planfulness (time perspective), exploration, information, decision-making, and reality orientation.

CASVE CYCLE:

Peterson, Sampson, and Reardon (1996) defined a CASVE cycle as a process for utilizing information correctly. The letters represent communication (identifying a need), analysis (interrelating problem components), synthesis (creating feasible alternatives), valuing (prioritizing options), and execution (forming means-ends strategies).

CONGRUENCY:

John Holland defined 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 an RI (realistic-intellectual) personality working in or choosing an 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:

Crystallization is the third tier of the Realistic Stage of Ginzberg and associates' theory. Crystallization is said to occur when commitment is for 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):

The differential aptitude test is for educational and vocational guidance for grades eight through 12. The test consists of eight subtests and cumulative profiles are useful for vocational counseling and selection of employees when client aptitudes are matched with occupational requirements.

DIFFERENTIATION:

Miller-Tiedeman and Tiedeman indicated 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 an average 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 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 classifies job applicants, classifying job orders, matching workers to orders, and assisting special groups. A nine-digit or a six-digit numbering system refers to an occupational code. 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.

HOLLAND'S OCCUPATIONAL CLASSIFICATION (HOC):

Holland's classification is an alphabetical listing of occupations by code related to the various major permutations of Holland's codes. This coding system allows users to search out related occupations or jobs as possible alternatives.

INTERESTS:

Four types of interest include expressed, manifested, tested, and inventoried. Expressed interest is a verbal statement of an object, activity, task, or occupation. A manifested interest is involvement in an activity or occupation. Tested interest is an objective assessment of information. Finally, an inventoried interest is derived from a questionnaire or inventory such as the Strong Interest Inventory.

LEISURE:

Leisure is 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:

MAPS is a classification scheme for occupational structure. The World of Work Map by ACT and the Occupational Aptitude Patterns Map by GATB are two examples. MAPS was devised by the American College Testing Program (ACT) and added ideas to the DOT and OAP (people, things, and data). The World-of-Work-Map Mapping is a concept utilized in Bordin's Psychoanalytic Theory composed of satisfiers and the degree of involvement (Herr & Cramer, 1996).

NOICC:

The National Occupational Information Coordinating Committee provided 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; NOICC, 2007).

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 ASPIRATION MODEL (OAM):
Gottfredson developed a four-stage cognitive proposition model for women in choosing a career or job. The propositions include size and power, sex role, social evaluation, and unique internal self.

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.

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 in 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 and 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 designed for computer application and updated as frequently as needed (U.S. Department of Labor, 2002).

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 displayed the typology on a hexagon according to reliability of adjectives. Consistency and congruence, two of several terms, according to six stereotype codes that include realistic, intellectual, artistic, social, enterprising, and conventional provide an interpretation for matching personality type with environmental type (congruency) and the degree of agreement within personality and in jobs (consistency).

ROLE SALIENCY:
The positions and roles a person occupies or plays. Saliency is latitudinal with life space and represents the constellation of different positions an individual holds.

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 (1996) defined work shadowing as "schemes in which an observer follows a worker around for a period, 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 an observation of work roles.

STANDARD OCCUPATIONAL CLASSIFICATION (SOC):

This classification bridges the Census Classification and the DOT, and covers all occupations 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.

Questions

Question 4-31:

A counselor working with an elementary teacher on career guidance project emphasized lifespan vocational development. What would be important to emphasize in K-6?

    a. an awareness of available choices and personal characteristics

    b. the need for self-motivation for alertness to self-change

    c. career exploration activities

    d. the gap between education and work skills

Answer: a. an awareness of available choices and personal characteristics

Question 4-32:

Which vocational theorist would indicate that a vocationally mature person will demonstrate achievement of developmental tasks?

    a. Anne Roe

    b. John Holland

    c. Donald Super

    d. John Hoppock

Answer: c. Donald Super

Question 4-33:

According to John Holland, a person who self-selects stereotype RIA would demonstrate which of the following concepts if he or she worked in a similar environment?

    a. congruence

    b. consistency

    c. differentiation

d. confluence

Answer: c. differentiation

Question 4-34

A counselor assisting a senior high school student who was in search for accurate and specific information regarding a particular job. Which source would be most helpful?

   a. O'Net

   b. Occupational Outlook Handbook (OOH)

   c. Vital Information for Education and Work (VIEW)

   d. Buros Mental Measurement Yearbook (MMY)

Answer: a. O'Net

Question 4-35:

In using the DOT classification system with a client who indicates he would like to be an optical engineer, the DOT code is 019.601-014. Which of the following would be accurate for an optical engineer?

   a. high relationship to data and things and low relationship to people

   b. high relationship to data and people and low relationship to things

   c. low relationship to data and high relationship to people and things

   d. low relationship to things and high relationship to data and people

Answer: c. low relationship to data and high relationship to people and things

Question 4-36:

Engaged workers perform better than non-engaged workers for all of the following reasons except that they:

   a. create their resources

   b. experience better health

   c. develop advanced work skills

   d. experience positive emotions

Answer: c. develop advanced work skills. Bakker and Demerouti (2008) also included as a fourth reason engaged workers to transfer their engagement to others. Engagement is a state of mind characterized by vigor, dedication, and absorbing.

Unit 4 - References

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UNIT 5 - Counseling and Helping Relationships

Introduction

The nature of helping relationships accurately reflects the foundation of guidance and counseling. Guidance and counseling have 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 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 2014 Code of Ethics and Standards of Practice, especially Section A: The Counseling Relationship, Section C: Professional Responsibility, and Section D: Relationship With Other Professionals. Become familiar with major theories, study the goals, techniques, counseling process, counselor role, dynamics, client behaviors, and outcome effectiveness. Compare and contrast the theories

regarding major facets. There are 41 content questions in this section; however, only 36 counts toward your total.

CACREP Objectives

CACREP 2016 objectives for helping relationship are not presented in full. The website www.cacrep.org presents in full the CACREP 2016 objectives but for this unit are paraphrased (CACREP, 2015, pp. 5-6):

a. theories and models of counseling

b. a systems approach to conceptualizing clients

c. theories, models, and strategies for understanding and practicing consultation

d. ethical and culturally relevant strategies for establishing and maintaining in-person and technology-assisted

e. impact of technology on the counseling process

f. counselor characteristics and behaviors that influence the counseling process

g. essential interviewing, counseling, and case conceptualization skills

h. developmentally relevant counseling treatment or intervention plans

i. development of measurable outcomes for clients

j. evidence-based counseling strategies and techniques for prevention and intervention

k. strategies to promote client understanding of and access to a variety of community-based resources

l. suicide prevention models and strategies

m. crisis intervention, trauma-informed, and community-based strategies, such as psychological first aid

n. processes for assisting students in developing a personal model of counseling

Question 5-1: (Objective A.)
Integrative psychotherapies focus on three approaches: theoretical integration, technical eclecticism, and a common factors orientation. Select the correct choice for the theorists for the above three in sequential order.

a. Prochaska, Lazarus, Wachtel

b. Lazarus, Wachtel, Prochaska

c. Prochaska, Wachtel, Lazarus

d. Wachtel, Lazarus, Prochaska

Answer: d. Wachtel, Lazarus, Prochaska (Day, 2004)

Question 5-2: (Objective A)
All of the following are goals for Gestalt therapy except:

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 the unconscious motivation

Answer: e. insight into unconscious motivation

Question 5-3: (Objective A)

A basic assumption of Rational-Emotional Behavior therapy is that humans:

a. think without emoting.

b. emote without thinking.

c. behave and then emote.

d. behave without thinking or emoting.

e. think, emote, and behave simultaneously.

Answer: e. think, emote, and behave simultaneously.

Question 5-4: (Objective A)

In Reality therapy, insight is:

a. necessary for behavior change to occur.

b. not necessary for behavior change to occur.

c. the end result of the teachings of the therapist.

d. something only the client can discover for himself or herself.

e. something that follows changed attitudes.

Answer: b. not necessary for behavior change to occur.

Question 5-5: (Objective A)

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 wellspring of creativity.

Answer: b. A person's lifestyle changes throughout the life span as his or her goals change.

Question 5-6: (Objective B.)

To conceptualize a client's presenting issue and to customize a therapy relationship, client characteristics are essential. Clients who have little support from other people are likely to benefit from:

a. short-term, brief therapies.

b. lengthier psychotherapy creating social support.

c. lengthier psychotherapy and psychoactive medication.

d.   shorter psychotherapy creating social support.

Answer: b. lengthier psychotherapy creating social support (Norcross, 2004)

Question 5-7: (Objective C.)

Theoretically and clinically consultation is what type of relationship?

   a.   collateral

   b.   linear

   c.   causality

   d.   triadic

Answer: d. triadic. Triadic-consultant, counselor, and consultee

Question 5-8: (Objective D.)

Clients and counselors interact with computers and software technology to track changes during therapy. All of the following are benefits of this self-help monitoring technology except:

   a.   triage sessions.

   b.   immediate feedback.

   c.   design strategy and counselor training.

   d.   reduces counselor's workload.

Answer: d. reduces counselor's workload

Question 5-9: (Objective E.)

Clients lacking funds or who choose to avoid counseling centers choosing instead session-to-session on-site counseling for depression, generalized anxiety disorder, panic disorder, agoraphobic disorder, and social anxiety disorder can access:

   a.   Internet-based self-help programs.

   b.   self-help manuals for the specific disorder.

   c.   practice yoga and calming exercises.

   d.   the assistance of a physician.

Answer: a. Internet-based self-help interventions. There are four different levels of programs with some offering assessment from a therapist at the start with session assignments accompanied by a talking head while others have minimal to no therapist involvement.

Question 5:10 (Objective E.)

Eels et al. (2014) identified eight reasons to consider computer assistance in psychotherapy. Five of eight reasons include cost, efficiency, increase access to treatment, suited for delivery of psychoeducation, and delivery of technical components of evidence-based therapies. Which one of the four is not one of the remaining three reasons?

   a.   facilitates recording, collecting, and management of information

   b.   offers unique learning opportunities

   c.   particularly useful for depression

d. patient preference

Answer: c. particularly useful for depression. There are legal and ethical concerns through the Internet for depression intervention. Suicidality and other types of dangerousness, confidentiality, using emerging technology, obtaining consent, and issues related to client identification can be problematic.

Question 5-11: (Objective F.)

Counselor characteristics that cut across all therapies are referred to as common factors. Although there are several specific factors several of them fall into a larger category. All of the following are common categories for those common factors except:

a. learning factors.

b. commitment factors.

c. support factors.

d. action factors.

Answer b: commitment factors. Learning factors (ex; cognitive learning, corrective emotional experience), support factors (reducing isolation, positive relationship, alliance), and action factors (behavior regulation, encouragement)

Question 5-12: (Objective G.)

The interview strategy that uses the acronym OARS is:

a. structured interviewing.

b. unstructured interviewing.

c. Carkhuff model.

d. motivational interviewing.

Answer: d. motivational interview (O-open-ended, A-affirming client's self-efficiency and support, R-reflection, and S-summary of complex reflection, organize resolving ambivalence, and promote change)

Question 5-13: (Objective H.)

A 52-year-old male presented with a marital issue. He expressed that he is no longer a good spouse. When asked to provide some examples he was unable to provide any detail or example of behaviors that were out of the normal for couple's interactions. Adjustment disorder was the diagnosis, and the counselor recommended six sessions of cognitive behavioral therapy. What intervention from the limited information would be appropriate for session work?

a. relaxation exercise

b. muscle relaxation

c. cognitive restructuring

d. in-vivo

Answer: c. cognitive restructuring

Question 5-14: (Objective I.)

One way in which a counselor can assess client improvement is to:

a. ask the client.

b. ask family members.

c. administer a test.

d. compare specific behaviors with initial assessment of the same behaviors.

Answer: d. compare specific behaviors with initial assessment of the same behaviors.

Question 5-15: (Objective J.)

Evidence-based practices suggest that clients demonstrating low resistance tend to get better when there are signs of:

a. therapist directiveness and guidance.

b. self-control methods.

c. minimal therapist directiveness.

d. paradoxical interventions.

Answer: a. therapist directiveness and guidance (Norcross, 2004)

Question 5-16: (Objective K.)

Which technique(s) is most often used in person-centered therapy?

a. active listening and reflection

b. questioning and probing

c. free association

d. paradoxical intention

Answer: a. active listening and reflection

Question 5-17: (Objective L.)

Treatment of suicide ideation and attempts as well as self-injurious behaviors has shifted from a negative framework (desire to die) to a positive framework (desire to live). The positive framework is a protective-based intervention. This approach interviews the client for all of the following except:

a. weaknesses and vulnerabilities.

b. strengths and virtues.

c. protective factors.

d. buffers against psychopathology.

Answer: a. weaknesses and vulnerabilities

Question 5-18: (Objective M.)

Considering the survivor is safe after a disaster there are psychological tasks to be performed by the first responder. Reports from several disaster follow-ups highlight for a responder which psychological task is considered to be the most important for survivors?

a. comforting and consoling a distressed person

b. providing goal orientation and support for specific reality-based tasks.

c. sharing the experience.

d. facilitating a beginning of some sense of mastery.

Answer: a. comforting and consoling a distressed person. The Disaster Health Response Handbook indicated comforting and consoling, protecting survivors from further harm, and ensuring basic needs are met, conversing with compassion, and recognition for what they have been through (Raphael, 1993).

Terms and People

At the conclusion of this chapter are the definitions and descriptions of these terms.

Abreaction	Integrative Therapy
Basic ID	Linchpin Model
Bibliotherapy	Logotherapy
Brief Therapy	Masculine Protest
Cognitive Restructuring	Mood GYM
Common Factors	Narrative Therapy
Compensation	Negative Reinforcement
Constructivism	OARS
Control Theory	Phenomenology
CORE-NET	Process Model Tentative Identification
DBT	Psychological First-Aide
Eclecticism	Secondary Reinforcement
Empowerment	Self-Injury
Evidenced based	Self-monitoring
EMDR	Social Learning Theory
Feminist Therapy	SOFTA-o
Figure/Ground	Solution-focused Therapy
Impasse	Unfinished Business

OBJECTIVE 5A: Theories and Models

Objective 5a. theories and models of counseling (CACREP, 2015, p. 11)

ACA 2014 Code of Ethics foundation is based on core values of the profession that include:

a. enhancing human development throughout the lifespan.

b. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.

c. promoting social justice.

d. safeguarding the integrity of the counselor-client relationship.

e. practicing in a competent and ethical manner (ACA, 2014, p. 3).

Definition of Theory

A theory is a model that is used to explain experiences for purposes of predicting future events or solutions. 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 serve as a guide for future research (Peterson & Nisenholz, 1995). Each theory attempts to explain the construct's origins, development, consequences and required for a better understanding of the construct (Suter, 2006).

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 to 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. Cullari (2001) indicated 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 people learn, change, and develop. Counseling theory attempts to explain how to deal with issues and problems, a plan of action, or a model (Cullari, 2001).

Theoretical Classification

There are several presentations available that classify theories according to different models. For the most part, they include differing amounts of cognition, affect, and behavior. Nugent (1994) classified them as psychoanalytic-psychodynamic, humanistic, behavioral, cognitive-behavioral, and brief therapies. Peterson and Nisenholz (1995) cataloged theories into psychodynamic, humanistic-existential, behavioral-cognitive, and transpersonal theories (spiritual and holistic). Finally, Gladding (2012) divided 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 (1975, 1977) reported that 64% of doctoral level students preferred eclecticism., In 1985 APA found 41% of 415 clinical therapists, stated a preference orientation for eclecticism. Lazarus and Beutler (1993) reported that as many as 60% to 70% of the professional counselors are eclectic in approach. The following description is provided only as a guide, as each will reflect a philosophical base, set of values and beliefs, theoretical model, and counseling practices.

Models of therapy

a. Moral model:

Reality therapy

Rational-emotive therapy

Existential therapy

Person-Centered therapy

Gestalt therapy

b. Compensatory model:

Adlerian therapy

Behavior therapy

Transactional analysis

c. Transpersonal model:

Spiritual

Wholistic

d. Medical model:

Psychoanalytic therapy

e. Constructivist therapies:

Solution-focused

Narrative therapy

f. Integrative and eclectic therapies:

Technical and theoretical integration

Psychodynamic behavior

Multimodal therapy

g. Enlightenment model:

Alcoholics

Daytop Village

Overeaters Anonymous

Weight Watchers

Responsibility

The major responsibility for the outcome of therapy resides with the therapist or the client. Below are theories identified as therapist responsibilities and theories identified for the client responsibilities.

a. Therapist:

Behavioral

Rational-emotive

Psychoanalytical

b. Client:

Client-centered

Experiential

Psychosocial

Solution-Focused

Problem-Focused

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) outlined eight components of a theory that are to help the counselor-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. the relationship between counselor and client—considered by many to be the main element
4. diagnosis of client problem—tied to theory
5. counseling goals—objectives which are terminal and process
6. techniques—methods to explore, define, and treat objectives
7. process—may be stages or conditions preceding each movement
8. evaluate outcome—progress or lack of it

The Counseling Process

The process of counseling can be as different as the theories of counseling. The process itself is a continuous, ongoing series of dynamics that describe how the counselor-client relationship contributes to the change process. Gladding (1988, 1996, 2002, 2012) and Peterson and Nisenholz (1995) described the counseling process as developing in definable stages, beginning with the relationship-building stage establishing structure and the 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 counselor's skill, and the quality of the therapeutic relationship (Gladding, 1988). Prochaska (1979) stated that the counseling process begins when there is a decision to change. According to Corey (2012, 2016) 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 powers. Prochaska (1979) referred 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) referred to process as a series of steps and comment upon common variables in the research and counseling process. They identified nine steps that include:

1. an awareness of problem and need for solution.
2. systematic study of the context and background of the problem.
3. summary of what was known about the problem and what has been tried before to solve it.
4. the 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. an evaluation of results (formative or summative).
9. inferences were drawn and generalizations made to other situations (p. 40).

Stages of the Counseling Process

THE BEGINNING PHASE: Relationship-building through involvement and exploration.

The goals of the first stage of counseling are to build trust, develop a contract, establish limits, and learn about the therapeutic process (Moursund, 1985; Moursund & Kenny, 2002). Building trust is a process in establishing rapport with the client. Through acceptance, client listening, positive regard, respect, genuineness, empathy, support, encouragement, and caring, the counselor establishes an atmosphere where the client is comfortable enough to begin to self-disclose (Gladding, 1988; Nugent, 1994). The counselor responds to client self-disclosure in ways that reinforce and encourage further exploration.

The counselor also teaches the client how to use the counseling process. Through modeling, selective attention, and reinforcement, the counselor teaches the client how to focus and talk about concerns. The counselor also teaches new skills, such as self-monitoring, effective communication, and how to differentiate between thinking, feeling, and acting (Moursund, 1985; Moursund & Kenny, 2002).

The initial stage is a time to make the tentative diagnosis of a problem. The particular counseling orientation will determine the type of diagnosis performed by the counselor. Some theories, such as person-centered, do not make a diagnosis, while others do. This part of the process uses tests or inventories to assist in the diagnosis or in setting counseling goals. It is also a time in which counselors

utilize different types of interviewing strategies such as structured, unstructured, and value-laden interviews.

The first stage of counseling involves contracting for change. Contracts establish mutually agreed upon goals that are specific, relevant to the concern, realistic, observable, and quantifiable (Gladding, 1988, 1996; Moursund & Kenny, 2002). Commitment to a contract provides direction to the working stage of counseling and establishes a means of knowing when the termination stage of counseling is appropriate.

According to social influence theory, Strong (1968) maintains the therapist's social power determines the extent to which therapy is successful. The variables that have been studied the most are expertness, trustworthiness, and attractiveness (Corrigan, Del, Lewis, & Schmidt, 1980). The most significant aspect of the therapeutic relationship is the working alliance, also called the helping alliance or the therapeutic alliance. Greenson (1967) proposed that counseling relationships consist of three interrelated components: the working alliance, the transference relationship, and the real relationship. Bordin (1979) defined the working alliance as consisting of three parts: an emotional bond between the client and therapist, an agreement on the goals of counseling, and an agreement about the tasks of the work. In summary, Gelso and Carter (1985) conceptualized the working alliance as "an emotional alignment that is both fostered and fed by the emotional bond, agreement on goals, and an 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, and attractiveness), relationship, low expectations of client improvement, high levels of ethnocentricity, dislike or disinterest in clients, and inexperience (Baekeland & Lundwall, 1975; McNeil et al., 1987).

THE MIDDLE STAGE: Working through understanding and action.

In the middle stage, the focus shifts from external problem solving to internal growing, changing, and deeper exploration. A shift in emphasis may see the presenting problem change in character or the client reach a solution. Counseling shifts from cognitive to emotional issues. Often the therapeutic relationship itself becomes the focus of the sessions (Moursund, 1985). As this shift occurs, the client begins to take more risks in looking at himself or herself, and reduces defenses and dependency on others (Nugent, 1994). Gladding (1988, 1996) and Nugent (1994) pointed 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 (2012) described 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, stated Moursund (1985), the counselor should be sure to follow the client and avoid getting in the way of the client's work. This means not forcing, but rather respecting the ebb and flow of therapy and trusting the client to do the work he/she needs to do.

THE FINAL PHASE: Termination

Gladding (1996, 2012) described 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) listed several tasks that are appropriate for the termination phase. For instance, the counselor should be aware of the client's needs and wants as well as his/her own needs and wants. Also, the client should be invited to share his/her feelings about termination. The counselor should self-disclose his/her feelings appropriately. It is also good to review major events of the counseling experience

and supportively acknowledge the changes the client has made. Finally, arrange for some type of follow-up and end on a positive note.

In conclusion, termination is a vital phase of counseling that can be determined by the success of all previous phases. The client must, therefore, be approached with knowledge and skill (Gladding, 1996). Thus, the ultimate goal of the counseling process is for the client to internalize the change process. When this is achieved, he/she is ready to autonomously pursue his/her goals and the counseling relationship is terminated.

Question 5-19:
The therapist expects which one of the following to take place in the initial phase of counseling?

    a. development of the working alliance

    b. working through transference

    c. flight into health

    d. working through of the problem

Answer: a. development of the working alliance. Working alliance of trust, expertness, and bonding.

The Six Stages of the Counseling Process

The counselor should be aware that the interview is the foundation for completing an assessment and diagnosis. The elements of the six stages of the counseling process include: assessment, symptom identification, diagnosis, referral, treatment planning, and follow-up (Hohenshil, 1996, p. 66).

1. Assessment is the gathering of pertinent information via interviews, psychological testing, structured interview instruments, problem checklists, mental status examinations, medical evaluations, and observations from which an interpretation or diagnosis is obtained.

2. The purpose of treatment is to bring about symptom modification or change over a period of time necessary to accomplish this purpose. During the initial interview signs and symptoms are to be gathered.

3. Diagnosis is the process of comparing the client's symptoms with the criteria in the DSM-5™ and developing a case conceptualization that becomes the treatment plan with identified global theories, strategies, and techniques appropriate for the identified problem or diagnosis.

4. Referral to a qualified professional may be necessary to obtain additional specialized diagnostic or treatment services.

5. Treatment planning includes a determination of the short- and long-term objectives, the most effective treatment(s), and the client's motivation for therapy.

6. Follow-up is necessary to ensure the client's continued well-being. If there is a relapse, the counselor can recommend one or more counseling sessions or additional treatment, if necessary.

The Counseling Process: Theory

If the vital role of communication is assumed, the counseling process can be viewed as an orderly progression of events. Each theoretical orientation highlights a progression that illustrates movement.

Examples are:

1. Adlerian-Individual Psychology
   d. establishing the relationship
   e. psychological investigation
   f. disclosure
   g. 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

Counseling Theories

Psychoanalytic Theory

Psychoanalysis was founded by Sigmund Freud (1856-1939). He studied under Jean-Martin Charcot and Josef Breuer (originator of the "talking cure" cathartic method).

Basic Assumptions

Deterministic Viewpoint

a. The key to understand human behavior is understanding the unconscious. People are driven by instincts.

b. This is based on a psychology of conflict, Id psychology (Seligman, 2010; Seligman & Reichenberg, 2014).

c. 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 are released. There is a source of fixed reservoir of sexual energy. Two most basic human instincts are 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) likened the ego to an integrator, pacifier, negotiator, and compromiser to socially meet the needs of the person.

Function: to develop muscular and sensory body and to sort out and understand the world.

Governed by: Reality Principle

SUPEREGO: Adopts parental values as well as the customs, values, and traditions of society and represents the conscience (model standard) and ego ideal.

Role of Anxiety

Anxiety develops as a result of conflict between id, ego, and superego. When the ego cannot control anxiety by rational and direct methods, it relies on ego defense mechanisms to help it cope (Corey, 2012, 2016). Ego defense mechanisms are unconscious means of reducing anxiety by denying or distorting reality. They are adaptive if not used to extreme.

Development of Personality: (Psychosexual Stages)

1. Oral Stage (1st year): Oral erotic and oral sadistic. Sucking reflex. Adjustment to weaning. Gratification- feeding.

2. Anal Stage (1-3): Anal expulsive and anal retentive.

3. Phallic Stage (3-6): Self-manipulation of genitals a pleasure source. Oedipal and Electra complex.

4. Latency Stage (7-13): Sexual motivations recede (dormant) and emphasis is on socialization, skill development, activities.

5. Genital Stage (12+): Heterosexual relations are source of pleasure. Techniques: catharsis, free association, interpretation of dreams, parapraxia (Freudian slips), analysis of transference, analysis of resistance.

Question 5-20:

In psychoanalysis, Freud utilized which technique to explore the unconscious minds of his patients?

   a. free association
   b. interpretation
   c. catharsis
   d. Freudian slips

Answer: a. free association

A Typical List of Ego-Defense Mechanisms

Freud was of the impression that the ego needed 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 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 over gratification 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 (Gintner, 2004; Houston, 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 (Gintner, 2004; Houston, 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 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.

Grohol (2016) categorized 15 of the most common defense mechanisms into primitive (7), less primitive (5), and mature (3). Primitive defense mechanisms included denial, regression, acting out, dissociation, compartmentalization, projection, and reaction formation. Less primitive defense mechanisms included repression, displacement, undoing, rationalization, and intellualization. The mature mechanisms included sublimation, compensation, and assertiveness.

Ego Defense Mechanism - Matching Exercise

This is a matching exercise to practice acquired knowledge of the defense mechanisms. Match the defense mechanisms with the correct definition. Answers are to be found immediately after the exercise.

a.   unconsciously exhibiting overly nice behavior to conceal hostile feelings

b.   pushing unacceptable reality or painful material into unconscious

c.   reverting to a less-mature state

d.   attributing to others qualities or traits that are unacceptable to his/her own ego

e.   deal with anxiety by closing his/her eyes

f.   directing energy toward another

g.   manufacturing "good" reasons to explain a bruised ego

h.   assuming abusing parents' way of handling

i.   masking perceived weakness or developing positive traits to make up for limitations

j.   redirecting sexual energy into creative behaviors

Question 5-21: Displacement   Letter: _____

Question 5-22: Sublimation   Letter: _____

Question 5-23: Introjection   Letter: _____

Question 5-24: Reaction Formation   Letter: _____

Question 5-25: Projection   Letter: _____

Question 5-26: Repression   Letter: _____

Question 5-27: Compensation   Letter: ____

Question 5-28: Denial   Letter: ____

Question 5-29: Regression   Letter: ____

Question 5-30: Rationalization   Letter: ____

Answers:

5-21. f. Displacement-taking out impulses on a less threatening target.

5-22. j. Acting out unacceptable impulses in a socially acceptable way such as a career. Sublimating aggressive impulses.

5-23. h. Introjection is to absorb the super ego from the parents. The child incorporates the attitudes of the parent(s) and assumes those are his/her own. Introjection is to incorporate external values and standards into the ego. The person will assume responsibility for events outside of their control and blame oneself such as a failed marriage or loss of a ballgame. The person fails to understand their thoughts and behaviors are coming from the outside as it is coming from the inside. It is the opposite of projection.

5-24. a. Reaction formation is taking the opposite belief because the true belief causes anxiety.

5-25. d. Projection is placing unacceptable behavior in oneself onto another.

5-26. b. Repression is to pull the threat into the unconscious such as to forget something traumatic that took place in childhood.

5-27. i. Compensation or substitution to attempt to make up for some feeling of inadequacy by excelling.

5-28. e. Denial is to argue against the anxiety by denying that the anxiety exists.

5-29. c. Regression is returning to a previous stage of development.

5-30. g. Rationalization is to give excuses for a shortcoming and to avoid a disappointment or criticism.

Summary: Psychoanalytical Basic Assumptions

    a.   medical model (biological bases)

    b.   deterministic view of human nature

    c.   personality is determined by the id, ego, and superego operating together as internal forces

    d.   unconscious motivation

    e.   irrational forces

    f.   sexual and aggressive impulses

    g.   early childhood experiences

    h.   treatment is a lengthy process of analyzing inner conflicts that are rooted in the past

    i.   therapy is the process of the therapist's direction in restructuring the personality

    j.   development of ego and differentiation and individuation of the self

Goals

    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.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Successful resolution of both psychosocial and psychosexual issues at appropriate developmental stages.

Negative: Failure to meet critical developmental task or a fixation at some early level of development.

Object Relations Theory: A Psychodynamic Theory

Key Figures: Margaret Mahler, Otto Kernberg, Heinz Kohut

Object relations, a theory of psychoanalytic thinking, and 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 believed 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

Mahler (1968) is best known for her separation-individuation theory and suggested that after a few weeks of birth a child is either sleeping or barely conscious but soon begins to go through a series of phases starting with normal-symbiotic (one with the mother) to separation-individuation phase. This phase has three substages of hatching (5-9 months), practicing (9-16 months), and rapprochement (16 months and beyond). Rapprochement included a beginning, crisis, and solution and eventually an emergence of the self (Levine, Green, & Millon, 1986; St. Clari, 1986).

Normal Autism: Infant perceives parts, not unified self or object. (3-4 weeks)

Normal Symbiosis: Pronounced dependency. (3-8 months)

Separation-Individuation: Child disengages from psychological fusion with mother and gains a sense of being autonomous. Ego emerges.

Four subphases

1. differentiation and Body Image. (4-5 months)
2. practicing begins when infant starts walking. (10- 18 months)
3. rapprochement. (18 months-2 years)
4. emotional Object Constancy and Individuality. (2- 3 years)

Ego Psychology

Key figures: Erikson (see Chap. 7 for his stage theory), Fromm, Horney, Rapoport

Ego psychology is an extension of psychoanalytic thought. However, the primary emphasis is on ego function or ego strength. Intrapsychic conflicts are not denied, but the striving of the ego throughout the life span for mastery and competence is emphasized. Ego theory went beyond Freudian psychology by incorporating cultural and social influences.

In Ego psychology, the ego is not dependent on id impulses. The ego has its source of energy and its 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 the inadequate resolution of early sexual and aggressive conflicts. Therefore, later stages of development are just as critical to development as the early stages. Abnormal behavior results from a breakdown in ego functions because of an inability to cope.

Ego theory does not attempt to resolve defense mechanisms, but rather it concerns itself with maladaptive energies.

Techniques:

a. control of process: maintain focus on tasks
b. control of ambiguity: maintain highly ambiguous state
c. transference: not as emphasized as psychoanalytic
d. diagnosis and interpretation
e. building new ego functions

Adlerian (Individual Psychology)

Key figures: Alfred Adler, a colleague of Freud's, 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, 1967).

Don Dinkmeyer, Sr. is another well-known Adlerian.

Adlerian counseling emphasizes the social context of 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 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.

An underlying 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 for perfection and to become successful. In summary, the basic assumptions include (Corsini & Wedding, 2005):

a. all behavior occurs in a social context
b. rejects reductionism for holism
c. is interpersonal psychology
d. consciousness and unconsciousness are used to further goals
e. cognitive reorganization and lifestyle are important to understand the individual
f. change occurs in the context of immediate change and long-range goals
g. causes do not push people rather by hereditary and genetics
h. striving is for perfection, completion, superiority, competence, and mastery
i. the individual is confronted with alternatives
j. the freedom to choose involves value and meaning
k. life has no intrinsic meaning

Human Nature

A positive view of human nature and a growth model. The growth model is grounded in principles of social psychology and can 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 exaggerating this sense of inferiority. The individual copes with inferiority by compensating (inferiority complex, superiority complex). The life tasks of the individual include social, occupational, and 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

Lifestyle is an individual's subjective convictions, worldview, and self-view (Seligman, 2010). Lifestyle 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 include (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, and perception of self, and parental relationships (Dreikurs, 1967).

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.

Middle-born is a negotiator, 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).

Youngest-born are attention-receivers, charmers, and tend to have role models.

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.

The masculine protest is a striving for power.

Early recollections: These are memories the individual holds of early experiences. The therapist is interested in the client's perception of the event. These early memories are considered lessons of life the client clings to as a guide or influence for their current functioning (Milliren et al., 2003).

Theory of Personality

Holistic: the individual is approached as an integrated unified personality.

Teleological: behavior is purposive, goal-directed. Fictional finalism is the imagined central goal that guides the person's behavior.

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. The interpretation leads to insight and self- understanding.
4. Achieving reorientation, or translating understanding into action.

Intervention Strategies: the lifestyle analysis (goals and motivation of the client), apperception (experiencing things mediated by the attribution of the 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:

a. prove their power
b. get attention
c. display deficiencies
d. get revenge

Goals for therapy are to:

a. establish a positive sense of self-esteem and overcome feelings of inferiority.
b. challenge faulty assumptions (basic mistakes) and re-educate, restructure, and to develop a healthy lifestyle.
c. foster and cultivate social interest.
d. encourage and motivate toward accomplishing socially useful goals. Causes of behavior are not the issue.

Techniques

Interpret family constellation	Early recollection
Contract	Homework assignments
Encouragement	Paradoxical intention
Confrontation	Empathy, intuitive guess
Asking the question	Task-setting
Spitting in the client's soup	Acting "as if"
Catching oneself	Push button

Summary: Adlerian Basic Assumptions

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 subjective 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 us 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.

Goals

a.   Help client develop social interest.

b.   Provide encouragement.

c.   Facilitate insight into mistaken beliefs

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Growth principle of client lifestyle. A positive connection exists between past, present, and future.

Negative: Disunity in personality, mistaken notions, and faulty assumptions. Too much inferiority, overcompensation, and discouragement. Too little social interest.

Person-Centered Therapy

Key figure: Carl Rogers founded nondirective therapy in the 1940s in reaction to psychoanalysis. Person-centered therapy was the first truly American system of psychotherapy. Person-centered is a unique approach based on a warm and responsive therapeutic relationship. This theory is phenomenological in perspective.

Human Nature

People are innately motivated to strive to reach their potentials (growth-oriented). Each person has a self-actualizing tendency that seeks growth and full functioning. Pathology is an impeded tendency brought about by the 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. A conflict is a discrepancy between basic needs and the need to gain approval from others. Counseling is a process of learning about the self. Four beliefs represent the perception of people: (1) people are trustworthy, (2) people innately move toward self-actualization, (3)

people have the inner resources to move in positive directions, and (4) people respond to their uniquely perceived world (Hazler, 2003).

Therapeutic Relationship

The counselor-client relationship is central to achieving change. The therapist participates fully as a person. Rogers believed that there must be present necessary and sufficient conditions for change to take place. These conditions are trust, openness, acceptance, permissiveness, and warmth (Kottler & Brown, 2000). The therapist's attitudes (core conditions) are necessary and sufficient for change to occur (Seligman, 2010, Seligman & Reichenberg, 2014). The counselor is nondirective and focuses on the core conditions. The client moves toward autonomy.

Core Conditions

Respect: Communicating unconditional positive regard. Accepting the client and trusting his or her ability to manage himself/herself.

Genuineness: Being fully and freely himself/herself by matching one's inner experiencing with external expressions.

Empathy: Being able to get into the internal frame reference of the other person and communicate the understanding of his or her subjective experience.

Concreteness: The specificity with which we treat the client's experience.

Immediacy: Ability of the counselor to get the client to focus on the here and now and talking about the counselor/client relationship.

Self-disclosure: Making the self-known by revealing personal information.

Confrontation: Confrontation is a skill in which the counselor invites a client to examine his/her behavior and the consequences and the counselor can point out discrepancies.

Goals

a. increased self-awareness and trust in one's actualizing processes (Seligman, 2010).
b. empower client through the relationship of trust and safety.
c. actualize potential for growth, wholeness, spontaneity, and inner-directedness.
d. an encounter with self.

Techniques

Techniques are considered secondary to counselor's attitudes (Corey, 2012, 2016). Therapy is relationship-centered, not technique-centered. Counselors use active listening, a reflection of content/feeling, clarification, summarization, confrontation, and 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) pointed out that the theory does not include spiritual or environmental domains and lacks in problem-solving approaches.

Summary

Person-Centered Basic Assumptions

a. The man can understand problems and has the resources within to resolve them.

b. Emphasis is on the basic trustworthiness of human beings.

c. The therapist gives little structure or direction.

d. Clients need understanding, acceptance, support, and positive regard from the therapist.

Goals

1. Provide climate of understanding and acceptance.

2. Enable clients to move toward greater openness, increased self-trust, and increased spontaneity.

Basic Health (Well-Being): Positive and Negative Conditions

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

Negative: Divergence of real self and ideal self.

Transactional Analysis

Key figures: Eric Berne (1910-1970); Mary and Robert Goulding (prominent during the 1970s)

Basic Assumptions

a. Humans are free to choose and shape their destiny (life script) through awareness (antideterministic view of human nature).

b. 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).

c. Children grow up with parental injunctions ("don'ts") that result in early decisions aimed at survival, recognition, attention (strokes). Games are created to support these early decisions.

Key Concepts

a. Games: a series of stereotyped and predictable patterns of behavior that end with surprise and bad feelings for at least one player (Corey, 2012, 2016). Games serve to prevent intimacy.

b. Rackets: habitual feeling (depression, guilt, anger) retained after a game (Corey, 2012).

c. Life Scripts: personal life plan created by the early decision regarding self, others, and the world.

d. Parental injunctions: verbal and nonverbal messages telling the child what he or she must do and be to get recognition (Corey, 2012, 2016). These are usually negative messages.

e. 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 structural analysis and the ego states.

a. Structural Analysis (Personality): The client examines the content and functioning of the following ego states:

b. Parent Ego State: Instructions, attitudes, and behavior handed down mostly by parents and authority figures. The Parent Ego State is composed of :

1. Nurturing Parent State-supportive, caring, encourager

2. Critical Parent State: harsh, fault finding (do and don'ts) Adult Ego State: The objective side of our personality that is logical

3. Nonemotional: The thinking part of our personality, the computer part of our personality, provides objective information using reality testing. Assimilator and evaluator of information focused on facts, not feelings. They keep the Parent and Child ego states in balance.

Child Ego State: Three components

Adapted child: controlled, product of demands, whines, cries, rebels

Natural child: spontaneous, impulsive, untrained, self-loving, pleasure-seeking, expressive

Little Professor: intuitive wisdom

Contaminations and exclusions are significant interactions between and among the ego states.

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

The process for transactional analysis is understanding the transactions in which the person engages.

Transactional Analysis: The study of transaction consisting of three types:

a. complementary: a specific ego state sent, a specific ego state responds. (example: child/child transaction)

b. crossed: unexpected response to a message. (example: child/adult transaction)

c. ulterior: the overt message is different from a covert message.

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).

Script analysis is a plan to gain control, develop congruency, and revise the life script (Peterson & Nisenholz, 1995).

Script Analysis: The script dictates where a person is going with his or her life and what paths were taken. The components of a life script include life position, rackets, and games, a life pattern.

Psychological (life) positions: This is a stance that the client assumes in early childhood regarding his or her intrinsic worth and that of others and includes:

I'm okay, you're okay: optimal position (evolutionary)

I'm okay, you're not okay: paranoid (revolutionary)

I'm not okay, you're okay: depressive (devolutionary)

I'm not okay, you're not okay: helpless (obvolutionary)

Question 5-31:
The following communication takes place between a 14-year-old female and her mother. The 14-year-old indicated she would like to join a volunteer organization such as Habitat. The mother replied that the daughter does not do enough work around the home and doesn't know how to work. This is an example of:

a. an injunction.
b. an egogram.
c. a victim.
d. a stroke.

Answer: a. an injunction. An injunction is a negative message.

Goals

Teach clients to recognize which ego state they are operating out of so that they can learn to choose a given ego state (Corey, 2016).

Teach clients how to be autonomous (i.e., script-free and game-free) through increasing awareness.

Teach clients to write their own script through understanding early decisions and then making new decisions (redecisions).

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

Techniques are didactic in nature and include:

a. contract.
b. script checklist.
c. script analysis.
d. structural analysis.
e. analysis of games and rackets.

Therapeutic Relationship

Client and therapist are equal partners with joint responsibility for the contract. The client finds his or her power to change (i.e., make decisions). Therapist serves as a teacher, trainer, and resource person.

Summary: Transactional Analysis Basic Assumptions

a. People are influenced by the expectations and demands (injunctions) of significant others.
b. Certain early decisions made may be nonfunctional, so that making new decisions 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.

Goals

a. Help the client become more autonomous through increased awareness and insight.
b. Help the client make new decisions based on awareness.

Basic Health (Well-Being): Positive and Negative Conditions

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

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

Gestalt Therapy

Key figures: Fritz Perls (1893-1970), Erving and Miriam Polster, and James Simkin.

An experiential therapy is focused on awareness and integration of fragmented parts of the personality in the "here and now" (Corey, 2012). Gestalt, meaning the whole figure, is rooted in existential philosophy and phenomenology, process-oriented rather than content-oriented (Seligman, 2010; Seligman & Reichenberg, 2014). Finally, Gestalt therapy emphasizes what and how and unfinished business (Kottler & Brown, 2000).

a. The most important area of concern is the immediate, present awareness of one's experience (Seligman, 2010).

b. Every element of the person is connected to the whole (holism).

c. Contact is necessary for growth. Good contact means interaction with the environment without losing one's sense of individuality (Corey, 2016).

d. Frustration is essential for growth, and without it, people have no reason to employ their resources and take responsibility for their growth rather than trying to manipulate others into doing it for them (Corey, 2012).

e. 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, 2010). 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:

a. losing contact with the environment and the resources.

b. over-involvement with the environment and becoming out of touch.

c. failure to put aside unfinished business.

d. experiencing a conflict between top dog and the underdog.

e. not handling dichotomies in life.

Central Constructs

Contact: Seeing, hearing, touching, smelling, talking, and tasting the environment.

Needs: Need satisfaction through figure (stands out) and ground (larger background of experience.

Polarities: The idea that something exists in the opposite

Contact Disturbance: Interpreted as the cycle of awareness disturbed through introjection, projection, confluence, and retroflection resulting in the individual isolation, losing touch with the environment and self (Yontef & Jacobs, 2005).

Theory of Personality

Blocked energy is a form of resistance. Often it shows up in nonverbal and verbal behavior (examples: body tensions, postures, restricted voice, verbal expressions, etc.).

Five layers of neuroses (similar to onion layers). Keep energy up in the service of pretenses (Corey, 2012, 2016):

1. Phony layer: Stereotypical, inauthentic, roles, games.
2. Phobic layer: Avoid emotional pain associated with denied aspects of ourselves. Fear of rejection if we are who we are and resistance to self-acceptance.
3. Impasse layer: Sense of deadness, feeling stuck, and lack of trust of inner resources.
4. Implosive layer: Fully experience deadness, expose defenses and contact the genuine self.
5. Explosive layer: Let go of phony roles and pretenses. Unused energy is found that was previously tied up with maintaining phony existence.

Five major channels of resistance: Ego defense mechanisms that prevent authentic experiencing:

1. Uncritical acceptance of others' beliefs and standards.
2. Projection: Disowning parts of the self by ascribing them to others (the environment).
3. Retroflection: Turning back onto ourselves something we would like to do (or have done) to someone else.
4. Confluence: A disturbance in which the sense of the boundary is lost between self and the environment.
5. Deflection: A way of avoiding contact and awareness by being vague and indirect.

Goals

a. Major goal: To help a client live a fuller life.

b. Deepen awareness, experience the "here and now" more fully. (Awareness is the curative in itself).

c. Bring unfinished business and other forms of resistance and blocked energy into present awareness.

d. Move from environmental support to self-support. Teach the client to take responsibility for thoughts, feelings, and actions.

e. 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 the interaction between client and therapist and should not be applied mechanically.

a. bring into bodily awareness signs of resistance

b. empty chair technique (externalize introjects such as top dog/bottom dog)

c. making the rounds (group technique)

d. "I take responsibility for…"

e. the exaggeration experiment

f. staying with the feeling

g. dream work

Summary: Gestalt Basic Assumptions

a. People must find their 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 meanings.

d. They expand their level of awareness and integrate the fragmented and unknown aspects of themselves.

Goals

a. Increased awareness in the "here and now."

b. Reintegration of all aspects of the self.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Creative adjustment. Capacity to feel, sense, perceive and interpret in the present meaning. Living an authentic existence the healthy person is spontaneous, emotionally responsive, and expressive.

Negative: Referred to as disease, not in harmony with the environment, a growth disorder resulting from the disruptions of the cycle of awareness (Wagner-Moore, 2004). There is a denial of parts of the self, lack of awareness and a manipulation of others, rather than taking responsibility for the self.

Existential Therapy

Key figures: Victor Frankl, Rollo May, and Irvin Yalom

Based on existential philosophy (Kierkegaard, Nietzsche, Heidegger, Jean-Paul Sartre, Martin Buber, Sidney Jourard, Abraham Maslow, and Irvin Yalom).

Basic Assumptions

a. Central concerns are loneliness, isolation, alienation, and meaninglessness.

b. Emphasis is on anxiety, values, choices, freedom, responsibility, and self-determination.

c. Growth and health are the focus, finding meaning in life, not a pathology and possessing the potential for self-satisfaction.

d. Frankl (1962) wrote "one could find the meaning in life by doing a deed, experiencing a value, and by suffering" (p. 113).

e. 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.

f. Human Nature

People are free, self-determining and capable of self-awareness and are good (Murdock, 2017). They are free and responsible. Anxiety is a part of humanness. Death and awareness of death are part of humanity and can be a catalyst for creating meaning. Being human means being "in the process."

People search for meaning in life through three sources: (1) creating work or doing a deed, (2) experiencing something or in contacting someone and, (c) attitude taken toward the unavoidable suffering" (Frankl, 1984, p. 133). The "Tragic Traid" (pain, guilt, and death) represents the inevitable suffering.

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

a.   Increase self-awareness by exploring.
b.   Help the client recognize the freedom to make choices and create meaning.
c.   Help the client realize the importance of responsibility, freedom, awareness, and potential.
d.   Help the client learn to live authentically.

Techniques

Few well-defined procedures and techniques can be drawn from any theoretical orientation (Corey, 2012, 2016). Confrontation is one technique used by existential counselors. Paradoxical intention is a method 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. Other methods include non-verbal behavior, self-disclosure, deflection, dream analysis, bracketing, and guided fantasy (Corsini & Wedding, 2011; Murdock, 2017).

Summary: Existential-Basic Assumptions

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.

Goals

a.   Increased self-awareness and more authentic existence.
b.   Acceptance of responsibility for making choices.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: To accept aloneness and create meaning in life.

Negative: Not living with authenticity; avoiding responsibility.

Rational-Emotive Behavior Therapy (REBT)

Key Figure: Albert Ellis formulated this theory in the 1950s.

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.

Basic Assumptions

a. Therapy is a process of re-education. Thoughts and beliefs are the roots of emotional disturbances.
b. Perception, thought, emotion and behavior tend to happen simultaneously (Corsini, & Wedding, 2000).
c. An emotional disturbance occurs because the individual keeps actively reinforcing magical beliefs and re-indoctrinating himself or herself. The person is responsible for the continuation of irrational thinking (Seligman, 2010, Seligman & Reichenberg, 2014).
d. Each person creates a perception of reality that determines behavior (Ellis, 2000).

Human Nature

Individuals have the potential to be rational as well as irrational. They have an innate self-defeating tendency to insist that life is perfect. They "catastrophize" and "musterbate." On the other hand, they also have an innate ability to self-actualize, but they often sabotage themselves (Seligman, 2010). What disturbs people are not events, but interpretations of those events.

Theory of Personality: ABCDE theory of personality change.

1. Activating event
2. Beliefs (thoughts or perceptions about that event which can be rational or irrational)
3. Consequences (feelings that result from beliefs)
4. Disputation that is directed at an irrational belief
5. Effect of the disputation (rational conclusion, positive emotion)

People are primarily responsible for their feelings about themselves, others, and the environment. People are prone to create emotional consequences, but the culture, society, and family exacerbate the tendency through social conditioning (Seligman, 2010). 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, 2010).

Goals

a. Increase happiness and decrease pain by eliminating self-defeating outlook.

b. Changing client's thinking will result in changes in feelings and behavior (Corey, 2012).

c. Directly dispute and teach the 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, 2010). Undermine irrational beliefs. Show how irrational beliefs cause dysfunctional consequences.

d. A basic change in values (cognitive restructuring).

Surviving and being happy is dependent upon involvements: (a) when alone, (b) socially with other people, (c) intimately relating to a few select people, (d) gathering education and information, (e) working productively, and (f) having recreational activities (Ellis, 1995, p. 18).

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. The therapist functions as a scientist who discovers and annihilates unrealistic, illogical thinking (Seligman, 2010).

Techniques

A variety of cognitive, emotive, and behavioral techniques are employed. The two primary techniques are teaching and disputing. The function of teaching is to learn about the link between emotions and behavior that result from thoughts, not events. Furthermore, self-talk influences behavior (Gladding, 2012). According to Walen, DiGuiuseppe, and Wessler (1980), there are three forms to disputing thoughts. They are cognitive (syllogisms), imaginal, and behavioral disputations.

Cognitive Techniques

a. recognize and give up "shoulds," "oughts," and "musts"

b. Socratic dialogue

c. reasoning, logic, and persuasion are used to dispute irrational thoughts and beliefs

d. syllogisms (two premises and a conclusion)

Imaginal (emotional-evocative) Techniques

a. role-playing

b. modeling

    c. humor

    d. unconditional acceptance

    e. imagery

    f. in vivo

    g. desensitization

    h. shame attacking exercises

Behavioral Techniques

    a. homework assignments

    b. assertion training

    c. operant conditioning

    d. desensitization

    e. relaxation

Summary: Rational-Emotive Behavior Therapy Basic Assumptions

Human problems are caused by our thoughts and perceptions of life situations, not by the situations themselves, nor by others, and not by past events.

It is the individual's responsibility to change distorted thinking that leads to emotional and behavioral disorders.

Therapists use active, directional procedures to help clients change faulty thinking.

The goal of therapy is to substitute a rational belief system for an irrational one.

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

Constructs:

ABC Model: A (antecedents), B (beliefs), C (consequences), D (dispute), E (evaluate)

A belief is a statement made to the self that has rational or irrational meaning. Irrational beliefs are self-demanding, other-demanding, and world demanding.

Goals

Change irrational beliefs into rational beliefs that lead to more effective functioning.

Teach the client how to use the scientific method to solve his or her problems.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Rational thinking, the underlying philosophy of values, flexibility, and open-mindedness. The individual reinforces self-interest, social interest, self-direction, tolerance of others, acceptance of life's ambiguities and uncertainties, flexibility and open to change, and values scientific thinking (Ellis, 2000).

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

Reality Therapy (Control Theory changed to Choice Theory)

Reality therapy design has been used when 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, 2000). The focal point of control theory is that all behavior is generated from within the person. The central tenets consisted of reality, responsibility, and right and wrong and that all individuals have two basic human needs to love and be loved (Seligman & Reichenberg, 2010). Thus, human brain functions influence inner perceptions. The client works toward a "success identity" and away from a "failure identity." The major emphases are problem-solving, personal responsibility, natural consequences, and the need to cope (Kottler & Brown, 2000). Reality theory is cognitive and behavioral, and the focus is present-oriented. Glasser's original theory evolved into a theme of control believing that people were driven by an inner control that guided their behaviors and emotions. The control system promoted the idea that awareness and assessment were central to changing or modifying the control system. Later Glasser dropped control and incorporated elements of choice theory to enhance the quality of life. Thoughts, feelings, and actions were the means to determine what we want and what we have.

Key figure: William Glasser, developed reality theory in the 1950s and 1960s and added components of control theory in the 1980s (Glasser, 1969, 2000). Cybernetic understanding for human functioning involves understanding self-regulating systems. The regulation takes place when we have a discrepancy between some desired state and a current state (Day, 2004).

Basic Assumptions

Human behavior is purposeful and originates from within the individual (Corey, 2012, 2016). The person's purpose is to get what it wants.

Glasser believed that all behavior was fulfilling five basic psychological needs such as belonging, power, enjoyment, freedom, and the physical need for survival. Successfully meeting these needs is a result of control.

Behavior change results from identity change.

Glasser's identify failure incorporates features of receiving inadequate love and consequentially feels worthless.

Human Nature

Individuals are self-determining and responsible for their lives. They are goal-oriented. The behavioral goal is 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, and people choose their behaviors (Glasser, 2000).

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 is 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, 2000).

Reality therapy rejects the medical model of psychopathology.

Mental health is 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, that 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, 2010, Seligman & Reichman, 2014). Therapy is a teaching process, not a healing process and 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.

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 healthy and rational (autonomous and responsible) and to clarify what they want in life.

a. 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, 2012, 2016).

b. Teach the client to accept responsibility for his or her life, live more effectively, and thereby achieve a success identity.

c. Formulate a realistic plan to meet personal needs and wishes.

d. Develop a relationship with the client.

e. Focus on behavior and the present.

f. Eliminate punishment and excuses from the client's life (Gladding, 1996).

The 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 are prerequisites for meeting 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. Glasser's (2000) ten axioms include:

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. Total behavior is made up of acting, thinking, feeling, and physiology.

9. Total behavior is chosen and direct control is only over acting and thinking.

10. Feelings and physiology are indirectly controlled through our actions and thinking.

Total behavior is designated by verbs and named by the part that is most noticeable.

Techniques:

a. reframing

b. humor

c. self-disclosure

d. metaphors

e. physical activities and meditation

f. allow consequences

Summary: Reality Therapy Basic Assumptions

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, and belonging.

d. People are responsible for their behavior, thoughts, and feelings.

Goals

a. Teach the client to take responsibility for his or her life and for getting his or her needs met.

b. Help the client develop a success identity through responsible behavior, which leads to feelings of self-worth and love

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Acceptance of responsibility for one's behavior and one's life. A success identity.

Negative: Refusing to face reality. Behaving irresponsibly by blaming the past, others, environment, and a failure to satisfy one's needs.

Examples of bad choices include: (a) individuals are lonely because they do not develop relationships and get angry, (b) choose a bad behavior to get help, and (c) choose to avoid tougher alternatives (Glasser, 2000).

Behavioral Therapies

Spiegler and Guevremont (2009) suggested 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 Wolfe (classical conditioning), Arnold Lazarus (multimodal therapy), and Albert Bandera (social learning theory)

Major Procedures for Counseling

Classical Conditioning: Ivan Pavlov, Joseph Wolfe, 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

a. systematic desensitization
b. internal inhibition (flooding)
c. counter conditioning
d. aversive conditioning (noxious stimulus)
e. implosive therapy (Stampfl)
f. relaxation training
g. questioning
h. bibliotherapy
i. doing the unexpected

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 the timing of stimuli (Kottler & Brown, 2000). Reading, writing, and driving a car are all examples of operant behaviors.

Techniques

a. shaping
b. contingency contracting
c. self-management
d. biofeedback
e. token economies
f. timeout
g. over correction
h. response cost
i. negative reinforcement
j. positive reinforcement

Cognitive-Behavioral: Aaron Beck, Donald Meichenbaum, Michael Mahoney, Arnold Lazarus, and 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

a. modeling
b. cognitive restructuring
c. assertion training (uses feedback, modeling, social reinforcement, behavioral rehearsal)
d. self-management
e. multimodal (uses classical, operant, and cognitive techniques)
f. imitative learning: Imitative learning is the acquisition of new responses through models demonstrating the desired behavior
g. emotional learning: Emotional learning is the substitution of acceptable emotional responses for those undesirable emotions (Krumboltz, 1966, 1996)

Summary: Behavioral Therapies Basic Assumptions

a. Behavior results from learning
b. Disorders are best understood from an experimental perspective (Corey, 2012, 2016)
c. Techniques are based on the results of rigorous research and evaluation, commitment to the scientific method, and experimental approach.
d. People affect and are affected by their environment
e. The current behavior is the focus of therapy
f. Therapy is action-oriented

Goals

a. establish a collaborative relationship between client and therapist.
b. establish an agreed-upon contract detailing mutually agreed-upon goals, treatment procedures, methods of evaluation.
c. use action-oriented techniques to eliminate maladaptive behaviors and to learn more adaptive behaviors.
d. learning and social or cultural conditioning and interaction between a person and environment shape people.
e. the client can eliminate maladaptive behavior and acquire constructive behavior.
f. comprehensive assessment, then setting of specific goals.
g. the therapist teaches the client how to recognize and alter maladaptive behavioral patterns.
h. the client must practice new behaviors in real-life situations.

i.   eliminate maladaptive behavior.

j.   learn adaptive behavior.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Using adaptive behaviors for problem-solving.

Negative: Faulty learning and unadaptive behavior

Cognitive Therapy

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).

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.

Comparison to other therapies

Cognitive compared to psychoanalysis:

a.   Cognitive doesn't demand early developmental history.

b.   Cognitive focuses more on conscious, not unconscious.

c.   Cognitive treatment is a collaborative effort.

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 the modification of attitudes, beliefs, and expectations.

Cognitive compared to REBT:

a.   REBT assumes problems stem from universal irrational ideas, but cognitive seeks to elicit and modify the client's thinking.

b.   Specific cognitive distortions.

c.   Cognitive initiates change through experiential learning. REBT initiates change through authoritative "disputing" by the therapist.

d.   Cognition places greater emphasis on experiments and real-life learning.

e.   Cognitive is more "behavioristic" than REBT.

Beck's Cognitive Therapy

Human Nature: People live by rules (premises) that influence distorted thinking. These can cause emotional problems if they are unrealistic or applied excessively or rigidly (Corey, 2012, 2016). Beck believes that people live by rules.

Goals

Recognize and discard self-defeating cognitions (cognitive distortions).

Discover the 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

a. Selective abstraction: Focusing on a detail out of context.

b. Arbitrary inference: Conclusions made by inadequate or improper information.

c. Overgeneralization: Blanket judgments or predictions based on a single incident.

d. Personalization: Overestimating extent to which particular events are related to the person.

e. Polarized thinking: Sorting information into dichotomies.

f. Magnification and exaggeration: Overemphasis on most unpleasant, negative consequences that can arise.

g. Assuming excessive responsibility: Attribute negative events to supposed personal deficiencies.

h. Incorrect assessments regarding danger vs. safety: Phobias or underestimating risks.

i. Dysfunctional attitudes about pleasure vs. pain: Setting up unrealistic goals that lead to depression and hopelessness.

j. The 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.

a. socratic dialogue

b. behavioral technique

c. self-monitoring

d. humor

e. problem-solving

f. homework

Meichenbaum's Cognitive-Behavioral Modification

Like the other cognitive-behavioral counselors, Meichenbaum believed the distorted thinking is the basis of stress and emotional problems. (Meichenbaum, 1977)

Techniques

Cognitive restructuring and stress inoculation therapy are two management skills he teaches to clients.

Lazarus's Multimodal Therapy

Arnold Lazarus tailored his therapy to use techniques from different theories, the cognitive-behavioral, psychoanalytic, psychodynamic, and humanistic. Multimodal therapy is theoretically based on social learning. Maladjustment is a result of a deficiency or dysfunctioning in faulty social learning (Lazarus, 2005). He uses the BASIC ID therapy in which:

B is behavior observed

A is the affective (emotion)

S is sensation (feeling)

I is images

C is cognitions (thoughts)

I is interpersonal relations

D is drugs (biological)

Lazarus (2006) introduced the terms of bridging and tracking also 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 patterns. An example is a SCI order, that is, sensory, cognitive, and image. Other clients create negative emotions with a different firing order such as the CISB (cognitive-image, sensory-behavior).

Summary: Cognitive Therapies Basic Assumptions

a. The primary motive for humans is the 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

a. Separate rational from irrational thoughts.

b. Demonstrate self-maintaining pathology.

c. Cognitive restructuring.

Basic Health (Well-Being): Positive and Negative Conditions

Positive: Distorted thinking.

Negative: Irrational thinking, blaming self and others.

Existential (Alvin Mahler)

As cited in Corsini and Wedding (2005), Mahler's existential therapy is a model of usefulness rather than a theory of truth.

a. Personality offers the potential for experiencing a relationship with another.

b. The client constructs his/her personal world.

c. The origins of the infant lie within the parents.

d. Personality development offers a deeper potential for re-experiencing a relationship with another.

e. Pain, unhappiness, and suffering are rooted in hateful, negative, antagonistic, and disintegrative relationships.

f. Change comes about through a major qualitative change in personality. It can be from negative to positive, from hateful to loving, and from disintegrative to integrative.

Dialectic Behavior Therapy (Marsha Linehan)

Linehan based her theory on research and theory construction with women. The term dialectic is a form of an argument in which opposing positions are taken to the one employed by the client. The therapist'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 the 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 and a child exposed to this environment often will fail 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. A second component of treatment is a group therapy. The client uses skills that are broken down into four 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 the naturalness of the mindfulness skills aimed at tolerating and

surviving crises and accepting life as it is. Emotion regulation skills include some identification of emotions and taking opposite actions.

Linehan's theory described dialectic dilemma as when the client swings between two opposites, both ends, are stressful. The client continues in crisis one following another and is referred to as unrelenting crisis. The client copes with the intense and painful feelings through self-mutilation and suicidal attempts.

Eye Movement Desensitization and Reprocessing (EMDR)

Another cognitive behavioral treatment paradigm is Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995). EMDR, an information-processing model, was specifically utilized for individuals who experienced trauma and diagnosed with Posttraumatic Stress Disorder (PTSD). EMDR is a combination of systematic desensitization and substitution of positive thought patterns for negative ones. This method employs re-experiencing a disturbing event guided by a therapist using an exercise of rapid, rhythmic back-and-forth eye movements. The back and forth eye movement unblocks the distressing event from a neurologically tapped state and releases it.

EMDR is a therapy of unfolding stages with a baseline of dysfunction. Selected are one or more disturbing memories for the treatment and 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 sometimes (15-30). After a restful period, the client reports on feelings, images, thoughts, and distress level followed with another series of eye movements with the same event or another one. Cognitive interweave is the term for encouraging taking new perspectives.

OBJECTIVE 5B: CASE CONCEPTUALIZATION

Objective 5b. a systems approach to conceptualizing clients (CACREP, 2015, p. 11) and Objective 5g. essential interviewing, counseling, and case conceptualization skills (CACREP, 2015, p. 12)

A consultation is a part of the counselor's strategy during assessment and treatment planning. The ACA 2014 Code of Ethics informs the counselor that during consultation or supervision client data gathered through an assortment of strategies is organized into a conceptualization plan. Every effort is made to protect the client identity and to avoid invasion of privacy (B.7.b.). When the identity of the client is made known during a consultation, it is only with prior consent of the client or organization. The disclosure is limited to what is necessary for the purpose of the consultation (B.7.b.).

There are some 20 case conceptualization models in the literature not all of which are focused on a diagnosis but apply to treatment plans. Some conceptualization models are theory specific with existential therapy and cognitive behavior therapy as two examples.

Neukrug and Schwitzer (2006) defined the case conceptualization as a tool for observing, understanding, and integrating a client's thoughts, feelings, actions, and physiological status. The three related processes are evaluation, organization, and orientation. The evaluation segment is a clinical interview consisting of sex, race, ethnicity, socioeconomic status, medical history, prior mental health treatment, religion and spirituality, relationship history, marital status, substance use and abuse, trauma

and abuse, and physical appearance. The counselor probes for any precipitating events that are current or in the past.

Conceptualization is the process of using theoretical frameworks to organize interview data, observational data, and assessment data to formulate hypotheses that explain the underlying dynamics of a presenting problem to formulate an accurate assessment and treatment plan. That is to understand what personal, interpersonal, intrapersonal or systemic dynamics are driving and maintaining a client's presenting complaint composed of behavioral, cognitive and emotional components. A clinical case formulation, according to Prieto and Scheel (2002), is "a conceptual scheme that organizes, explains, or makes clinical sense out of large amounts of data and influences the treatment decisions." The case conceptualization is the essence of the treatment plan presented with rationale and justification. The case conceptualization includes:

a. symptoms or problems that need to be changed.
b. a large amount of information that needs to be organized.
c. a conceptual scheme that provides an explanation.
d. treatment decisions that lead to specific procedures.

The case conceptualization is communicated with the client, with team members if in a hospital setting and with case managers. Most case conceptualization models begin with the presenting problem, followed by gathering data, defining problems clearly as data, not as a diagnosis, listing problems, specifying goals, and assessing for a problem or a diagnosis. A client's chart is created that includes a treatment plan, identified goals, interventions, and timetable, diagnosis and consent forms. Finally, monitoring progress documentation matching the goals with specific behavioral and psychological measures. Monitoring tools should be particular to the symptoms and identified goals but also include client compliance (medication, homework), prep-post measures, specific coping skills taught and practiced along with feedback for the client's awareness to changes.

Models of Case Conceptualizations

Steven-Morris Model

This model is atheoretical based on a cognitive schema framework. Data gathering includes background information, presenting concern, verbal content, verbal style, nonverbal behavior, client emotional experience, counselor's experience and personal reactions, client-counselor interaction, test data, diagnosis, inferences and assumptions, goals for treatment, and evaluation of outcome (Steven & Morris, 1995).

Inverted Pyramid Model

The inverted pyramid model is a stepwise method to identify and understand client concerns with a diagram that visually guides and clarifies the conceptualization process. The emphasis is on early assessment and treatment planning. The model has four steps outlined with each step emphasizing three to four actions. The four steps include problem identification, thematic grouping, theoretical inference about client concerns, and narrowed inferences about client difficulties (Schwitzer, 1996).

Linchpin Model

The concept of the linchpin is to organize all of the key factors around one causal, explanatory source, frame the problem regarding amenable to direct intervention and finally to be shared with the client focusing on the benefit. The three steps are to organize facts around a "linchpin," target factors amenable to interventions and share the data with the client (Bergner, 1998).

INTERVIEWING & SKILLS DEVELOPMENT

Objective 5g. Essential interviewing, counseling, and case conceptualization skills (CACREP, 2015, p. 12)

Effective outcome assessment is the result of a sound conceptualization, an integrated implementation, and monitoring for behavioral change.

Skill development in conducting a case conceptualization involves a training format that includes an awareness of what is normal behavior and what is not normal behavior for the client's present age and development (characteristics of symptom severity, frequency, and duration). Broad areas for these observations include client participation in family, academic, social, and occupational domains. Client complaints require assessing for symptoms that meet criteria for a DSM-5 disorder or a Z-code clinical issue.

Skill areas for symptom gathering include specific questions regarding family (race/culture) and individual clients. The presenting issue will require the counselor to seek background information and accumulate knowledge for inquiries that will include cultural values, mores, inter/intrapersonal relations, cultural conceptualization of distress, psychosocial stressors, cultural vulnerabilities and resilience factors, cultural identity within different races, gender, and spiritual consideration, work experiences and employment practices. Cultural concepts of distress include cultural syndromes, idioms, and explanations for the client's perception and belief for the cause of the presenting issue.

Not all presenting issues meet criteria for a DSM-5 disorder but rather may be a problem for clinical attention representing different levels of conflict regarding frequency, duration, and severity. The DSM-5 refers to these issues as Z or V codes. All presenting concerns deserve respectful and ethical behavior by the counselor when developing a case conceptualization and a treatment plan for problem resolution.

Ethical observations and counselor responses for interviewing, symptom assessment, instrumentation, and referral include:

a. Interviewing Skills: Cultural Formulation Interview (CFI, APA, 2013), clinical and biopsychosocial interview categories, motivational interview (health, psychological, family, education, social history, substance use/abuse, trauma, self-harm), structured, semi-structured, and unstructured interviews, and open and closed questioning. Specific topic areas for specific disorders are available in training programs and the literature to assist the assessor.

Ethics: B.1.a. Multicultural/Diversity Considerations-respecting client rights for cultural meanings of confidentiality and disclosure.

Literature example: Wilkinson et al. (2002) recommended categories for adolescents to be asked for bipolar conditions to include: medical, psychiatric history, family psychiatric conditions, direct observations, physical examination, and a personal interview.

b. Symptom identification: A skillful assessor interviewing with specific questions or a mental status examination probes for symptoms to include the duration, frequency, and severity consistent with the DSM-5 criteria (specifiers, severity ratings, comorbidity, and differential diagnosis). The counselor needs to be aware of comorbidity and differential diagnosis to avoid misdiagnosing.

Ethics: E.5.a.-Special care to provide proper diagnosis of mental disorders

Ethics: E.5.b. Cultural Sensitivity-culture affects the manner in which clients' problems are defined and experienced

Ethics: E.5.c. Historical and Social Prejudices in the Diagnosis of Pathology-misdiagnosing pathologies for certain individuals and groups.

c. Instrumentation: types may include Mental Status Examination (MSE), DSM-5 Self-Related Level 1 Cross-Cutting Symptoms Measures (pre-interview), inventories, instruments, screeners, rating scales, and checklists as a second source to validate the assessment (rule in/out).

Ethics: E.2.c. Psychometrics-the counselor has a thorough understanding of psychometrics

Ethics: E. 6.a. Appropriateness of Instruments-validity, reliability, psychometrics limitations and appropriateness of instruments

d. Referral resources: The counselor may use collateral services (physician, neurologist, psychiatrist, school counselor) to validate the chief complaint or for a second opinion to rule in/out a disorder. The referral may be necessary based on criteria or medical-related physical conditions or for comorbidity and a differential diagnosis.

Ethics: A.11.b. Values Within Referral-risk of imposing values when inconsistent with the client.

B.7.a. Respect for Privacy-information shared in consultation

D.2.b. Informed Consent in Formal Consultation-rights and responsibilities of both parties regarding the purpose, services, costs, potential risks, and benefits.

e. Treatment matching: The counselor provides evidence-based research (effectiveness and efficacious studies), strategies, and techniques to provide symptom relief and resolution for the presenting complaint and goals.

Ethics: A.1.c. Counseling Plans-share the plan with client and provide   freedom of choice

C.7.a. Scientific Basis for Treatment-use techniques/procedures /modalities that are grounded in theory

f. Monitoring change: The counselor when identifying goals plans for feedback means to assess for change. Measuring change may be with pre-post measures, self-reports, compliance (medication, homework), observers involved with the client (releases secured), and physiological indicators.

In summary, the case conceptualization begins with subjective and objective data gathering pertinent to the chief complaint or problem statement. The first session is a time to rule out biological or environmental causes and to determine if a crisis or emergency is the issue. It is important in the interview process to be skillful and knowledgeable about the family of differential diagnoses for different disorders. The clinical interview is the primary tool for collecting the data. Broad-based and relationship bonding skills include non-verbal behaviors, accurate observations, reflection of feelings, accurate

paraphrasing and summarizing, effective open-ended probing, and focused questions on developing a hypothesis.

A cognitive-developmental approach to case conceptualization is to recognize, understand, and integrate discrete facts about the presenting issue. It is important to understand the relationship between these facts and how this knowledge can be used to determine an effective treatment intervention. The counselor probes and observes the current level of functioning and clinical signs and symptoms. A mental status interview for the client's orientation to time, place, and person may be used to cover topical areas such as cognition, affect, appearance, and speech.

It is important that the counselor deciphers the difference between the presenting issue and a psychological disorder and the information is derived from probing the client's history, patterns of behavior and how those patterns fit with certain clinical presentations. As data are being gathered a framework to explain the cause (etiology) of the problem begins to emerge. Integrating the facts accurately to provide a base understanding of the presenting issue narrows the probes to etch out when the problem started and what contributed to the development. Sequencing questions help to unfold the symptoms, sustaining elements, and pattern of the presenting complaint. Also, it is important to assess the client's resiliency skills and resources that will help to alleviate the symptoms.

The case conceptualization should include integrating client motivation and readiness for change. Organizing the data for making inferences and identifying themes or patterns is the second step of the framework. The final component of the framework is orientation. Interpreting and analyzing using a theoretical model allows for the integration of the facts acquired during the evaluation and set the stage for an organization of the work to be accomplished. Some theoretical models include solution focused brief therapy (SFBT), cognitive behavioral therapy (CBT), psychodynamic, postmodern theories, and biopsychosocial approaches (Neukrug & Schwitzer, 2006).

Neukrug and Schwitzer outlined Prochaska's case conceptualization atheorectical model, a temporal contextual framework (T/C) consisting of four core constructs that include change, decisional balance, self-efficacy, and temptation (Prochaska, DiClemente, & Norcross, 1992).

Case documentation and record keeping reflect the counselor's procedural knowledge and the client's needs and difficulties. Prieto and Scheel (2002) developed the STIPS format for note writing consisting of current signs and symptoms (S), discussion topics (T) used in counseling, counseling interventions (I), the client's progress (P) and the counselor's continuing plan for treatment, and special (S) issues regarding the client.

COUNSELOR SKILL DEVELOPMENT:

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, 1980). 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, a behavioral interview for a skill deficit 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 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, and feedback (Larson, 1984). The goal is the demystification of the therapeutic process, the empowerment of the client, and the systematic transmission of identified skills to helpers and helpees. The emphasis is on prevention, although the model is also effective in remediation. Some of the coping skills examples are Life Skills Education by Winthrop Adkins (1984); Structured Learning Therapy by Arthur Goldstein; Relationship Enhancement Therapy by Bernard Guerney; Listening and Focusing by Eugene Gendlin; Skilled Helping: Problem Management by; and Parent Effectiveness Training by Thomas Gordon (Larson, 1984).

OBJECTIVE 5C: CONSULTATION

Objective 5c. theories, models, and strategies for understanding and practicing consultation (CACREP, 2015, p. 11). Consultation in the ACA Code of Ethics (2014) is covered in Section D.2.: competency (D.2.a.) and consent (D.2.b.).

History of Consultation

The history of consultation is rather thin, dating back to clinical consultation by physicians. Brown, Pryzwansky, and Schulte (1991) described 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) pointed out that clinical models grew out of medical practice, mental health, but that behavioral, and organizational models were lacking in theory. She does indicate that some models are based on individual psychology, operant learning, and social learning theory. All models include an intervention. According to an intervention model by Morrill, Oetting, and Hurst (as cited in Brown et al., 1991) the basic aim is to identify a target, the purpose of an intervention, and a method of intervention.

Definition of Consultation

Dustin and Ehly (1984) defined 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 support to a third party. Triadic is work related, issue focused, voluntary, and nonjudgmental (Kurpius & Fuqua, 1993). 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) defined collaboration as a shared role between the consultant and consultee regarding an objective development, the definition of the problem, intervention planning, implementation, and evaluation.

Dustin and Ehly's (1984) model of consultation is a stage model composed of the following stages:

1. Phasing in: relationship building reentry, listening, self-disclosure, empathy
2. Problem identification: focusing skills, setting goals, commitment
3. Implementation: feedback, resistance dealing
4. Evaluation: risk-taking, persistence
5. Termination: feedback

Consultation versus Counseling

The natures of counseling and consultation are different. Counseling is a "direct relationship in which the aim is to alter the behavior of the person/client receiving the service" (Brown et al., 1991, p. 7). Consultation is an indirect service; the consultant indirectly assists the client through the consultee. Consultation is triadic; often the client is not physically present, while counseling is direct with the client. Frequently, consultation is directed at the hidden client while counseling is directly at the client. The consultant may not have direct contact with the client while a counselor does (Newman, 1993).

Ethical Issues in Consultation

Newman (1993) outlined four aspects of consultation that are potentials for ethical decision-making. These four are relationship issues, values in consultation, competence, and intervention.

Target Populations

a. individuals
b. groups
c. organizations
d. communities

Purposes of Consultant Intervention

Primary: This type of intervention is proactive. The aim is to enhance the mental health of some group, which is assumed to have positive mental health.

Secondary: This type of intervention is designed to identify and treat the condition before it becomes serious. Early identification is a common goal of secondary intervention.

Tertiary: This type of intervention is concerned about reducing the debilitating mental-health problems

Methods of Consultation

Direct: face-to-face such as teaching, supervision, and counseling

Consultation: Includes a variety of approaches

Informational: Media, TV, radio, books (examples)

Internal Consultant vs. External Consultant

It is believed that the internal consultant often has less status, is restricted to his/her role definitions, and finds it difficult to be objective. There are also some advantages such as familiarity, knowledge of power structure, and resources not available to an external consultant.

Types of Consultants

Client-centered: Focus is on consultee's management of a particular client; prescriptive.

Program-centered: Focus is to serve as an expert in mental health administration and provide recommendations.

Consultee-centered: Focus is on program development and administrative administration with a focus on increasing the consultee effectiveness.

Types of Consultation

Mental-health Consultation:

Gerald Caplan developed the most influential model of consultation, often referred to as mental health consultation. Caplan defined consultation as a "voluntary, nonhierarchical relationship between two professionals who are often of two different occupational groups" (Brown et al., 1991, p. 6).

Caplan (as cited in Brown et al., 1991) suggested 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.

Caplan described the relationship with a consultee as a "coordinate relationship" and the cornerstone for an effective consultation (Mendoza, 1993). The consultant is proactive, correcting distortions in a trusting relationship and encouraging the consultee's input.

Theme interference is one aspect of Caplan's model that is unique and a view held by the consultee that the situation is hopeless. The client makes several false starts and confirms his/her view.

Caplan identified two goals for intervention: first, improve the functioning of the consultee, and second, develop skills of the consultee for present and future use.

Caplan's four types of consultation include: client-centered case consultation, consultee-centered case consultation, program-centered administrative consultation, and consultee-centered administrative consultation.

Behavioral Consultation:

Bergin (as cited in Brown et al., 1991) defined behavioral consultation as a problem-solving endeavor that occurs within a behavioral framework. The foundation is formulated on a behavioral change and the scientific method. The premise is that all behavior is learned. The consultation and intervention emphasize a relationship and behavioral orientation set of services provided to a client through the mediation of important others in that client's environment.

This set of services is an indirect service in which the client is the focus. The client can use indirect services and rely on behavioral principles to design, implement, and assess the consultative interventions. The primary 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.

School Consultation:

School consultation is defined by Dettmer, Thurman, and Dyck (1993) as "activity in which professional educators and parents collaborate within the academic 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.

Edgar Schein proposed three models of consultation: (a) purchase-of-expertise for an organizational problem, (b) doctor-patient where the focus on the consultation was an organizational problem, and (c) the process model focus on how the organizational problems are solved (Rockwood, 1993).

Question 5-32
A counseling agency was experiencing some employees experiencing physical and emotional stress and statements of over-burdened work. The workers have had an unusual number of sick days, requests for vacations, health problems such as high blood pressure, and conflicts with other employees. The manager is considering bringing in a consultant and should consider which type of intervention?

a. primary

b. secondary

c. tertiary

d. entry

Answer: c. tertiary. The focus is on those already disabled.

OBJECTIVE 5D: TECHNOLOGY RELATIONSHIP

Objective 5d. ethical and culturally relevant strategies for establishing and maintaining in-person and technology-assisted relationships (CACREP, 2015, p. 11).

Counselors and clients interact with technology in a variety of their duties as therapists and recipients of counseling services. Specific relationships include skills pertinent to assessment, referral, testing, treatment, monitoring, and discharge.

According to Chapin (2014), self-regulation is the ability of the body and mind to assess a situation and then decide what physiological and behavioral changes are necessary to return to an optimal state. The brain and the autonomic nervous system can be in a state of dysregulation. Any number of events can bring about a state of dysregulation such as high fevers, poor diet, hormones, and emotionally suppressive psychosocial environments including inadequate attachment, abuse, neglect and trauma all of which can affect neurological functioning. Some self-regulation strategies several of which involve neuroscience techniques include:

    a.   establishing a compassionate and empathic therapeutic relationship

    b.   focusing on exercise, diet, aerobics

    c.   training in regulating peripheral skin temperature that relaxes muscles

    d.   diaphragmatic breathing

    e.   heart rate variability

    f.   mental imagery

    g.   therapeutic harmonics

    h.   audiovisual entertainment

    i.   transcranial direct current stimulation

    j.   neurofeedback (p. 24)

Meditation is another technique and practiced with ties to neuroscience, technology, and in several religions. Meditation establishes a more stable and clearer mind, emotional balance, a sense of mindfulness, and compassion. Meditation involves three types. First is a focused-attention to time and centering the mind in the present moment. Second is mindfulness for open-monitoring (cultivating a less emotionally reactive awareness to emotions, thoughts, and sensations). The third type is the Buddhist tradition of compassion and loving kindness (Ricard, Lutz, & Davidson, 2014).

During meditation, researchers have been able to map changes. The first stage, attention, the mind wanders from an object, and the mediator is to refocus attention to the body rhythm of inhaling and exhaling. Stage two is becoming aware of the distraction. Stage three is to detach the attention from the distracter. Attention, the fourth stage is to control the direction toward an object such as breathing. Meditation produces changes in the function and structure of the brain for improved physical health.

OBJECTIVE 5E. Technology and Counseling Impact

CACREP objective 5e. recommends an understanding of neurobiological behavior regarding the nature and needs of persons at all developmental levels. Understanding neurobiological behavior includes brain chemistry and effects on human growth and development (CACREP, 2015, p. 11).

The definition of neurobiological behavior involves "the relationship among brain anatomy, function, biochemistry, learning, and behavior" (CACREP, 2009, p. 60). Neurobiological behavior is a form of feedback in recognizing, monitoring, and training clients to self-regulate in those areas where brain waves and chemistry is of such importance for improved health (sleep, blood flow, anxiety).

The function of neuroscience feedback is to allow clients to monitor and make changes to brain wave patterns that assist in self-regulation and symptom reduction. Research has reported changes in alpha, beta, and theta waves associated with different emotions and disorders.

Interventions focus on the physiological basis of behavior. Neuroscience and brain wave control has allowed clients to change physiological activity (brain wave patterns) and control their own physiological and emotional processes (i.e., self-regulate). In the past, the client utilized equipment that measured change through an awareness of physiological activity and recently without the use of instruments (Heinrich, Gevensleben, & Strehl, 2007; Myers & Young, 2012).

Neurofeedback (NFB) outcome research has established levels of effectiveness resulting in reducing symptoms for attention deficit hyperactivity disordered clients (Arns, deRidder, Strehl, Breteler, & Coenen, 2009; Williams, 2010), autism spectrum disorder (Cohen, Linden, & Myers, 2010), Asperger's syndrome (Thompson, Thompson, & Reid, 2010), sexual behavior problems (Longo, 2010), drug addiction (Sokhadze, Stewart, & Hollifield, 2007), and epilepsy (Walker, 2010). Also, NFB appears to improve autonomic regulation and to promote brain competencies, help to remediate brain-based functional disorders, and ameliorate underlying conditions (Arns et al., 2009).

Ivey et al. (2009, pp. 45-47) listed five concepts that can change the brain in positive ways, building new pathways according to the principle of neuroplasticity and include:

a. The brain is capable of changing and remodeling itself (neurogenesis).
b. The brain is capable of building new pathways and create new learning (neurogenesis).
c. Counseling skills are measurable with brain imaging (attending), and empathy identified and measured.
d. Emotions are fired in different parts of the brain.
e. Training in the frontal cortex will promote strengths and wellness.

Neuroscience and neurofeedback benefits are evident in assessment, treatment planning, and interventions for (Myers & Young, 2012),

a. assessment and treatment planning (QEEG: brain map)
b. diagnosis and differential diagnosis (EEG) such as too little alpha in right hemisphere (social withdrawal); too much alpha on the right brain: mania; high beta: OCD (Peniston & Kulkowsky, 1989)

c. interventions: computer graphics

MONITORING:

Unsworth, Cowie, and Green (2012) conducted a qualitative research study with four primary therapists who were familiar with CORE-NET and CORE-OM (Clinical Outcome Routine Evaluation Outcome Measuring) and five therapists in a support counseling service who were just becoming familiar with CORE-NET. Feedback for client improvement or deterioration or rupture in the relationship was tracked visually on a computer screen. Six themes were reported: (1) therapists were initially anxious and resistant, (2) therapists adapt 'creatively', (3) outcome measures help the client/therapist relationship, (4) clients perceived visual measures as helpful, (5) CORE scores inform supervision, and (6) proper and ongoing training/support of therapists is necessary. The first impact of immediate feedback after each session is critical to track therapy for client improvement, deterioration or a rupture in the relationship. When software monitoring indicates a rupture, the counselor and client have an immediate opportunity to repair the relationship. A second impact reinforced therapist training and designing a strategy to repair relationship ruptures. A third effect is that visual information can be used to triage sessions. A final result is that the counselor has documented evidence toward researching counselor effectiveness.

A computerized cognitive-behavioral therapy (c CBT) Blues Begone package was researched in the United Kingdom to treat moderate depression (Purves & Dutton, 2013). This type of self-help replaces the face-to-face interaction with a symbolic relationship, a talking head. The National Institute for Health Clinical Excellence (2009) reported that sub-threshold to moderate depression could effectively be treated by self-help or computerized cognitive behavioral therapy although effectiveness studies are lacking. The cCBT program is a virtual therapeutic relationship with an animated talking head. The program includes assessment, a CBT framework of 30 tailored sessions to match the client symptoms. There is no therapist and the program is considered a stand-alone. Clients reported that they did not experience the responsiveness and depth but did feel they were able to gain composure, order, and shifts in thinking for new solutions. Three themes were summarized; meaningful relationship shape from confusion, stimulation, and empowerment. Research for computerized therapy is yet to be determined if the symbolic relationship can replace the face-to-face relationship. Technology as a therapeutic alternative is yet to meet efficacious or effectiveness research rigor.

TREATMENT:

A recent technology innovation application for treatment is the Smartphone for bipolar disorder regarding a client's major fluctuations in affect and activity, as well as marked changes in perception and cognition. Monitoring and measuring mood episodes that cycle (circadian rhythm) on an approximate regular basis are difficult to store in memory and over time (Soreca, Frank, & Kupfer, 2009). Client recall for self-monitoring has always posed a problem regarding memory in reporting the frequency and intensity of symptoms. An advantage of the Smartphone is the presence of it with the client at all times, so the data collected is in real time and in the natural setting in which the client is experiencing an event or social happening (Matthews et al., 2016). The application is to assist the client in emotion regulation while dysregulation is occurring.

Berger, Boettcher, and Caspar (2014) reported there had been evaluations of field trial interventions, more than 100 studies for anxiety disorders, depression, and other disorders. There is growing research

and effectiveness outcome data regarding computerized cognitive-behavioral randomized trial studies for social anxiety disorder, panic disorder, and agoraphobia disorder. Many of these studies were compared to standardized treatments, control groups or a wait list with positive outcomes. Most of the studies reported for computerized self-help programs were with minimal therapist contact.

Eells, Barrett, Wright, and Thase (2014) compared three Internet computer-assisted programs for treating depression, Good Days Ahead, Beating the Blues, and MoodGYM. The Internet computer-assisted programs for CBT, DBT, and IPT were utilized instead of the standard face-to-face psychotherapy for different disorders. The authors provided eight reasons to consider the software computer applications to include: (1) cost, the program is written once, (b) efficiency, reducing time, (3) increase access to treatment through the Internet, (4) facilitates the delivery of technical components of evidence-based therapies, (5) delivers psychoeducation and can be standardized, (6) recording, collecting, and management of information, (7) offers learning situations, and (8) client preference. The program consisted of motivational enhancement, psychoeducation, cognitive restructuring, self-focused attention and detached mindfulness, exposure and behavioral experiments, summary and repetition, lifestyle modification and problem-solving, repetition and relapse prevention. The disadvantages are (1) computers do not have a human connection (empathy, emotional caring, interpersonal collaboration), (2) software development that matches standard therapy, (3) movement from outcome-based programs to self-help programs, so effectiveness is yet to be determined, (4) methodological flaws for trials, (5) acceptance by clinicians, (6) insurance coverage, and (7) ethical and legal concerns are not clear when the program is via the Internet (Fisher & Fried, 2003; Lillevoll et al., 2014). There are multiple forms of computer-assisted software, DVD-ROMS, and CD-ROMS that are mostly text-based.

SELF-HELP: Newman et al. (2011) identified four different levels of involvement and tasks performed with Internet computer-assisted therapy programs involving cognitive therapy, CBT, motivational interviewing, family therapy, and problem-solving therapy. Of twenty-one studies reviewed three were self-administered, six were self-help, five with minimal involvement of a therapist, and seven mostly therapist administered.

A computerized-assisted self-monitoring evaluation program for generalized anxiety group therapy used a mobile alert to provide for bibliotherapy (treatment content), homework, and hourly alerts for self-monitoring. At the completion of the CBT Internet therapy, clients reported a greater reduction in distress than did a group without the use of a computer program (Barrett & Gershkovich, 2014).

A second technology program, Internet-Based CBT for anxiety, was reviewed by Barrett and Gershkovich researching a comparison between the self-help Internet-based CBT program and a standardized Internet-based self-help treatment and a wait list. The self-help group was composed of social anxiety, panic disorder, and GAD clients. Both groups revealed a change score that was statistically significant compared to the wait list.

Computer-assisted mental status evaluation programs have been available for some time in report writing for managed care. The Mental Status Checklist Computer Report is accessible on a personal computer (Polanski & Hinkle, 2000).

COMPUTERIZED TRAINING: Because there are few trained CBT therapists, Kobak, Craske, Rose, and Wolitsky-Taylor (2015) developed a Web-based CBT training program for therapists. The program includes an interactive multimedia online tutorial for didactic training on CBT concepts and a real-life applied

remote observation through video conference of trainees conducting CBT with immediate feedback. Specific modules for clients include welcome and introduction, principles of CBT, teaching clients about the nature of anxiety, explaining treatment rationale to clients, teaching clients self-assessment skills, helping clients develop a hierarchy, teaching clients breathing techniques, managing anxious thinking (cognitive restructuring), exposure therapy, and enhancing client motivation.

SUPERVISION TRAINING: o-SOFTA and e-SOFTA

SOFTA is a video training/supervision program composed of four components. The components include engagement in the therapeutic process, emotional connection with the therapist, safety within the therapeutic system, shared sense of purpose within the family, observational rating tools (SOFTA-o), and self-report measures SOFTA-s (Escudero, Heatherington, & Friedlander, 2010; Friedlander, Escudero, & Heatherington, 2006). The e-SOFTA program rates therapists and clients on specific behaviors regarding factors that contribute or detract from a strong working alliance. SOFTA-o tracks observations and rates clients (self-report ordinal measure) and therapists on behavioral dimensions for a strong working alliance (Escudero, Friedlander, & Heatherington, 2011). The e-SOFTA with supporting data gathered from case studies and group comparison designs recommended continued alliance research for supervisors or self-supervision.

In summary, the e-SOFTA was created for observing and monitoring family therapy progress and is based on the System for Observing Family Therapy Alliances (Friedlander et al., 2006). Several computer self-help programs designed for therapy or training emphasize the importance of the client-counselor relationship, the alliance. The feedback system for the routine outcome measuring (ROM) provides treatment progress with on-track session feedback for improvement, deterioration or a rupture in the relationship. The SOFTA observational dimensions include engagement in the therapeutic process, emotional connection with the therapist, safety within the therapeutic system, and a shared sense of purpose within the family.

OBJECTIVE 5F: Characteristics and Behaviors that Influence the Counseling Process

Objective 5f. counselor characteristics and behaviors that influence the counseling outcome (CACREP, 2015, p. 12)

Three influencing factors have been observed that cut across some theoretical approaches that support client improvement and growth during counseling. These factors include (Lambert & Cattani-Thompson, 1996):

a. Support factors include catharsis, identification with therapist, mitigation of isolation, positive relationship, reassurance, release of tension, structure, therapeutic alliance, therapist warmth, respect, empathy, acceptance, genuineness, and trust

b. Learning factors include advice, affective experiencing, and assimilation of problematic experiences, changing expectations for personal effectiveness, cognitive learning, corrective emotional experience, and exploration of the internal frame of reference, feedback, insight, and rationale.

c. Action factors include behavioral regulation, cognitive mastery, encouragement of facing fears, taking risks, mastery efforts, modeling, practice, reality testing, success experiences, and working through (p. 603).

Laska, Gurman, and Wampold (2014) provided a description of the common factor perspective for randomized controlled trials in how therapy works (RCTs). The literature appears to offer definitions for evidence-based practice (EBP) and empirically supported treatments (EST) as one in the same. These authors attempt to point out the difference in the two. Treatment for EBT is composed of specific techniques that remediate deficits for a particular mental disorder. There are some common factors to all psychotherapies that include alliance, induction, and expectancy of change and with specific psychological procedures to alleviate the symptoms and disorder (Barlow, 1996, 2004, 2010). A CBT technique such as prolonged exposure for PTSD is an intervention and considered a change agent (Foa, Hembree, & Rothbaum, 2007).

The Common Factors (CF) perspective "focuses on factors that are necessary and sufficient for change: (a) an emotionally charged bond between the therapist and client, (b) a confiding healing setting in which therapy takes place, (c) a therapist who provides a psychologically derived and culturally embedded explanation for emotion distress, (d) a description that is adaptive and accepted by the client, and (e) a set of procedures or rituals engaged by the client and therapist that leads the client to enact something that is positive, helpful or adaptive" (Laska et al., 2014, p 469).

Common factors (CF) include alliance, empathy, goal consensus/collaboration, positive regard/ affirmation, congruence/genuineness, and therapists. Laska and Wampold (2014) reported ten things to remember about common factor theory. In summary, CF is not a treatment and does not fit all clients or conditions for therapy.

Leibert and Dunne-Bryant (2015) drew from common factors for producing client change. Self-reports measured three common factors: client factors, client-counselor relationship, and client expectancy. Client expectancy and the therapeutic alliance significantly predicted treatment outcome.

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 (2010) recognized 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. 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), congruence (genuineness), empathy (understanding), positive regard (accepting), immediacy, and respect. Other features have also been suggested such as self-awareness, open-mindedness, flexibility, objectivity, trustworthiness, personal integrity, and a sense of values. Whiston and Sexton (1993) reported that Horvath and Symonds (1991) found that the working alliance accounted for 30% to 45% of change and social influence models were helpful. LaCrosse (1980) indicated that perceived expertness, attractiveness, and trustworthiness accounted for 35% of client change. Session length can also be a factor in that a 50% improvement rate

was found at the end of eight sessions, 75% by the end of 12 sessions, and 85% of improvement by the end of the first year (Howard, Kopta, Krasue, & Mann, 1986).

Meier and Davis (2001) reported characteristics of the healthy and well helpers include:

a. aware of personal issues
b. open to supervision
c. not hiding behind the use of too many tests
d. 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 is, willingness to accept personal responsibility for one's behaviors, and development of realistic levels of aspirations (George & Cristiani, 1990).

Studies have revealed that superior clinician's efforts and activities focus on the nature of and amount of time spent in therapeutic and non-therapeutic activities. Ericsson and Lehman (1996) referred to these characteristics as deliberate practice (DP). DP is defined as individualized training activities that lead to improved functional aspects of the therapist's performance through repetition and refinement (pp. 278-279). Chow et al. (2015) conducted a 4-year DP study consisting of 1,632 clients and 17 therapists from a full sample of 4,580 clients, 69 therapists, and 45 organizations. Previous studies have focused on personality characteristics, professional development, and work practice with limited or inconclusive results. The Clinical Outcomes in Routine Evaluation-Out Measure (CORE-OM; Connell & Barkham, 2007; Evans et al., 2000) measured for anxiety, depression, physical problems, and trauma. Functioning measured general operation, close relationships, and social relationships. The Retrospective Analysis of Psychotherapists' Involvement in Deliberate Practice (RAPID; Cote et al., 2005; Ericsson et al., 1993) measured therapist engagement in 20 therapeutic activities and five non-therapeutic activities to improve on specific aspects of clinician outcome. These activities include the amount of time that therapists spend in practice outside work to improve therapeutic skills. The authors identified several limitations of the study but highlighted those activities rated as significant. Four specific activities had higher than average ratings and included: (a) reviewing difficult/challenging cases alone, (b) attending training workshops for specific models of therapy, (c) mentally running through and reflecting on the past sessions in your mind, and (d) mentally running through and reflecting on what to do in future sessions (p. 342). A significant finding indicated that outcomes and cognitive efforts involved "reviewing of therapy recordings alone." The extra time from self-reports amounted to 2.8 hours per week.

Sometimes it is helpful to review reasons individuals who are experiencing distress avoid coming to counseling. Kushner and Sher (1989) indicated that less than one-third who are in distress seek mental health services. Vogel, Wester, and Larson (2007) isolated eight factors through a literature review. Factors they found included social stigma, treatment fears, fear of emotion, anticipated utility and risk, social norms, self-disclosure, and self-esteem. These authors suggested that influence factors are prominent for the avoidance reactions. Less well documented are studies for other avoidance factors of gender, race, and ethnicity, setting and problem type, and age. Suggestions to address social factors may be to advocate on a larger social scale to reduce the negative perceptions that society holds toward mental health services. Helping clients to learn and identify ways to cope with the stigma is a possibility. The same can be said for treatment fears. To lessen this concern is to challenge the negative perceptions.

The fear of experiencing a negative effect can be by educating clients about the personal control they have regarding disclosures and readiness for counseling or change. The use of motivational communication in discussing readiness for change can be a topic that helps to dispel what might be considered a forced choice for change. Conducting a cost-benefit analysis for counseling that is worked out jointly and is visible, written-out or placed on a working board can help in weighing options. Social advocacy in a group effort is a positive direction for meeting some of the avoidance factors due to social norms.

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 condition of positive wellness. The wellness concept includes health-related activities that are preventive and remedial (Gladding, 1996, 2012). There are several models representing human effectiveness. Individuals who live effectively in all aspects of their lives 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) included a list of five life tasks that have 11 dimensions for 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 on 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 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 saw human personality as growing from within, rather than being shaped from without. Psychopathology, on the other hand, was seen primarily as the result of frustrating or twisting man's essential nature from without.

Within the value system for human nature, anything that contributes to the development of man's inner nature is good, while anything that disturbs, blocks, or denies that nature is bad or abnormal.

Maslow wrote a paper titled "The Need to Know and the Fear of Knowing," in which he outlined each of the intrinsic aspects of what he called B-values or Values of Being. "Self-actualization is an experiencing fully, selflessly, with full concentration and total absorption" (p. 45). He viewed self-actualization as a process.

Maslow hypothesized the conditions for optimum development or actualization within a theory of Hierarchy of Needs. Briefly, Maslow classified 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 will develop a warped picture of true human potentialities.

Rogers' Fully Functioning Person

Carl Rogers approached the construct of an effective human personality out of his theoretical orientation and clinical experience. He conceptualized the "fully functioning person" as the fully successful client in Client-Centered Therapy (Person-Centered). Rogers isolated and described three primary characteristics of this hypothetical personality:

1. Be open to his or her experience. She or he would not be defensive or resistant to aspects of the environment that might produce change. All aspects of his or her environment would be available in the form of accurate, realistic perceptions. There would be no built-in barriers that shut out the possibility of fully experiencing his/her surroundings.

2. Live in an existential way. She or he would experience life regarding an ongoing, "becoming" process. She or he would live in a fluid stream of experience, rather than in a rigid or stereotyped way. There would be an absence of tight organization or imposed structure.

3. Trust himself or herself to 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 sense 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), described the nature of psychological maturity consisting of six primary characteristics of the mature person. Allport's theory revolved around motivational variables, genetic factors, and ego concepts. Allport's list is:

1. Extension of Self: The mature person was able to extend his or her concept of self through feelings of caring and belonging to other individuals, institutions, and humanity. Through this process of self-extension, the welfare of others becomes as important as the well-being of self.

2. Warm Relating of Self to Others: The mature person was capable of intimacy and love and interpersonal relationships were characterized by empathy and compassion rather than possessiveness and hostility.

3. Emotional Security: For the mature personality, emotional security arose out of acceptance of self. This security allows him or her to tolerate frustrations and to avoid overreaction to disturbing, but

relatively inconsequential, situations. The outcome of a secure person reflects self-control and the ability to defer gratification or adjust the inevitable.

4. Realistic Perceptions, Skills, and Assignments: The mature person was able to function efficiently in the areas of perception and cognition. He or she was capable of accurate and realistic intellectual behavior. He or she had problem-solving skills and techniques.

5. Self-objectification, insight, and humor: The mature person had realistic self-insight. He or she understood him or herself, and had a sense of humor, and can put him or herself in perspective without distortion.

6. Unifying Philosophy of Life: "The mature personality works out a unifying approach to life that yields consistency and meaning to their 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, value-oriented, and possesses humor and insight.

Question 5-33:
The literature indicates that greater than 50% of the clients who are likely to benefit from counseling avoid seeking mental health services. In many of those instances of individuals avoiding counseling might be explained by:

a. approach/avoidance conflict

b. unexplained reasons

c. client's belief they can resolve the issue without counseling

d. there is a poor match between counselor and client especially with majority-minority

Answer: a. approach/avoidance conflict. Kushner and Sher (1989) explain the dilemma consisting of several avoidance behaviors.

OBJECTIVE 5G: INTERVIEWING

Objective 5g. essential interviewing, counseling, and objective 5b. for case conceptualization interviewing skills (CACREP, 2015, p. 12)

Objective 5g. conceptualization skills component is covered within CACREP Objective 5B.

Microskills Counseling: Allen Ivey and Maryanne Galvin

Ivey and Galvin (1984) developed microskills based on social learning theory. This model teaches specific interviewing skills called microskills that beginning counselors can, within 45 hours of training, generate multiple appropriate responses to various stimuli. Ivey outlined the basic listening skills to include open and closed questions, encouragers, paraphrasing, reflection of feelings, and summarization. To these skills, he added nonverbal attending patterns of appropriate eye contact, body language, the tone of voice, speech rate, physical space, and time. He believed these skills are attending skills and are most helpful in the early phase of counseling. To assist in insight and motivating clients to action, social influencing skills, confrontation, focusing, and self-disclosure skills are required.

Microskills hierarchy:

1. Attending behavior
2. Client observation skills
3. Open and closed questions
4. Encourage, paraphrase, summarize
5. Reflection of feeling
6. Reflection of meaning
7. Focusing
8. Influencing skills
9. Confrontation
10. Skill sequencing and structuring the interview
11. Skill integration

Social influencing skills are: intended to motivate the client to change. Social skills include 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 a choice and directs attention and discussion to relevant client areas (problems). Ivey (1994) suggested the counselor is to first focus on the client and then to focus on the problem. When counseling from a multicultural theory, Ivey indicated focus should achieve a balance between the individual, family, and multicultural issues. The final skill area is self-disclosure, a focus on oneself (counselor). This personal sharing can deepen the relationship and provide the opportunity for insight.

Applications: professionals and paraprofessionals, patients, inpatients, parents, couples, children, public offenders

Interpersonal Process Recall (IPR)

Norman Kagan (1984), using a film-based model of video or audio-taped interviews, had 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 interpersonal process recall (IPR):

1. Facilitating communication—learning skills of effective counselors

   a. Respond to clients with exploratory questions and behave so as to encourage the client to explore further.
   b. Listen intently and compassionately to the client.
   c. Focus on the client's affect and attend to the client themes that are subtly communicated.
   d. Be frank, honest, and gentle.

2. Affect Simulation—overcome fears of interpersonal involvement
3. Counselor recall—video, stop tape where you remember feelings and thoughts, then elaborate

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4. Inquirer training—student learns inquirer role of respectful probing

5. Client recall—the client views or listens to a tape and responds to the inquirer regarding interview

6. Mutual recall—both counselor and client participate with the inquirer

7. Transfer of learning

Applications: mental health workers, teachers, physicians, nurses, correctional officers, military personnel

Human Resources Development Model (HRDM)

Robert Carkhuff (1987) developed a listening and responding communication model based upon the work of Carl Rogers and B. F. Skinner. The central components of his skills design are the core conditions of helping. The following is an overview intended to elicit a working knowledge of the core conditions of the model. Carl Rogers and Robert Carkhuff both rejected the notion of making humanity average, instead preferring that people grow. Also, 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 thought that Rogers did not go past insight. The model is based on 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 (person-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 essential 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 on the other person in the relationship is critical (Gendlin, 1984).

The core conditions were the main components of the communication, and Carkhuff believed they were most effective when applied at certain stages of the model. The core conditions, in order, were respect, concreteness, empathy, genuineness, immediacy, self-disclosure, and confrontation. Respect, concreteness, empathy and genuineness were most effective during stages one and two while immediacy, self-disclosure, and confrontation were most effective in stages three and four.

Skinner's reinforcement schedules were critical to the action stage of the model. Also, reinforcement is shown:

a. as the therapist attends to the client during early stages

b. during exploration when the therapist gives accurate responses

c. 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 the helpee involves (involvement)

2. Responding (helper responds with content/ feeling /meaning) and the helpee uses (exploration)

3. Personalizing (helper personalizes) and the helpee understands (understanding)

4. Initiation (helper initiates) and the 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 worldview (Hackney & Cormier, 1996).

GENUINENESS: Genuineness is a reference to being real. Genuineness 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) described 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 and understand what the client is experiencing (thinking and feeling) and to convey this in such a way the client can sense this understanding. The process is listening, understanding, communicating an awareness, know-how, and assertiveness.

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 the 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 the relationship, and the latter is "here and now."

SELF-DISCLOSURE: Self-disclosure is 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 used minimally during the 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 to change. The technique of confrontation works well when there are discrepancies between actions-thoughts, feelings-thoughts, and feelings-actions. Confrontation should be utilized when the relationship is strong enough to sustain this type of communication.

Question 5-34:

Which one of the counselor responses is an example of empathy?

Client: I am so tired of his nagging and telling me I am a selfish person. It makes me so upset when he compares me to women he says are more mature.

Counselor: You _____

a. don't know what to make of this statement. You are not those other women.
b. think he is so angry and comparing you to other women is unfair.
c. are distraught with how he views you in the negative.
d. cannot figure out how he can be so down on you.

Answer: c. are distraught with how he views you in the negative. An empathic response includes an accurate reflection of the feeling (distraught) and content (negative view). Rogers believed the core conditions are ATTITUDES, while Carkhuff believed they are SKILLS. Carkhuff believed Rogers' system was unidirectional, that is, the counselor was limited from being himself/herself and was not able to impact the client. Also, he allowed clients to talk about their feelings rather than express them to the counselor.

The counselor provides encouragement, support, warmth, challenge, and confrontation in ways that empower the client to make changes consistent with the client's values and goals. Some theoretical orientations see the relationship between client and counselor as the essential process that produces change (Prochaska, 1979). This relationship, built on self-disclosing communications, can be conceptualized by the Johari Awareness Model. The Johari Awareness Model examines the dynamics of communication.

It divides communication regarding an individual into four quadrants involving knowledge of behavior, feelings, and motivation (Hanson, Stevic, & Warner, 1986).

Quadrant 1 is the open quadrant that contains material about the self that is known to both the client and the person with whom he/she interacts. The client openly communicates this material to the counselor.

Quadrant 2 is the blind quadrant that contains material about the self that is known by others but is not recognized by the person. This is information the counselor picks up that the client did not intend or realize he/she communicated.

Quadrant 3 is the hidden quadrant containing material about the self that the person is aware of but is not known to people with whom he/she interacts. The client is consciously aware of this information but does not share it.

Quadrant 4 is the unknown quadrant that contains material about the self that is out of the awareness of both the client and the counselor.

The process of counseling involves increasing the area of Quadrant 1 while decreasing the areas in the other three quadrants (Hansen, Stevic, & Warner, 1986).

The Johari Window is a picture of change process and another way to view the process. The ultimate purpose of counseling is to help the client achieve some 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 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 pursue his/her goals autonomously. Effective communication is essential to manage the process effectively. 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 communicate effectively, to understand the message, and in return be understood by the client. Verbal and nonverbal skills are elements in the sequential stages in the counseling process.

Verbal

The counselor communicates via several skills found in most communication-skills-training programs. Some of these are:

1. Attending and understanding skills such as reflection, clarification, paraphrasing, interpretation, and summary. These skills are means to assure the client can know that he/she is conveying correctly what he/she wants to say and that the listener accurately hears.

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 indicated that minimal encouragers could 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?" and "What year are we talking about?" yield specific answers, while open-ended questions tend to allow the person to bring about specificity. Examples of open-

ended questions are "What sort of things brought you to this point?" and "How do you see yourself as a bad parent?" Open-ended questions allow the client to start where he/she wants and to share at the depth he/she is comfortable.

Nonverbal

Nonverbal communication is that part of communication which is conveyed through expressions of the face, body posture, and physical movements. Paralanguage, kinesis, and proxemics, along with the verbal message, contribute to the understanding of a complete message.

a. Paralanguage is the study of extra-linguistic features of speech, voice tone, voice quality, and pacing (voice set). A comprehensive study of voice tone would include the emotional significance, artificially produced tones, deception in tone, and the paralinguistic importance in a clinical setting (Weitz, 1979).

b. Proxemics is the use of space and the study of human factors and includes territoriality, crowding, and cultural differences.

c. Kinesis is the "study of observable, isolable, and meaningful movement in interpersonal communication" (Leathers, 1976). Significant body movements tend to be the entire head, face, neck, trunk, shoulder-arm-wrist-hand, and hip-joint-leg-ankle, foot. Each of the eight areas is divided into individual parts as well as integrated for understanding.

Question 5-35:
The study of nonverbal behavior that relates to the personal space in which an individual feels comfortable speaking to others is called:

a. paralanguage.

b. kinesis.

c. proxemics.

d. synergetic

Answer: c. proxemics.

Motivational Interview

According to Chanut, Brown, and Dongier (2005) the four basic principles of motivational interview (MI) are to express empathy, develop discrepancy, support self-efficacy, and roll with the resistance. This type of interview is designed to assess the ambivalence many clients come into treatment with regarding change and what it will cost them to make a change. Cost is defined as behaviors the client must give up, to encounter from others, and to manage self-discipline and accountability in order to change. Motivational interviewing is a popular form of interviewing in the addiction field (substances, diet, exercise, gambling, etc.) as well as other behavior problems. Motivational interviewing focuses on the goals of the client to increase internal motivation through exploring and resolving ambivalence about a change (Miller & Rollnick, 2002). Two important terms within motivational interviewing are ambivalence and resistance. One way to deal with resistance is rolling with resistance. Some examples of rolling resistance are to state reasons to change and reasons not to change in the same sentence (double sided

reflection) and state reasons to change so the client takes the opposite stance and hopefully makes a commitment to change.

Strategies for implementing motivational interviewing is through the utilization of (O) open-ended questions, (A) affirming the client's self-efficacy and support, (R) reflections, and (S) summaries (complex reflections, organize resolving ambivalence, promote change). The acronym is OARS.

Prochaska's six stages of readiness for change can be utilized to manage the ambivalence. The Motivational Interviewing Treatment Integrity Code (MITIC), an instrument in research developed by Moyers, Martin, Manuel, and Miller (2003), codes the interview for competencies in pausing utterances, giving information, open/closed questions, reflections, affirming, emphasizing control, support, advising, confronting, directing, and empathy. Prochaska's six stages of readiness for change are precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska, DiClemente, & Norcross, 1992).

Question 5-36:
Discrepancy is one of the four guiding principles for effective interviewing and treatment. The counselor attempts to develop discrepancy through?

    a. increased cognitive-dissonance.

    b. confrontation.

    c. past behaviors.

    d. narratives.

Answer: a. increased cognitive dissonance. To increase cognitive dissonance is to examine this discrepancy between the client's present behavior and core values.

Question 5-37:
Motivational interviewing rolls with resistance and does not confront the client. A technique that MI interviewers use to roll resistance and to avoid an argument is?

    a. empathy.

    b. support self-efficacy.

    c. ignore the resistance.

    d. reflective listening.

Answer: d. reflective listening. MI does not view resistance as a client characteristic rather as the health of the collaborative relationship and therapeutic rapport between the client and counselor.

Question 5-38:
All are strategies to roll with resistance when the intervention suggested by the counselor is incompatible with the client's level of recognition except to:

    a. avoid recommending change and advocate for the client to recommend a change.

    b. negotiate with the client to identify a first target to change among several targets.

    c. recognize that motivation to change is permanent.

    d. state reasons to change and not to change in the same sentence.

Answer: c. recognize that motivation to change is permanent. MI believes that motivation to change is not stable rather modifiable and in a stage of fluctuation.

In addition to motivational interviews, three additional types of communication methods to obtain valuable diagnostic information are unstructured, structured, and semi-structured. In most cases, either a structured or semi-structured interview is preferred. However, an unstructured interview can be very effective, because it requires a professional who is highly skilled in communication, confident, empathic, and able to create an atmosphere of trust wherein the client is most likely to share personal information and feelings.

Example of Unstructured Interview to Elicit Behaviors

When the interviewer suspects a personality issue, say the client is behaving or expressing pathologically narcissistic features and avoiding responsibility for a failed marriage, the counselor might ask open-ended questions about the client's family and other matters that are important to him, follow up with more specific questions, pay attention to the counselor's "counter-transference feelings," and wait until there is an opportunity to confront gently.

Q. "Tell me about your relationship with 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 aleck 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. "What was it that 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 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 appropriate in certain circumstances to use a structured interview to assess specific issues, including those that 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) recommended 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 center of attention?"

Lanyon and Goodson (1982) recommended 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 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 on 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 that contribute to understanding the client's symptoms. In all interviews, it is of primary importance to focus on the chief complaint and presenting illness while determining if the client's symptoms are severe enough to cause an impairment or dysfunction that incapacitates the client's interactions in social, interpersonal, occupational, or academic environments. A thorough 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 some data gathering interviews. Day (2004) considered conceptualization of a case as a theory of the person. Three methods or models to categorize and organize information that explains the past, current and future behavior are the inverted pyramid (Schwitzer, 1996), analytical thinking, Stevens and Morris (1995), and Linchpin (Bergner, 1998). Specific case conceptualizations are available for individual therapies such as cognitive behavioral.

There are specific intake interviews and questions for specific therapies such as solution-focused. Examples of solution-focused questions are what brought you here, how can I help, the miracle question, relationship questions, exception questions, scaling questions, and is there anything else? Each of these may have secondary or more detailed questions to accompany the first question for expansion. One example is the scaling question with four or five subquestions with responses ranked on a scale of 1-10 (where are you now? confidence scale, motivation scale, risk scale and resiliency scale).

OBJECTIVE 5H: TREATMENT/INTERVENTION

Objective 5h: developmentally relevant counseling treatment or intervention plan (CACREP, 2015, p. 12)

The treatment plan includes the goals or objectives to meet the client's symptoms and identified problem. A treatment plan is organized to describe:

1. Overall-global plan
   a. how the needs and problems contained in the diagnostic summary are to be met (theory, techniques)
   b. what the counselor plans to do to help the client meet the needs and problems (action plan)
   c. reflect the client's motivation (willingness) to carry out the treatment
   d. what is to take place after an analysis of the current problem
2. Theory of choice
   a. specific techniques matched with symptoms for reduction or increase
   b. time-line
   c. monitoring process

OBJECTIVE 5 I: MEASURABLE OUTCOMES

Objective 5 i. development of measurable outcomes for clients (CACREP, 2015, p. 12)

Effectiveness of Counseling

The ACA 2014 Code of Ethics reminds counselors to continually make concerted efforts to improve in areas of client care and personal development. Specifically Section C.2.d. refers to monitoring effectiveness and efficacy through peer supervision and research. Also, with the advent of distance counseling Section H.4.d. (effectiveness of services) if it is deemed to be ineffective, that face-to-face services are delivered. If face-to-face counseling is not possible then assisting the client in identifying a service is recommended.

There have been many studies related to the outcome of therapy. More information on efficacy studies is to be found in the professional counseling and ethical practice unit. Outcome research is the term most frequently applied to the investigation of the impact of counseling on clients, that is, on those practices and activities. Eysenck (1966) found that adults and children treated by professional counselors and therapists did not improve, on the average, any more than untreated people in control groups. 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 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 the transfer of training in 50% of the cases and are more cost-efficient than traditional therapies (Goldstein, 1981).

Nugent (1994), reported on meta-analysis research, summarized studies of Smith, Glass, and Miller (1980) and found an 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 to 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 suggested 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 (1996) cited 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 (Anderson & Lambert, 2001; Lambert & Cattani-Thompson, 1996). Anderson and Lambert (2001) reported that the median number of 11 sessions was required for the clinically significant change to occur. In evaluating the literature on outcome effectiveness, Corey (2012, 2016) cautioned against drawing hasty conclusions. He pointed 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 regarding 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, & Whipple, 1975). Bohart (2000) reported that the client is the most important common factor.

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 interpersonal psychotherapy.

OBJECTIVE 5 J: EVIDENCE-BASED PRACTICE

Objective 5 j. evidence-based counseling strategies and techniques for prevention and intervention (CACREP, 2015, p. 12)

Sexton (1999) isolated two broad domains in which counseling effectiveness has research support. The two specific areas are clinical models and the counselor. His definitive statement is that there is no "best" theoretical approach. The research points in the direction of "common factors" that drive effective counseling. Lambert (1991) stated that approximately 30% of client 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 (effective 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 ability to relate (a match with the client). It is also crucial that counselors have the ability to assess the problem (Sexton, 1999).

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 is 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 in 80% of studies (Norcross, 2004, p.1).
   a. Clients with high resistance benefit from self-control methods, minimal therapist directiveness, and paradoxical interventions.
   b. Clients with low resistance benefit more from therapist directiveness and explicit guidance.
2. Impairment is the severity of the client's subjective distress and reduced functioning (Section F.5.b.).
   a. Clients manifesting impairment in two or more areas of functioning are likely to benefit from treatment that is lengthier and from psychoactive medication.
   b. Clients who have little social support from other people are also likely to benefit from lengthier therapy and development of social support outside of therapy.
3. Coping style
   a. Internalizing clients tend to benefit from interpersonal and insight-oriented therapies.
   b. Externalizing clients tend to benefit from symptom-focused and skill-building therapies.

4. Stages of change (precontemplation, contemplation, preparation, action, and maintenance

    a. Cognitive-affective in the precontemplative and contemplative stages

    b. Behavioral in action and maintenance

5. Personality: Anaclitic (relatedness)/sociotropic and introjective (integrated identity)/autonomous styles

    a. Anaclitic/sociotropic clients tend to benefit from therapies that offer closer interaction and personal interactions

    b. Introjective/autonomous clients tend to do better in therapies that offer separation and autonomy.

6. Assimilation of problematic experiences

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

OBJECTIVE 5K: COMMUNITY-BASED RESOURCES

Objective 5k. strategies to promote client understanding of and access to a variety of community-based resources (CACREP, 2015, p. 12)

Community resources can be a referral or information about Web listings for assistance.

1. American Association of Suicidology http://www.suicidology.org/web/guest/home

2. American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/PracticePDFs/SuicidalBehavior_Inactivated_04–16–09.pdf

3. American Foundation for Suicide Prevention (AFSP) http://www.afsp.org/

4. International Association for Suicide Prevention:
   IASP Guidelines for Suicide Prevention www.med.uio.no/iasp/english/guidelines.html

5. National Suicide Prevention Resource Center
   http://www.edc.org/projects/national_suicide_prevention_resource_center

6. Risk Management Foundation Harvard Medical Institutions http://www.rmf.harvard.edu/files/documents/suicideAs.pdf

7. Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
   http://store.samhsa.gov/product/SMA09–4432

8. Suicide Awareness Voices of Education
   http://www.save.org

9. Suicide Prevention International
   http://www.suicidepreventioninternational.org/

10. Suicide Prevention Resource Center
    http://www.sprc.org/

11. WHO Suicide Prevention
    http://www.who.int/mental_health/prevention/suicide/suicideprevent/en

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). NVOAD is made up of the American Red Cross and The National Organization for Victims Assistance, (NOVA). Several national disasters have taken place recently, such as tornadoes, fires, floods, tsunami, earthquakes, bombings, and other catastrophic incidents where many individuals are involved in a trauma event.

OBJECTIVE 5L: SUICIDE PREVENTION MODELS

Objective 5l. suicide prevention models and strategies and 7c. (CACREP, 2015, p. 12)

Major ethical issues when working with a client's suicidal and self-injurious behaviors are confidentiality, foreseeable harm, informed consent, and in developing a safety plan. The 'no suicide contract' raised major ethical concerns such as the potential for coercion for the protection of the provider and restricting a service user's choice. A proactive and collaborative approach is the development of a safety plan. A safety plan includes a list of coping strategies, sources of support, and help-seeking behaviors to lower the risk of suicide. The first step is to assist the client in triggers or cues that signal a suicide crisis. Step two is to identify coping strategies to prevent or avert the development of a suicidal crisis. Step three is to determine what access the client has to lethal means (specific plan and if available to eliminate the access).

Treatment:

Lester (2005) identified eight major tactics for preventing suicide: (1) psychiatric treatment with medication (antidepressants), (2) psychotherapy (CBT, DBT, visualization of alternative solutions, correct overestimation, problem-solving), (3) routine handling at emergency rooms, (4) crisis intervention at specialized suicide prevention centers, (5) educating physicians on the detection and treatment of depression, (6) preventing access to lethal methods for suicide, (7) school education programs, and (8) therapy and support groups for survivors (p. 32).

Winter, Bradshaw, Bunn, and Wellsted (2013) conducted a systematic review of published treatment articles for reducing suicide with the majority of studies from the United States and the United Kingdom. A total of 67 meta-analysis reviews and 17 qualitative synthesis studies were reviewed. Findings concluded that dialectical behavior therapy, cognitive-behavioral therapy, and problem-solving therapy met evidence for effectiveness.

Blumenthal and Kupfer (1986) suggested five components 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. Stanley and Brown (2012), McMyler and Pryimachuk (2008) recommended a safety plan. The safety plan for brief interventions is intended to assist the client in identifying warning signs for distress, coping skills, social supports, clinical resources, and ways to restrict access to lethal means.

Suicide training:

Two intervention training programs for counselors, teachers and those working with youth are the Applied Intervention Skills Training (ASIST; Shannonhouse, Lin, Shaw, & Porter, 2017) and the Gatekeeper training (Wyman et al., 2008). The ASIST is an empirically supported intervention program (Lang et al., 2013) focusing on increasing comfort, competence, and confidence about responding to that individual considering or have engaged in suicide attempts. Training consists of self-perceived attitudes toward suicide, self-perceived knowledge about suicide, self-perceived comfort, competence, and confidence in responding (p. 5).

Psychosocial treatment:

According to Goldston et al. (1999) adolescents are most at risk shortly after hospital discharge. Thus, early intervention is recommended.

Glenn, Franklin, and Nock (2015) conducted an evaluation of 29 random control trial (RCT) self injurious thoughts and behaviors (SITB) in youths effectiveness studies. The research evaluation included a 5-level research methodology developed by Chambless and Holon (1998) used to determine the level of effectiveness.

Treatments reviewed for effectiveness include CBT, CBT-Individual plus BCT-Family, CBT-Individual plus CBT-Family plus Parent Training, CBT skills-Group, DBT, DBT-Group only, Family-Based Therapy, FBT-Attachment, FBT-Parent Training, FBT-Ecological, FBT Problem Focused, FBT-Emergency only, Interpersonal Psychotherapy (IPT-Individual), Psychodynamic Therapy-Individual plus family, and Combined Skills Group Intervention.

Results: Cognitive behavioral therapy (CBT), FBT, IPT, and a fourth psychodynamic therapy appeared to offer treatment plans that were considered effective. None of the treatment modalities met criteria for Level 1, Well-established.

Level 2: Probably efficacious include CBT-Individual + CBT-Family + Parent Training, FBT-Parent training only for SITB, FBT-Attachment for thoughts of suicide ideation (SI,) IPT-Individual for SI, and Psychodynamic Therapy-Individual + Family for deliberate self-harm, self (DSH), or para-suicide.

Level 3: Possibly efficacious include FBT-Ecological for suicide attempts (SA)

In summary, CBT, FBT, IPT, and psychodynamic therapy found common elements to be relationship or interpersonal functioning, emotion regulation, problem-solving, or interpersonal effectiveness skills. Whisenhunt, Stargell, and Perjessy (2016) cited David Klonsky's research to point out that emotion regulation was the single most common goal or target symptom for treatment.

The Pieta House Suicide Intervention Model (PH-SIM) created by Joan Freeman in Dublin, Ireland, approached prevention utilizing protective factors for change designed to increase in positive and decrease in negative outlooks, and engage in therapy resulting in moving away from a negative outlook with a desire to die and toward a positive outlook and desire to live

Protective factors are considered buffers for taking one's life. The protective factors include physical needs, emotional needs, and aspirational needs across the factors of health, work/school, hobby,

relationships, family, friends, spirituality, giving back, and self-improvement. The model for a healthy lifestyle includes nine factors involving emotional needs connecting with family and friends and aspirational needs to progress from viewing their lives in dying to living and contributing to society through a spiritual review (Surgenor, 2015; Surgenor, Freeman, & O'Connor, 2015). The treatment utilizes CBT, DBT, and problem-solving strategies.

Question: 5-39:

All of the following treatment modalities for children and adolescents met 'probably efficacious' treatments for self-injurious thoughts and behaviors (SITBs) except:

    a. interpersonal psychological therapy.

    b. cognitive behavioral therapy.

    c. dialectic behavior therapy.

    d. family-based therapy.

Answer: c. dialectic behavior therapy. There were no effective treatments at this time for children and adolescents in the literature. DBT has support for adults.

Question: 5-40:

To ensure that counselors may hospitalize a client with suicide ideation and those who have attempted suicide, without securing the cooperation of other mental health providers, counselors need access to what commitment document?

    a. 1050.

    b. 1032.

    c. 1013.

    d. 1000.

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

OBJECTIVE 5M
Crisis/Trauma Intervention/Psychological First Aid

Objective 5 m. crisis intervention, trauma-informed, and community-based strategies, such as psychological first-aid (CACREP, 2015, p. 12)

In recent years there have been some crises with a sufficient magnitude of trauma and death such as 9-11, hurricanes Katrina and Sandy, bombings and some sweeping fires and tornadoes causing deaths, emotional and financial trauma. Countless numbers of tragedies stemming from fire, water, the wind, and earthquakes have called for major responses from the federal and state governments and local safety personnel. Also, first responders and debriefing counselors are deployed to sites in which major disasters have taken place. Responses to victims of these disasters first gained attention with the Coconut Grove fire. The Coconut Grove fire is the critical point at which Dr. Lindeman observed that many of the survivors of the fire had similar emotional responses and needs (Lindeman, 1944). 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 later applied to crisis theory. These stages of grief included 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.

Gerald Caplan was involved with the survivors and is credited with shaping crisis theory. He described a crisis as when a person experiences an event that is greater than the usual problem-solving methods. He proposed that this was a time of disorganization where several attempts are made to solve or respond to the situation. Parad and Caplan (1960) identified five elements of a crisis for a family. These five are:

1. A problem is encountered in which the solution is considered insolvable.
2. The problem over-taxes the psychological resources.
3. The problem or situation is viewed as a threat or danger to life goals.
4. The crisis mounts to a peak and then falls.
5. Crisis awakens the past and present unresolved key problems.

A crisis is an 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, 1997). James and Gilliland (2001, 2016) described six different authors' definitions of crisis. A summary of those definitions described a crisis as "a perception or experiencing 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 (2002) defined 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 social and work environment should be mobilized so that the client can continue coping, apart from the therapist (Moursund, 1985). An acute crisis is considered to last no more than six to eight weeks (Janosik, 1984). A final crisis definition by Cavaiola and Colford (2006) is a "predictable or unpredictable life event that an individual perceives stressful to the extent that normal coping mechanisms are insufficient" (p. 3).

Three Levels of Crisis

Situational: A sudden change in the environment involving the loss of a loved one, loss of finances, job, and home.

Intrapsychic: A conflict between the ego and superego and a crisis that challenges the deepest values.

Disintegration of the ego: A psychosis, ego-fragmenting drug crisis induced by a hallucinogenic drug.

Two-Levels of Crisis: Collins and Collins (2005) suggested two levels of crisis, that of situational and developmental.

Situational: When there is an apparent 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 unable to function adaptively in response to expected stressors and potential conflicts" (Collins & Collins, 2005, p. 7).

Aguilera and Messick (1982) viewed a crisis as a time of danger and opportunity. Individuals tend to react in one of three ways. Depending on 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 harmful effect and revisit elements of the crisis at different times of his or her life. The third group of individuals psychologically are at the mercy of the crisis and appear incapable of moving forward without assistance (James & Gilliland, 2001, 2016).

Crisis Theory

It is important for counselors to understand crisis theory so that they do not 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 a crisis. The counselor should respond to the client within the first 24 hours of the crisis. Treatment should be relatively direct and short (three to six sessions) with emphasis on direct problem-solving skills (Moursund, 1985). The goal is to help the client regain his/her previous level of functioning. According to Brammer (1985), crisis theory has three components: normal development crises, situational crises, and existential crises. James and Gilliland (2001) added a fourth: environmental crises.

A normal developmental crisis occurs in the normal developmental aspects of human growth and development. Examples given by James and Gilliland might be a birth, graduation, and retirement. Situational crises are typically unforeseen events such as an assault, illness, breaking and entering of one's domicile, and being fired. Existential crises can be identity confusion during the adolescent years and at other times a loss of meaning in life. Environmental crises are natural or human-caused, which affects all members of a community or nation. These can be disasters or fears of an impending disaster, such as another Washington sniper, 9/11, and another outbreak of anthrax mailing.

Gilliland and James (2001) provided an outline of steps in working with a client in crisis. This outline is to:

a. define the problem
b. ensure client safety
c. provide support
d. examine alternatives
e. make plans
f. obtain a commitment from the client

Crisis Theory Models

There are some crisis theories such as psychoanalytic, systems, adaptation, interpersonal, chaos, and, another by James and Gilliland (2001, 2016), 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 going through a crisis is in a state of disequilibrium in which his/her usual problem-solving skills and coping skills are failing to work. This model appears to be most appropriate for early intervention. The goal of crisis counseling is to restore the pre-crisis equilibrium (Gilliland & James, 1988; James & Gilliland, 2001).

Cognitive Crises: Cognitive crises are based on faulty thinking and cognitive distortions concerning the events or the situations involved. The goal is to help the client become aware of these distortions and adopt more adaptive ways of thinking and acting (Gilliland & James, 1988; James & Gilliland, 2001). This model is most appropriate for the time after the crisis.

Psychosocial Transition: The client is a product of his or her heredity and environment (genes-learning). The goal of counseling is to assess both internal and external difficulties contributing to the crisis, determine workable alternatives to current behaviors, and utilize environmental resources (Gilliland & James, 1997; Gilliland & James, 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 the greatest pressure is at the moment, and what is the expected solution. 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. Resources include situational support (i.e., significant people, work, activities, and finances) as well as personal coping skills (i.e., positive and constructive thinking patterns, verbal skills, psychological health).

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 client's safety 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. 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 negative 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. Past solutions 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 of planning revolves around control and autonomy in the hands of 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 agreement should emphasize what the client can do (referred to as response-ability).

Types of Crises

There are many kinds of crises or traumas. The intensity and destruction of crises will vary from war, hurricane, floods, fires, to an individual teenager's thoughts of being pregnant, suicide ideation and attempt, to an adult who because of an impending divorce feels can no longer respond to the situation or continue with life. Shallcross (2013) pointed out the need for first responders to receive resiliency training, learn how people experience stress and to work with an experienced crisis team. It is also important to realize that those first responders can also experience the trauma as a part of working in the disaster environment.

The crisis in context theory composed of the microsystem, mesosystem, exosystem, macrosystem and chronosystem is a necessary foundation of the work of Bronfenbrenner's (1994, 1995). The three crises principles include the individual, system, and community and each in proximity layers to one another (Myers & Moore, 2006). Also, the three premises are layers of a crisis, reciprocal effect, and time factors.

> Individuals and systems experience the impact of crises in layers. The layers are dependent on two elements: (a) physical proximity to the disaster on physical distance and (b) reactions that are moderated by the perceptions and meanings attributed to the crisis event (p. 141).

> An understanding of the impact of crises is to consider that a mutual effect occurs among individuals and systems affected by the event. Understanding the reciprocal effect involves recognition of two elements: (a) the interactions among the primary and secondary relationships and (b) the degree of change triggered by an event.

> Time directly influences the impact of crises. Two elements of time are (a) the amount of time that has passed since the event and (b) special occasions such as anniversary dates and holidays following the event (pp. 141-143).

The resulting meaning of the three premises is to recognize that the level of crises, reciprocal effect, and time factor provide the impact of a crisis. The result is not to predict the severity rather isolate the factors for response and to identify needs for further counseling or intervention.

Rape and Sexual Assaults

The literature suggests that rape and sexual assault are used interchangeably (Collins & Collins, 2005). Rape may be date rape, gang 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 some other types of rape and respective definitions. A rape victim is unlike other victims, but a person who has suffered a unique trauma. Post-counseling is divided into three periods: hours after, weeks after,

and long-range. Provide the assaulted victim with objective information about what to expect from police, examination, and family.

Psychological First Aid During and Post-Disaster

Recovery and coping after a disaster is a process of meaning-making (Pak, 2016). The meaning-making model is a two-level framework, global and situational. Global involves a person's sense of meaning and purpose in the world and is the individual's beliefs and their ranking of goals and values. Situational meaning is global for a particular situation and the influences involving the interpretation and reactions to that situation. The person experiencing the disaster appraises the situation in terms of understanding why the event took place. A second step is to determine the extent that meaning is congruent with their global view to include their goals (reality). Research points to the fact that individuals who have high levels of belief in their ability to cope with a disaster experienced lower levels of distress. Purpose in life is correlated with post-disaster resilience (Feder et al., 2013) as well as religiousness and spirituality (Ali, Farooq, Bhatti, & Kuroiwa, 2012).

Responses may be different if the responder is present at or immediately after the disaster or if the first aid is post disaster. The 2000 Disaster Mental Health Handbook has a detailed set of offering and guidelines that includes types of disasters, normal reactive processes, stressors, risk factors, mental health outcomes (acute stress disorder, PTSD, depression, bereavement, health outcomes, and natural versus human-made responses) and special populations (NSW Health, 2000). The psychological responder is to be conscious of safety needs and is capable of reassuring responses, counseling for assessment, and aware of mental health complications that are associated with a loss such as acute stress reaction and PTSD. The manual suggests techniques that have been helpful for different mental health conditions.

Singh and Raphael (1981) suggested that practical help is more helpful than psychological care. Although the role of first responders is to assist in establishing safety, food, and water, and accommodations, psychological first aid is vital. Psychological care or first aid is the social provision of physical care dealing with the fear and loss of family members, belongings, sense of stability, and the future.

Immediate responses to a disaster include psychological first aid, provision of information, triage, debriefing, supportive counseling, and convergence.

Psychological first aid offers support, reassurance, comfort, and calm communication and a physical presence. Providing emotional well-being through psychological first aid includes basic human responses of comforting and consoling. Raphael (1993) likened these tasks as conveying compassion and recognition for what the victims have gone through and presently experiencing. The Disaster Mental Health Handbook includes the following psychological first aid recommendations:

a. protecting the person from further threat or distress as is possible

b. furnishing immediate care for physical necessities, including shelter

c. providing goal orientation and support for specific reality-based tasks

d. facilitating reunion with loved ones from whom the individual has been separated

e. sharing the experience

f. linking the person to systems of support and sources of help that will be ongoing

g. facilitating the beginning of a sense of mastery.

OBJECTIVE 5N: PERSONAL MODEL OF COUNSELING

Objective 5 n. processes for aiding students in developing a personal model of counseling (CACREP, 2015, p. 12)

Fitzpatrick, Kovalak and Weaver (2010) suggested that influencing factors account for the trainee's development of a personal theory or model of practice.   Fitzpatrick, Kovalak, and Weaver (2010) researched how trainees developed a theory of practice with an initial idea of developing a single theory. Research reveals that most trainees identified with eclecticism or combining two or more theories.

Developing a theoretical orientation is difficult. Historical studies focused on personal philosophy in early development, cultural experiences, family, personal characteristics (values), supervisors or mentors, the particular culture of a training program with an identity training in a theoretical orientation (Adlerian/Play), and eventually a research-based effective theory. The same study revealed that the process of tentative identification with a particular theory for best client care was influenced by professionals and personal factors. A second core factor was a reaction to reading for a deeper understanding of theories. The third core factor was practice with a theory-based intervention reinforcing the ability to apply theory. The fourth core influence was to question if the theory fits with the trainee. The fit involved reflections and aspirations. The fifth core was supervision.

In summary, the Process Model of Tentative Identifications identified five influences for a personal model of counseling to include: (a) tentative identification with a theory, (b) reading, (c) personal philosophy, (d) practice, and (e) supervision. Fitzpatrick et al. (2010) found the influences from this study supported trainee influences from earlier studies (Bitar, Bean & Bermudez, 2007; Boswell, Castonguary & Pincus, 2009; Castonguay, 2006; Oteiza, 2010).

The relational-cultural theory (RCT) is a human development model and outgrowth of the work in the 1970s of Jean-Baker Miller and associates at the Stone Center (Jordan, 2010). The RCT model focuses on growth-fostering relationships and deepening connections with others rather than separation and individuation. The center point of growth is self and identified as a self-in-relation model (Duffey & Trepal, 2016). Growth takes place in how people respond to relational and cultural adversity and the impact of chronic loss and disconnections.

Disconnection is a relational paradox occurring out of experienced disagreements, misunderstandings, and conflicts in relationships as a form of safety. The emotional distance reduces growth producing connections resulting in loss and isolation.

The implications for counselors and clients is that human development across the lifespan evolves from a self-in-relational model consisting of five good things. Each of the five good things increases in complexity and capacity for mutual relationships.   The five good things include zest, empowerment, clarity, self-worth, and connection (Miller, 1986). Neuroscience through brain imaging traces this linkage for personal connections (Banks, 2015).

Family Systems Perspective

Objective 5a. theories and models of counseling and objective 5 b. a systems approach to conceptualizing clients

Many family therapists utilize systems theory with families. A system's approach operationalizes the family members influencing one another. The family is in constant change, and as a result, any change with another family member influences change with other members and the family as a whole. Based on the concept of a healthy family that is open and self-regulating it can reconstitute itself using negative and positive feedback loops to balance. It is important to recognize the characteristics of a healthy family because it makes it easier to assess when a family is dysfunctional. According to Krysan, Moore, and Zill (1990) characteristics of a healthy family include; a) commitment to the family and its individuals, b) appreciation for each other, c) willingness and desire to spend time together, d) effective communication patterns, e) high degree of religious/spiritual orientation, f) ability to deal with crisis in a positive manner, g) encouragement of individuals, and h) clear roles.

This overview of family counseling summarizes some important developments, influences, and contributors in the field of family therapy. Historically, family counseling has several notable figures and contributions. Such contributors include Sigmund Freud in his writings and subsequent consultation with the father of Little Hans, Moreno's group work in psychodrama, exhaustive research in roles in families with schizophrenic members, and general systems theory first developed by Ludwig von Bertalanffy (Bertalanffy, 1968; Goldenberg & Goldenberg, 1991). The family as a social system derived from marriage counseling, psychiatry, and research on schizophrenia (Brown & Christensen, 1999).

An accepted definition of 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 the family offered by Murdock (2012, 2017) is: "A 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, born of or adopted, of the sexual 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

The second definition by Schulz (1976) pictured 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) described 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, 2007, 2015) stated: "functional families follow the rules and are flexible in meeting the demands placed upon them by family members and outside agencies" (p. 399). Family systems counselors stress how a change in one member's functioning affects all other family members as well as the family as a whole (Gladding, 2007, 2015).

Peterson and Nisenholz (1995) viewed 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 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, counseling some and referring the remaining members, and whether or not a gender-specific counselor is the better choice. Some issues which surface, each with entanglements might involve 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 conflicts can be phrased as a question for this examination.

More recently feminist theory advocated that sexism and structured inequalities are not corrected through improving relationships among family members. Rather the goal is to strengthen the growth of a robust and competent woman in control of the resources and to work toward change (Libow, Raskin & Caust, 1982). A standard view is that sexism limits the psychological well-being of women and men (Enns, 1992).

Becvar and Becvar (1988) and Srebalus and Brown (2001) stressed the importance of understanding the developmental stages of a family. Counselors working with families would do well to understand social class structure and behaviors, ethnic family lifestyle 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:

a. unattached adult
b. newly married
c. childbearing
d. preschool-age child
e. school-age child
f. teenage child

g. launching center

h. middle-age adult

i. retirement

At each of these stages, one or all 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 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 of a family who are healthy have viable role models, take appropriate responsibility for family processes, have adequate resources to solve problems, have adequate inter- and intra-personal skills, have adequate judgment skills, and have systemic skills (respond to limits, that is; they are responsible, adaptable, and flexible).

Question 5-41:
In planning a treatment program for a family, a system-oriented counselor would use an intervention that focuses on:

a. linear causality

b. circular causality

c. hexagonal causality

d. member causality

Answer: b. circular causality. All members influence each other in the family.

Theoretical Perspectives in Family Counseling

Theory: According to Gladding (2007, 2015), the profession of marriage and family counseling has grown rapidly since the 1940s. In working as either a marriage or a family counselor, the helping professional must be aware of the theoretical basis of the approach being employed in the counseling process.

Psychodynamic: Nathan Ackerman is the current theorist representing psychodynamic family therapy. Psychoanalytic theory suggests that the inner lives and conflicts of family members interlock and bind together, thus creating disturbances for family members. 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 family behavior patterns. Goals of therapy may include:

a. insight

b. psychosexual maturity

c. strengthening of ego

d. functioning for a more satisfying object relationship

Interlocking pathology, a term used by Ackerman, is a term to describe how an unconscious process takes place with family members that keep them together. An inadequate separation from the mother will lead to returns to the mother-figure. Major family theorists and practitioners who work from the psychodynamic perspective are Ackerman, Framo, and Boszormenyi-Nagy. In Kernberg's object relations theory the term splitting has been used by psychodynamic therapists to explain choices that couples make and resulting in family interaction patterns. Their terms to describe the family include family identities, social roles, and role relationships (Wagner, 2008). Treatment techniques are similar to individual therapy, transference, dream analysis, confrontation, focusing on strengths, life history, and complementarity. The therapist may not have all family members present but the counselor would attempt to get them to engage in transference and to ventilate feelings (catharsis), examine cultural and family patterns, explore the unconscious, and to utilize family strengths.

Experiential Theory

The familiar family therapist is Carl Whitaker. It was his idea that each client in therapy is both patient and therapist. Families are changed as a result of their experiences. Experiences are outside our awareness (unaware of their emotions and suppress them) and gaining access is through nonverbal or symbolical means. The focus of therapy is processes and what occurs during the family session. A core strategy is to build on the absurd (half truthfulness), and treatment occurs in stages. His therapy is often referred to as the Leaning Tower of Pisa because it is unconventional and later labeled symbolic-experiential.

To the experiential family therapist, free choice and conscious self-determination are more important than conscious motivation. "Self-awareness of one's immediate existence leads to choice, responsibility, and change" (Goldenberg & Goldenberg, 1991, p. 91). The experiential family therapist is an active facilitator for growth and provides the family with new experiences. Goals of treatment include:

a. growth
b. deeper fulfillment
c. more effective communication
d. increased awareness
e. increased authenticity

Skills used to treat families are spontaneity, creativity, and the therapist's personality. Whitaker was not technique oriented rather process oriented. His process included redefining symptoms, modeling fantasy providing alternatives to real life, separating interpersonal and intrapersonal stress, utilizing interventions, augmenting despair of a family member, promoting affective confrontation, and treating children like children and not like peers (Keith & Whitaker, 1982).

Systemic Therapies

Systemic is the study of biological processes leading to increasing complexity of organization (whole). Cybernetics often is associated closely with systemic as an outgrowth and is the study of methods of communication and control that are common to living organisms. Systemic therapy is the study of the relationship of the pieces or parts of a system. Terms common to systemic therapies are boundaries,

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hierarchic, homeostasis, servomechanisms, feedback loops, and double bind communication and the identified client.

Communications: Humanistic

Virginia Satir, an experiential family therapist, has a combination of systemic theory, ego psychology, and Gestalt. Satir, a recognized family communication expert, in her communications theory, suggested that family disturbances have a cause, faulty communication. It is her belief that four problem areas constituted most of the family difficulties. The trouble areas are self-worth or self-esteem, communication patterns, rules, and contact with society (Satir, 1972). These humanistic theorists believe that interaction among members is essential to understanding dynamics and the psychological processes of any person. The therapist will concentrate on how members send messages, what they perceive other members' communications to be, and what processes of feedback and behavioral response affect the transmission and processing of messages. Satir in Conjoint Therapy suggested 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 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. 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 postulated 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 leads in role-playing a situation with actions and reactions interpreted. She will use different props to illustrate where members are regarding each other. Satir developed a technique called sculpting. Sculpting is when family members will assume certain positions that reflect how they communicate with one another. She was adept at having clients exaggerate a posture to realize a communication. The therapist is active and directive in consciousness rising. In summary, her theory has four components. These components are family member feelings of self-worth, communication abilities of the family, a system focused, and rules of the family. Satir's theory is in three stages. The first stage is to contact each family member and create trust. The second stage is chaos, a time when the family members move through their comfort zone and are challenged to open up and reveal. The third and final stage is integration, a time of closure unveiled during the chaos stage (Reiter, 2014).

Strategic Family Therapy

Strategic family therapy is a method-oriented theory for problem-solving. Strategic systems therapists pay little attention to history. The attention is toward the changes as the family develops. Jay Haley, who was influenced by Gregory Bateson (double bind theory) and Milton Erickson, believed relationships were defined by communications and power struggles. Haley thought 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. Techniques or strategies for treatment include reframing, directives, paradox, ordeals, pretend, and positioning. Haley's main terms are a family hierarchy, coalitions, and paradoxical directives (Goldenberg & Goldenberg, 1991). Important aspects are:

a. focus on power and control struggles

b. here and now communication (present)

c. communication defines nature of the relationship

d. develop a strategy for each presenting problem

e. the therapist is in control, directive, manipulative

f. relabeling dysfunctional behavior

g. stages are: social—observes family interaction, problem—information gathering, interaction—family discusses problems, and goal setting—precise problem and contract.

Haley considered paradoxical work to be one of the most powerful in his treatment. It is giving permission to the family or family members to do something. The forms of paradox are restraining, prescribing, and redefining. Restraining is to tell the family they are incapable of doing something. Prescribing is to instruct to enact a troublesome behavior in front of the therapist. Redefining is to attribute positive meaning to the symptomatic symptoms (Haley, 1976).

Family Systems Theory supports the position that family systems can be studied from structural, functional, and developmental perspectives.

Murray Bowen's theory refers to an emotional system composed of communication and need fulfillment request. It is a theory suggesting that difficulties are passed down and repeated in families if not rectified. Repeating family behaviors is more likely when family members are fused and emotionally cut off. Prochaska and Norcross (1999) interpreted 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. An undifferentiated process creates ego mass, which is interpreted as "stuckness." Bowen employed eight concepts that are interrelated and connected logically. These concepts are; 1) differentiation, 2) emotional system, 3) multigenerational transmission process, 4) nuclear family emotional system, 5) family projection process, 6) triangles, 7) sibling position, and 8) social regression. A differentiated self is the most widely known concept in his theory. To have a solid sense of self Bowen believed that the individual desires to have individual expression and fulfillment and at the same time wanting to be a part of a stable relationship. A useful concept in his family system is triangulation, which is the source of tension and conflict. The therapy focuses on emotional units through understanding mother-child symbiosis, eight interlocking concepts, and the genogram. Bowen saw himself as a coach rather than a therapist.

Denial and isolation are two forms of emotional cutoffs some clients use to cope with their unresolved attachments to parents.

Structural Family Theory

Salvador Minuchin defined family as a differentiated social system that develops identifiable transactional patterns for how, when, and to whom each member relates. This therapist is concerned with what maintains the psychopathology rather than the causes. Causes for these family issues are history and what can be changed are the contemporary factors not history. A family system will carry out its task through subsystems. That is, each person participates in some subsystems. Troubled families have rigid boundaries (enmeshed) or diffused boundaries (disengaged) and are clear, diffused, or rigid. This therapy focuses on the process of feedback between circumstances and the person involved. The coalition is an alliance between specific members of a family and a third member. Subsystems are an important aspect of Minuchin's theory that are smaller units in the system. Some examples are sibling subsystem, parental, and cross-generational. Boundaries and permeability are focal points in the therapy. These boundaries or lack of cause emotional cutoffs, lack of clarity in identity, and triangulating. The therapist joins the family with the idea of changing the family organization, so that family members experience change, are aware of alignments, triangulation, parentified child, power, and rules of a family.

Component parts are:

a. family's hierarchical organization (wholeness) and independent functioning of subsystems complementarity of functions
b. boundary permeability—too accessible or not at all (enmeshed, disengaged, clear)
c. disengagement
d. alignment, power, coalition
e. triangulation
f. family mapping
g. family pathology as a result of dysfunctional sets

Techniques used by this therapist tend to be: consciousness raising, joining, reframing, social isolation, and joining the family (accommodation, mimesis, confirmation, and tracking), marking boundaries, and blocking. Tracking is to follow the content of the family. Mimesis happens when the therapist joins in some way with the family, becomes like them, not necessarily in entirety but in specific ways such as humor or conversation. Confirmation is to use a feeling word that expresses how a family member may be feeling. Accommodation is the final way the therapist joins the family by making a personal adjustment to achieve alliance (Gladding, 2007, 2015).

Question 5-42:

A structural family therapist's task is to join the family. There are four ways to join the family. In addition to tracking, accommodating, and mimesis. What is the other method?

a. alignment
b. confirmation
c. coalition
d. complementarity

Answer: b. confirmation

Key Terms in Family Counseling

To prepare for the NCE, it may be helpful to study key terms related to family theory and practice. Often, family counseling terminology will be embedded in questions throughout the exam.

Alignments:
Alignments are 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 dynamic occurs when one person does have an effect on all other members and 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:
Coalitions are covert alliances or affiliations, temporary or long-term, between individual and 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 and becomes a continuing loop. Haley described complementary relationships when two people engage in two different types of behavior that fit together (Reiter, 2014). The example Reiter offered was when one person was in a superior position, and the other person in a secondary and one offered criticism and the other accepted and one offers advice and the other accepts it (p. 130).

Conjoint:
Conjoint involves two or more family members seen together in a therapy session.

Conjugal family:
Husband, wife, and children born in 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).

Co-Leadership (Leadership)

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 can 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 a major 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 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 self needs or member needs.

Enmeshment:

A family organization in which boundaries between members become 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 family system that do not alter the basic organization of the system itself. These changes are solution attempts that are within the existing rule structure of the family (Reiter, 2014).

Flawed relationship:
Each is viewed as a representative of the family system, and flawed relationships exist between members or dyads within a family. Treatment efforts by therapists are to alter the flawed 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 to ensure a stable environment. Homeostasis state is always threatened by external and internal stresses.

Identified patient:
The family member with the presenting symptom is 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 created the problem by joining the football team.

Marriage:
Two subsystems, each of which brings 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:
The redundancy principle is a behavioral pattern that 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-change:

Fundamental changes in a system's organization and function. Second-order changes are with rules in the system (Reiter, 2014).

Skewed marriage:

A weak partner allows the stronger partner to dominate. A schism exists.

Stepfamily:

A linked family system created by the marriage of two persons, one or both of whom 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 the parental conflict.

Couples Counseling

Counselors frequently encounter couples in therapy. They may be a high-school couple who found it difficult to share their selves with others, one or both are overly possessive of the other (controlling), jealous, experiencing non-acceptance by the other's parents. Other issues may be interracial dating/marriage, religious differences, sexual inadequacies/promiscuity, risky sexual behavior (for example unprotected sex), experimentation, or a myriad of concerns. These same concerns are relevant with married couples, those contemplating a second relationship, or for couples who have been married for many years. The couple may be experiencing readjustment concerns from communication, to being overly needy, loss of purpose or other dynamics not previously experienced should there be grown children that have departed the home. 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. Helpful during those experiences may be some form of mediation, consultation, and counseling. Once again, the counselor has a decision based on 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) suggested that there are six key areas of marital adjustment.

Marital adjustment areas:

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 a dated source, these key areas remain common concerns shared in therapy by couples. Other issues, which 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, and worker. 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 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 offered treatment to couples experiencing sexual problems. This treatment program relied 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 (referred to as "spectatoring") his or her sexual performance instead of abandoning himself or herself to the giving and receiving of erotic pleasure with a partner. Masters and Johnson pointed out that in order "to enjoy what is occurring, and partners must suspend all such distracting thoughts or anxieties about being evaluated (or evaluating oneself) for sexual performance" (as cited in Goldenberg & Goldenberg, 1991, p. 236).

In conclusion, family and couples counseling is often the context for sex therapy. When counseling couples in this area, it is crucial that counselor(s) make a thorough assessment of all presenting concerns and that any medical problems be ruled out as causal factors. Furthermore, a referral may be a necessary step in assessing a couple's difficulties in the area of sexual relations.

Question 5-43:

A family of four requested family counseling at a local 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 a conflict with his wife. In this stepfamily, who is most likely the scapegoat?

a. father
b. stepmother
c. children
d. none of the above

Answer: d. none of the above. A scapegoat is a member 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 using the presenting information.

Question 5-44:

A male, 17-year-old student, and a community counselor met for an evaluation. A faxed report was placed in the prospective client's folder and presented to the counselor. The report included reports from two instructors who shared similar stories suspecting that the student was overly anxious. The student did not desire recognition of any form, rarely if ever would raise his hand to answer or ask a question. When he was called on his face would redden or flush and he made obvious attempts to swallow. On one occasion he became upset and left the classroom. His parents, when contacted by the school 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 include personality tests. The counselor decided it was important to administer a personality test to determine if personality features might exist. When it became known a personality test was to be administered, 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 required to release the test results because in doing so would violate the rights of the youth.

    c. inform the parents the counselor will meet with them after he/she has notified the client (student) that his parents desire the results.

    d. immediately destroy the results, as test results are only good at the time administered.

Answer: c. The Buckley Amendment provides for the right of parents to review the records. Informing the client before is a respectful behavior and conveys to the client expectations before and after communication and actions. Sharing this information before meeting with the parents to go over the results allow the counselor time to prepare the client for any concerns. Informed procedures are initial actions taken by the counselor to provide the purpose of testing, interpretations, and costs associated with the procedures. Agency policies dictate procedures regarding testing and release of information and the parents have the right to the results.

Question 5-45:

A family of four self-referred because the parents felt that they may have caused some harm to their five-year-old son 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 specially trained in very young children

    c. refer the family to a family center for group therapy

    d. refer the boy for assessment

Answer: d. refer the boy for assessment

The immediate concern is to discern the seriousness of the problem. If harmful acts have indeed been committed, referral for assessment is warranted.

Question 5-46:

A clergy member referred a church couple for marital counseling. The stated concern quickly expanded beyond a lack of patience for each other to spending little time together and blaming (selfish behaviors). The female reported that they feel taken advantage of by the demands placed on 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 and he will drop whatever he is doing and respond to their call. His wife does not appreciate this intrusion and it has caused friction and a lack of intimacy to the point they have neglected to respond to each other with tenderness in the form of hugs, holding hands, and loving affirmations. The counselor's best course of action would be to:

    a.   counsel the couple for intimacy and familial issues.

    b.   request the parents attend 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: c. Counsel the couple for intimacy and familial issues.

Unit 5 - Terms

ABREACTION:
Abreaction is a pent-up feeling and usually occurs after recalling a repressed painful experience (trauma) and sometimes referred to as catharsis.

BASIC ID:
BASIC ID is a 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 a time-limited treatment that establishes a limited number of goals and sessions. 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 taking is focused on the present circumstances, teaching skills, and reinforcing practicing new behavior and little attention is devoted to the past.

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; 2007). Cognitive restructuring is a technique for cognitive and cognitive-behavioral therapies.

COMMON FACTORS (therapy):

The two most common factors include client expectations and a therapeutic relationship. Common factors across therapies reported in research include alliance, bond, healing setting, and the explanation for emotion distress, adaptive explanations, empathy, goal consensus, positive regard, affirmation, genuineness, and congruence.

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). The reality is developed or constructed inside the person and based on the culture, language, or theory applied to a particular phenomenon (Prochaska & Norcross, 1999). Empiricism is an opposing thought that is reality and discovered through correct scientific methods.

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, 2012, 2017).

CORE-OM:

Clinical Outcome Routine Evaluation-Outcome Measuring (CORE-OM) is a computer software program designed to provide feedback on a computer screen to observe client improvement, deterioration, and or a rupture in the client-counselor relationship. The monitoring with immediate feedback is helpful during supervision and feedback with a client.

DIALECTIC BEHAVIOR THERAPY:

Dialectical behavior therapy is a biosocial theory emphasizing an invalidating environment in which personal communication is not accepted as accurate. The treatment is composed of mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance skills.

ECLECTICISM:

A theoretical orientation that involves choosing the particular psychological principles that are best suited to a particular problem and 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 any combinations); and technical eclecticism (procedures from different systems are selected and used in treatment).

EMPOWERMENT:

Wellins, Byham, and Wilson (1991) defined 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:

Sharf (2008) provided a summary of treatments or theories that have published research designed studies with statistical data to support that client outcome have been positive and effective 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).

EMDR:

Eye movement desensitization and reprocessing (EMDR) is a cognitive behavioral treatment. The therapy is a combination of systematic desensitization and substitution of positive thought patterns for negative ones. This treatment unfolds in stages, and the client is trained in smoothing and relaxation while immersing in a disturbing memory.

FEMINIST THERAPY:

Brown's (1994) definition and philosophy of feminist therapy are 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 evolutional change in radical feminism. According to this theory, men and women are socialized differently. Major principles include the person 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, 2010).

FIGURE/GROUND:

In Gestalt psychology, perception involves seeing an object (figure) against a field (background) and the individual focus for one-awareness (figure) at the time, and everything else becomes the ground. Figure/ground is referred to as the front and back of awareness.

IMPASSE:

The sense of being "stuck," experiencing threatening feelings, imagining something terrible will happen. In Gestalt therapy, the layer of the 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:

Integrative therapy (IT) is a transtheoretical approach by Prochaska and Norcross. IT is based on client readiness to change, the 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 ten processes of change (Sharf, 2008).

LOGOTHERAPY:

Victor Frankl developed Logotherapy. It 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.

MOOD GYM:

Mood GYM, Good Days Ahead, and Beating the Blues are three self-help software programs designed to supplement or replace standard psychotherapy treatment for different disorders. MoodGYM is recommended for treating depression.

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 changing philosophy. Life is a series of stories and thinness and thickness refers to the qualities of those stories. Telling the stories, again and again represents thicker and thicker. 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) identified a critical term for narrative therapy to be externalizing (outside of the client).

NEGATIVE REINFORCEMENT:

Withdrawing an unpleasant stimulus when the desired behavior is performed and the result is to increase desired behavior.

OARS:

Motivational interviewing based on the acronym OARS includes open-ended questioning (O), affirming the client's self-efficacy and support (A), reflection (R), and summaries comprised of complex reflections (S), to resolve of ambivalence and promote change (OARS).

PHENOMENOLOGY:

The 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.

PROCESS MODEL TENTATIVE IDENTIFICATION:

This model identifies five influences for a personal model of counseling that includes a tentative identification, reading, general philosophy, practice, and supervision

PSYCHOLOGICAL FIRST-AID:

First responders during a crisis are encouraged to offer psychological first aid that consists of practical help for physical care in the form of safety, food, water, shelter, contacting loved ones, and availability (comfort, compassion, emotional support).

SECONDARY REINFORCERS:

Money, praise, love, blame, objects, events, and needs have reinforcement value because of their association with primary reinforcers.

SELF-INJURY:

Treatment categories for self-injury clients include external factors, defining self-injury, the potential for harm, conditions for treatment, counselor reactions to working with the self-injured, and client's response to treatment.

SELF-MONITORING:

The process of observing specific factors regarding oneself and how one interacts with the environment.

SOCIAL LEARNING THEORY:

Social learning theory considers the social context that impacts learning. Thus, learning takes place through observation and imitation. Albert Bandura is the key figure.

o-SOFTA:

A system for observing family therapy alliances (o-SOFTA) is a computerized video program to observe and rate clients and therapist behaviors on dimensions that contribute to or detracts from a strong working alliance. e-SOFTA is a program for family therapy.

SOLUTION-FOCUSED THERAPY:

The counseling emphasis is on the strengths of the clients rather than on their weaknesses to resolve a problem. Change occurs through 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 too small changes. Clients who cooperate, possess the ability to solve their problems and have the ability to construct solutions benefit from solution-focused therapy.

UNFINISHED BUSINESS:

A Gestalt therapy term for an unexpressed feeling from the past that interferes with effective psychological functioning in the present.

Unit 5 - References

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UNIT 6 - Group Counseling and Group Work

Introduction

The content of Unit Six focuses on the dynamics and process of group work. The first part of this unit outlines several major group theories and the process of group work. Each theory operates from a philosophical foundation for group process and dynamics. For study purposes and understanding successful group work, it is important to differentiate among the theories and to understand the role of the leader and participants, various techniques and stages, and the dynamics and process of the working group. Not all groups are human growth groups thus do not necessarily provide stages or phases of different types of groups.

The majority of examination questions about groups have not been about group theory. Group theories appear to be similar to individual counseling theories so those questions are found within the counseling theory unit. The majority of group content involves the specific dynamics and processes of group work, such as self-disclosure, cohesiveness, communication, interpersonal interactions, member roles, norms, stages, and leadership.

Academic preparation in group work should include 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 group leader responses for individual member behaviors that

occur during a group. It is recommended to review the Multicultural and Social Justice Competence Principles for Group Workers (ASGW, 2012). This document includes a preamble, definitions, social justice, social privilege, oppression, and acting. Principle one includes awareness of self and group members for multicultural and social justice advocacy competence. Principle two involves strategies and advocacy skills and principle three requires 12 advocacy competencies for social justice advocacy.

A good starting point is a precise definition of a group, group guidance, group counseling, and group psychotherapy. There are approximately 21 group questions, of which 16 counts toward your total score.

CACREP Objectives

CACREP 2016 objectives for group counseling are abbreviated and preparing for the NCE one may desire to download from the CACREP website the full standard objectives.

These objectives are briefly outlined for the CACREP 2016 standards (CACREP, 2015, P. 12).

a. theoretical foundations of group counseling and group work

b. dynamics associated with group process and development

c. therapeutic factors associated with group effectiveness

d. characteristics and functions of group leaders

e. approaches to group formation, recruitment, screening, and selecting members

f. types of groups and considerations that affect conducting groups

g. ethical and culturally relevant strategies for designing and facilitating groups

h. direct experiences in which students participate as group members in a small group activity, approved by program and 10 clock hours over the course of one academic term

Question 6-1: (Objective A.)
The group theory that encourages spontaneity, creativity, presence, encounter, and tele is:

a. Person-Centered.

b. Psychodrama.

c. Adlerian.

d. Psychoanalytic.

Answer: b. Psychodrama.

Question 6-2: (Objective B.)
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

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Answer: a. anxiety, defensiveness, resistance, and control struggles

Question 6-3: (Objective B.)

A member who is terminating from an ongoing or open group should do which of the following?

    a. deal with his or her separation issues

    b. close off the unfinished business because of lack of time

    c. give feedback to the other members

    d. announce ahead of time (sessions) of departure

Answer: d. announce ahead of time (sessions) of departure

Question 6-4: (Objective B.)

"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 individual development and feedback

    d. to enable responsible self-disclosure and feedback

Answer: d. to enable responsible self-disclosure and feedback

Question 6-5: (Objective C.)

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

    a. initiating

    b. transition

    c. working

    d. termination

Answer: c. working

Question 6-6: (Objective D.)

Research in group work suggests that leaders who utilize structured exercises can expect which outcome?

    a. a significant increase in depth of process involvement compared to non-structured leader groups

    b. long-term outcome will be less effective than non-structured leader groups

    c. the process outcomes will be most positive

    d. the members will provide less feedback than those from non-structured groups

Answer: b. long-term outcome will be less effective than non-structured leader groups

Question 6-7: (Objective D.)

The code of ethics for group counselors indicates that a group leader or members of a group are to respect the rights of each group member. Should a member decide to be silent, the members and leaders may be confused as to an appropriate action. Counselors are trained to involve members and also respect members. Leaders should be careful to avoid the use of:

a. techniques to bring the member out.

b. coercion to bring the member out.

c. a wait and see attitude.

d. non-verbal communication to bring the member out.

Answer: b. coercion to bring the member out. ACA (2013) Code of Ethics Respecting Client Rights and B..1. a. Multicultural/Diversity Considerations.

Question 6-8: (Objective E.)

The ethical code for growth group formation recommends a pre-interview. One reason for this ethical recommendation is to:

a. organize a group.

b. ensure that each member knows before the start of a group who the leader is and to reduce the power differential.

c. reduce any pre-group anxiety.

d. eliminate applicants who might possibly exhibit anti-group efforts.

Answer: d. eliminate applicants who might possibly exhibit anti-group efforts. The ACA Code of Ethics (ACA, 2013; A.9.a. Screening) recommends to select members whose needs and goals are compatible with the goals of the group.

Question 6-9: (Objective F.)

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

a. task.

b. encounter.

c. growth.

d. Balint

Answer: a. task

Question 6-10: (Objective G.)

Which of the following is a primary consideration in developing a growth group?

a. interviewing all group members before the first session to explain goals of the group

b. keeping the group from becoming too large

c. ensuring that a trained, capable leader will be present

d. ensuring that each member feels accepted

Answer: a. interviewing all group members before the first session to explain goals of the group

Question 6-11: (Objective H.)

In 1992, the Association for Specialist in Group Work (ASGW) published standards for group leaders. Two levels of training are required at the master level programming. The first level refers to the cognitive requirement of knowledge and skill acquisition. The second level for trainees specializes in one of four group work specializations. Which group specialization would emphasize interpersonal and interactive feedback, and support methods in the present?

a. facilitative

b. psychoeducation

c. counseling

d. psychotherapy

Answer: c. counseling (Conye & Wilson, 1998)

Terms

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

Autocratic Leadership	Group Mind
Balint	Group Think
Blocking	Here and Now
Capping	Icebreaker
Charismatic Leader	Leveling
Co-leadership	Lewin, Kurt
Conformity	Mandate Phenomenon
Contagion	Mindlessness
Critical Incidents	Norms
Dynamics	Power
Emergent Norm Theory	Primary Group
Empowerment	Ringleman Effect
Encounter	Self-help group
Entitativity (group)	Sociometry
Fidelity	T-Group
FIRO	Task roles
Fishbowl	Universality

GROUP

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 relationship depends upon the kind of group (Brodbeck, 1958). Shaw (1976) defined a group as "some people in interaction with each other. Two or more individuals who are interacting with one another in such a manner that each member influences and are influenced by another person in the group" (p.11). A group includes "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" (Gladding, 2015, 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 influence on the other, and share some goal.

Group Guidance: Group guidance is intended to prevent the development of problems. Information is provided, and group size is from 20 to 35 and includes 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) described 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, an 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) defined 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, a neurotic emphasis and severe emotional problems, and is long-term (Brammer & Shostrom, 1960). In summary, group psychotherapy is remedial, reconstructive, and helps clients with serious psychological problems through depth analysis.

OBJECTIVE 6A: Theoretical Foundation-Counseling

Objective 6a. Theoretical foundations of group counseling and group work (APA, 2015, p.12)

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 the underlying principles and foundation of different types of a group along with the theory principles, techniques, 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. A person-centered or client-centered therapy is an intensive experiential group therapy (Rogers, 1967).

Philosophy: Individuals strive to become fully functioning and self-actualized. This attitude and a set of behaviors become internalized and allow the person to be ever expanding and attaining his/her full

capacities. Rogers believed that each has an internal drive to become a whole person. The theory relies on the natural ordering tendencies of life. Each is aware of his or her incongruence and is capable of reorganizing to achieve congruence. Maladjustment occurs 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 allow the formative tendency to operate and the leader allows for change and encourages the here and now of experiencing. Group procedures reinforce the self-knowing and understanding of others.

Rogers (cited in Burke, 1989) indicated that the therapist utilizes three attitudes - genuineness, unconditional positive regard, and empathy - to assist the person in the formative tendency. Rogers saw the powerful inducements for change were being present with the person (presence) and being congruent.

Stages: Rogers did not outline his therapy as progressing in stages although this has been described in that way by several authors. Rogers saw individual and group therapy progressing as a process, free flowing from one stage to another. The process is an evolution in development, which reflects more of a sequencing of events and process. Posthuma (2001) cited Rogers' analogy of raindrops falling on a window pane (separate is each raindrop), and if a person touched one drop and moved that drop down the windowpane, it will link up with another and form a larger raindrop. The leader or another member has to be insightful and synthesize a common bridge of understanding. Jacobs, Schimmel, Masson, and Harvill (2016) referred to this behavior as typing together. Rogers (1951, 1967) theorized that group process evolved in 15 'stages' beginning with milling around and concluding with behavior change. The following 'stages' are offered to be suggestive of a process (Corey, Corey, & Corey, 2014; Gladding, 2015):

    milling around

    resistance to personal expressions/ explorations

    descriptions of past feelings

    expression of negative feelings

    expression/exploration of personally meaningful material

    expression of immediate interpersonal feelings in the group

    development of healing capacity

    self-acceptance and beginning of change

    cracking of facades

    feedback

    confrontation

    helping relationships outside group

    basic encounter

    expression of positive feelings/closeness

    behavior change in group

The role of the 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 promotes growth and change. The leader reflects warmth, acceptance, respect, caring, and empathy. The leader provides understanding meanings, and intents, conveys acceptance and provides linking. The leader participates as a member, giving up authority, devotes a willingness to recognize that others in the group can lead, self-discloses when appropriate, strives for personal influence and believes members can move in their direction.

The role of the group member: No specific guidelines in selecting members. Ground rules are developed by the membership and goals include self-awareness and awareness of others.

GESTALT: Fritz Perls

Philosophy: Gestalt group therapy is composed of existential, experimental, and phenomenology. The basic philosophy is that much of what each person needs to live in the world is outside of his/her ego boundary. To bring the material through the ego boundary, the person needs to be aware of the need and to expend the energy to bring this transportation about to completeness, wholeness to a gestalt. The basic drive is denial aggression. Bringing something through the ego boundary is called contact.

The person is born with the capacity to cope with life. The child's development is interfered with and must introject, project, retroflect, repress, and suppress instinctual strivings to be normal.

Key Terms: denial aggression, impasse, contact, figure, rehearsal, background, awareness, here and now, unfinished business, introject, personality (multilayered), cliché, playing, impasse, implosive-explosive, genuine, I-Thou, closure, elasticity, proactive, rounds, role reversal, empty chair, top-dog/underdog dialogue.

Method: All members are seen in individual therapy to assess the degree and severity of disturbance. Also, the members' attitudes and willingness to participate are assessed. The curative process is centered upon awareness and the goal is to move from environmental support to self-support.

With awareness, clients can recognize blocks and impasses. Therapy involves assisting the client to discover within himself/ herself the resources to resolve blocks and impasses. The client proceeds to recognize parts and integrate into a whole. Other issues include the here and now, recognizing and accepting polarities, and re-experiencing present business.

Stages: Everything is based upon the Here and Now. The past and future do not exist except in relationship to the Here and Now. The Gestalt Institute of Cleveland has suggested a stage evolution of trust and safety, establishing norms, exploration, confrontation, confluence, and working. They view each event as composed of a cycle that includes centering, sensation, awareness, energy, action, contact, resolution, and withdrawal (Gazda, 1989).

Role of Leader: The leader is to challenge members, confront and encourage while in the Here and Now. The leader is a facilitator and provides feedback, perceptions, attitudes, and feelings. The leader is a model in the I-Thou relationship and determines much of what will take place with whom and when.

Role of Member: Active contact, interactional, self-awareness, and a willingness to re-experience contact.

Techniques: Action-oriented, language exercises (I talk, you talk, questions, qualifiers, the shoulds, oughts, can't), nonverbal, take responsibility, matching rounds, fantasy, rehearsal, reversal, exaggeration, exercises, dream work, the first person (Corey et al., 2014).

Goals: The outcome goal is for members to have more awareness of themselves in the Here and Now. Each member will remove layers of neurosis (phony, phobic, impasse, implosive, and explosiveness).

ADLERIAN: Alfred Adler - Rudolph Dreikurs (Primary Group Developer)

Philosophy: The basic assumption is the social nature of humans and based upon the holistic view of man. Adler believed in family education, and his approach is 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 an inferiority, which is the motivating force for individual's goal-orient for mastery, power, and perfection.

Key Tenets: social development, cooperation, and education.

Key Terms: holism, autonomy, creativity, choice, teleology, lifestyle, phenomenology, inferiority, identity confusion, ego integrity, family constellation, basic mistakes, earliest recollection, psychological disclosures, personal identity.

Method: The group is the setting in which inferiority can be challenged and the mistaken beliefs and values can be examined and are 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 viewed Adlerian counseling in phases. Gazda (1989) and Gladding (2015) viewed the process as developing in the following four phases:

Phase 1: Developing a relationship

Phase 2: Analysis and assessment

Phase 3: Insight

Phase 4: Reorientation

The group process is linked through the interpretation of a person's early history and the individual, interpersonal, and group process goals.

Role of Leader: The role of the leader is to interpret and guide for change by understanding present behavior, monitoring group process, establishing structure and guidelines, challenging client's beliefs and goals, and encouraging therapeutic conditions (Corey et al., 2014). The leader is a participant in the group, and an effective personality is important.

Role of Member: The role of the member is to provide support for other members, assist in interpretations for others, and be 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 of origin and achieve social adjustment.

REALITY THERAPY: William Glasser

Philosophy: Glasser's basic concept is "success identity," whereby each person has an internal force that drives him or her toward this success identity. A behavioral change will produce a change in one's identity. This theory is active, directive, and didactic. Reality theory advocates helping people take control of their lives in the form of choices. The individual attempts to meet his/her psychological and physiological needs. Choice theory as a part of reality therapy explains how the brain works.

Key Tenets: Glasser (1984) stated that all behavior is "generated by us for the purpose of satisfying one or more basic needs" (p. 323). Glasser maintained that one of the five internal needs of belonging, power, freedom, fun, and the physiological need of survival brings individuals to counseling.

Key Terms: belonging, power, freedom, fun, doing, thinking, feeling, physiology, success identity, involvement, value judgment, present vs. the past, commitment.

Method: Cycle of counseling is a rational process and not necessarily procedural. Involves the environment, counselor attitudes, exploring wants, needs, and perceptions, focus on current behavior, evaluating self, plan and act, and commitment. Glasser rejected the term "mental illness," emphasizes the present, is unconcerned with transference or the unconscious, stresses evaluating one's behavior considering personal and societal values, and finding a better way to assuming responsibility.

Stages: There are no stages. There are only eight steps. Glasser stresses that his choice theory is a process and does not to attempt to fit it into a procedure. The steps are: develop a meaningful relationship, emphasize the present behavior, stress the client actions that are getting them what they want, plan positively, establish a commitment to the plan, accept no excuse, apply no punishment, and never give up (Gladding, 2015).

Role of Leader: The role of the leader is to be active and directive, involved, maintain control, challenge, model, relationship development, leader of the discussion, teach, set limits, connect real life with learning, confront excuses, and encourage strengths.

Role of Member: The role of the member is to be supportive, encouraging, creating relationships with other members, setting goals, making commitments, and acting.

Technique: Questioning, self-help procedures, humor, paradoxical techniques, interviewing, no excuses for failure, contract method, role playing, discussion, involvement, structured, cognitive, and behavior-oriented.

Goals: To move beyond self-defeating behavior and to become unstuck. Group members realize they can take control of their lives.

PSYCHODRAMA: J. L. Moreno

Philosophy: The total involvement of all group members through their expression of feelings in a spontaneous manner. This is achieved through a drama enacted via role-playing. The aim is to free people up from old feelings that are irrational. This is a holistic approach that reinforces spontaneity and creativity. Moreno believed that humans have the capacity to encounter one another in an open, honest manner.

Key Beliefs: Spontaneity and creativity, the situation, tele (total feelings between feelings), catharsis (end products of the 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 re-enacting events, role-play with the warm-up process, action phase, and discussion. The psychodrama experience is a holistic interaction of the protagonist in his/her encounter. This encounter is a physical and psychological contact of persons in the Here and Now.

Three phases:

Phase 1: Warm-up - designed to alert and inform participants about the experience. This phase will elicit goals and willingness to trust others in the audience to participate. The scene is developed, and members are told that they share what they want to reveal.

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

Phase 3: Discussion Phase/Integration Phase - when the action is shared and discussed. Observations and reactions are provided to stimulate understanding for all members. This is a personal and nonjudgmental sharing.

Role of Leader: The role of the leader is a producer, catalyst, facilitator, analyzer, and debriefer. The leader has a direct responsibility to the members.

Role of Members: The role of the member is to be auxiliary egos and protagonists.

Techniques: Role-play, self-presentation, role-reversal, soliloquy, double technique, mirror technique, magic shop, and future projection.

Goals: The desired outcome is the release of the natural human spontaneity and creativity. The individual works through past, present, and anticipated events.

RATIONAL-EMOTIVE BEHAVIOR THERAPY (REBT): Albert Ellis

Each of three theorists (Albert Ellis, Aaron Beck, Donald Meichenbaum) described a cognitive behavioral group therapy. Aaron Beck and Donald Meichenbaum provided models that reflect the

cognitive structures of the client, although each of the three emphasized different perspectives. Albert Ellis attacks underlying belief systems that have been reinforced by the client. This theory is well known for the three basic "musts." They are: "I must," "You must," and "Conditions must" (Donigian & Hulse-Killacky, 1999).

Philosophy: The basic personality theory assumptions hold that humans are capable of rational and irrational thinking (dual nature). These ways of thinking are the cause of emotional reactions, and resultant behaviors. When self-defeating behavior is replicated, people become dysfunctional. Cognition and feelings are interlocked. REBT is a cognitive approach that assumes each person has the potential for rational and irrational thinking.

Key Terms: ABC Theory, "musterbation," self-indoctrination, confrontation. Four types of thoughts (positive, negative, neutral, and mixed) and three feedback modes (cognitive, imaginal, and behavioral).

Method: Teaching and feedback in which an active directive intervention uses the ABC approach; a) activating event, b) belief system, c) emotional consequences, d) dispute and e) effect method.

Stages: There are no emphasized stages. Instead, the above ABC process is enacted, which includes interviewing, motivating, problem-solving, and action.

Role of Leader: The leader role is both active and directive, confronting, and active. The leader serves as a teacher, illustrating how a person connects emotions and behavior. Many people have conditioned themselves into "musts." The leader will encourage members to dispose of musts, shoulds, and oughts, using activity-oriented exercises.

Role of Members: The role of the member is 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) reported that the goal of REBT is to "stop awfulizing, catastrophizing about life's misfortunes and frustrations. Also, the goal is to accept oneself and others as being fallible and human" (p. 288). The desired outcome is to learn how to think rationally; overcome irrational beliefs using the ABC model, better knowledge of REBT and personal understanding of the change process (Gladding, 2015).

EXISTENTIAL: Victor Frankl and Ludwig Binswager

Philosophy: Existentialism is founded upon freedom of choice and based upon four concerns: freedom, death, isolation, and meaninglessness (Yalom & Leszcz, 2005). Each person is encouraged to lead a fully authentic life. An example of existential thought is Victor Frankl's logotherapy (Corey et al., 2014).

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 doings. The leader encourages members to shed their superficial beings and replace this with an authentic way of life.

Stages: There are no clear stages rather a process of phases that represent self- awareness. There are no rules, therefore, this therapy can be a painful process for members. The initial concern is what roles members should play. As this concern is discarded, members begin to question how they perceive and interpret their existence. The focus is on what other people 'make' them feel. The middle phase is a deeper self-exploration of their value system for new insights. The final phase is learning what each member learned and transmitted into action.

Role of Leader: The role of the leader is to be with the client. There are no specific techniques for being a leader of an existential group. The leader will encourage members to be open, participate, share, and develop the therapeutic alliance. The leader will challenge members to change positions, look for opportunities from failures, be creative for the future, and study their defensive styles.

Role of Members: The role of the member is to offer illustrations of their conflict strategies and to accept responsibility for themselves, be open and participating.

Techniques: No real techniques. The focus is on a relationship development and to challenge the client work.

BEHAVIORAL: B.F. Skinner

Corey et al. (2014) contend that behavioral theory is not a single theory. Rather, it covers a broad array of techniques and understandings rooted in learning theory. Behavioral therapy reinforces experimental methods and documentation of observable behaviors. The acquisition of data is important. Lazarus, a multimodal therapist, proposes a BASIC ID theory for group work.

Philosophy: The basic assumption is that individuals express problems composed of learned 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: The role of the leader is to interview, assess, apply techniques, model, reinforce, teach problem-solving, and create a climate of trust and respect. The leader uses contracts, cognitive restructuring, and modeling.

Role of Members: The role of the member is contracting, listing behaviors, problem-solving, learning new skills, reporting progress, yielding feedback, role-playing, and participating in various techniques.

Techniques: There are numerous behavioral techniques depending upon the specific behavioral orientation of the theory author. Some examples are stress inoculation, assertiveness training, modeling, reinforcement, diagnosis, and cognitive restructuring.

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 learn how to assess changes, develop and alter their behaviors, and to understand the power of reinforcement.

PSYCHOANALYTIC: Sigmund Freud

Philosophy: As in individual psychoanalysis, group therapy attempts to restructure the individual's personality. The bringing of 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 and realize that 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 events, 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, 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.

Role of Leaders: The leader is not necessarily a member of the group, however, will attempt to create a climate for exploration, support, and expression. The leader may set limits, provide resistance interpretation, interpret meaning, process intragroup conflict, transfer leadership, and use transference interpretations.

Role of Members: Each member establishes a similar relationship to those in birth family. Examine defense mechanisms, share insights, and interpret member dreams and expressions.

Techniques: Free association, alternate session, dream analysis, insight.

Goals: Pass through the desired stages successfully.

TRANSACTIONAL ANALYSIS: Eric Berne and Robert Goulding

Philosophy: This is a method of changing our way of thinking, feeling, and behaving. We are responsible for thinking, feeling, and behaving as it pertains to our life. Individuals are programmed or scripted early in life and are capable of change.

Key Beliefs: TA is similar to REBT in cognition and participatory learning.

Key Terms: Injunctions, structural analysis, stroking, counter injunctions, games, life scripts, contamination, transactional analysis, ego states, and parent-child-adult.

Method: This is a didactic and cognitive model. The recognition of the ego state and the method an individual communicates determines how the person has set up his/her life plan and in turn determines his/her actions.

Stages: A process for a contract is developed whereby the individual establishes 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: The role of the leader is 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, contact members, develop a contract, and be in the process.

Techniques: Game analysis, structural analysis, transactional analysis, life-script analysis, and rackets.

Goals: The desired outcome is for everyone to adopt an "I'm Ok" stance.

OBJECTIVE 6 B: DYNAMICS AND PROCESS

Objective 6b. dynamics associated with group process and development (CACREP, 2015, p. 12)

The ACA Code of Ethics regarding group work includes an emphasis on screening (A.9.a.), protecting clients (A.9.b.), and group work (B.4.a). The ASGW ethical code has coverage across the domain of group work practice and training.

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 first appeared in the schools although the leaders were not necessarily trained in the dynamics and process of effective groups. Jesse Davis and Charles Jacobs were credited with utilizing groups for curriculum requirements during the 1930s. Capuzzi, Gross, and Stauffer (2010) credited 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, 2001). Cooley believed that social process and social control were always found in face-to-face encounters and referred to these groups as primary groups. The psychological structure of the group was most important in understanding individuals. He believed that individuals were responsive to each other's feelings, actions, and opinions (Bonner, 1959). Cooley went on to write about group influence, group cohesion, and decision-making. Kurt Lewin in the late 1920s and early 1930s was influential in developing group dynamics (Lewin, 1944). Lewin and Associates began to promote the use of groups as agents of change, a concept from which the present-day T-groups, encounter, and sensitivity groups evolved. According to Gazda (1989), Dr. Richard Allen in the 1930s coined the terms "group counseling" and "case conference."

Brief History

For a brief history of group development and individual contributors, Gladding (2015) is a recommended source for history and models.

Jacob Moreno in 1936 coined the term "group psychotherapy." He is the founder of psychodrama and organized the first society for group therapists.

Frank Parsons and Jesse 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.

Jacob Moreno and Kurt Lewin identified group dynamics, a concept Hubert Bonner developed in the late 1800s. Between 1935 and 1939, Newcomb (1961) formalized the study of sociometrics. This term refers to the attitudes of individuals rooted in groups to which people belong and the relationships shared with one another. He went on to point out that group members will evaluate one another based on their conformity to group norms (Cartwright & Zander, 1968).

William 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.

Lewin, Lippitt, and White (1939) conducted a leadership study at the Iowa Child Welfare Research organization 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).

Muzafer 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 and is particular to the group. Then the person will use the group range and norm rather than his/her judgment (Sherif, 1936).

Solomon Asch (1952) conducted a study on individual independence from group forces. He found that groups encourage conformity and discourage nonconformity.

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 included 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.

William 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 brief, all concerns are similar, participants are goal-oriented, and the focus is on counseling and therapy for solutions (Gladding, 2015).

Dynamics-Process (Dynamics and Process)

It is not always clear what constitutes dynamics and what is a 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 are behaviors that are necessary for a group process to take place. Group dynamics are forces within a group that lead to group process (i.e., the interaction of group members).

Forsyth (2013) indicated that there are important distinguishing characteristics of most groups. Some features are interaction, structure, size, goals, norms, cohesiveness, and the concept of change. Cartwright and Zander (1968) elaborated on the definition of group dynamics, a term associated with Kurt Lewin. Their definition is as follows: "a field of inquiry dedicated to advancing knowledge about the nature of groups, the laws of their development, and their interrelations with individuals, other groups, and larger institutions" (p. 7). Group dynamics and group process are two terms frequently used interchangeably throughout the literature.

Group dynamics are considered 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, 2001) of forces in a group includes "nonverbal behaviors, communication patterns, levels of participation, expression of feelings, and resistances and avoidances" (p.7). Bion (1985) referred to three group dynamics: dependency, fight-flight, and pairing.

Group process may be thought of as the interplay of the group forces (dynamics) that make up or lead to the development of the group. Fuhriman and Burlingame (1990) identified process variables including 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) listed 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 speak from the first person. It is easy to review definitions for group dynamics and group process and note how they tend to blend with one another.

Group Process

Groups are interpreted as going through stages, phases, cycles, and cybernetics although boundaries are vague. These categories do not fit all of the different types of groups and are best adapted to personal growth groups.

Development, Phases, Cycles and Stages

The authority cycle presents stages regarding relationships between the leader and the members in terms of how authority is displayed, transferred and shared. The stages are dependence, counter interdependence, counter dependence, and independence (Posthuma, 2001).

Socialization Stages

Society is viewed as a group and every child, irrespective of culture, is socialized during their development and according to his/her culture. Consequently, it is believed that all groups go through a socialization process. Moreland and Levine (1982) suggested a process in which groups experience socialization in a series of sequential stages. These stages are as follows:

INVESTIGATION: A cautious search for information wherein members engage in reconnaissance. The group estimates the value of each member.

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

MAINTENANCE: Role negotiation where members take on roles that are comfortable. The group may force members to take on roles they are not comfortable with (divergence).

RESOCIALIZATION: Members take on marginal roles. This may stimulate a crisis in which the members are not contributory. The members may become dissatisfied and play a lesser role. The group may react to members who are not contributing and thus create a crisis. This crisis, if resolved, often finds the members recommitted (convergence).

REMEMBRANCE: Member reminisces about time together, and the group validates contributions of members. From this process, a tradition will emerge as an outcome, negative or positive.

This socialization process takes place in groups that typically have a shorter time span than a lifespan of socialization.

Stages or Phases of a Group

The life of a group follows some ordered sequence of happenings similar to socialization. This sequence of events from the beginning of a group to the termination has been referred to as a group process, life to death. Some authors see the process as occurring in sequential stages, while others call them phases, themes, and even a cybernetics hierarchy. The following illustration is provided 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), calls 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 can attend to the goals and accomplish the group task.

Stage 5: Termination.

Corey et al. (2014) outlined a set of stages to include setting up. Briefly, the first stage is formation, which includes announcing and recruiting members and selecting and screening for membership. Stage two is the orientation and exploration that will include identity, trust, goal setting, responsibility taking, and structuring. Stage three is the time for resistance, anxiety, conflict, control, challenging the leader, and difficultly with members, a time of transition. Stage four includes cohesion, productivity, and therapeutic emerging factors. Stage five, the final stage, is one of consolidation and termination.

Question 6-12:
Ambiguity during the early sessions of growth groups tends to have which effect?

    a. fosters competition for communication

    b. exacerbates distortions, interpersonal fears, and stress

    c. creates norms beyond the group's maturity

    d. causes an increase in the dropout rate

Answer: b. exacerbates distortions, interpersonal fears, and stress

The following listing of authors and their respective process terms that denote stages or phases is intended to be descriptive of the life of a group. Although there are similarities in terms for many of the theories, there do exist several authors whose terms do not necessarily reflect a beginning and end, let alone a sequential process. In those cases, it is recommended that the reader recognizes the uniqueness of the portrayal of a group movement.

Stages/Phases of a Group

PROCESS as defined by stages, phases, themes and cybernetics. Also, process in three phases may be the beginning, middle, and end.

The group stage theories of Tuckman and Jensen (1977), Corey et al. (2014) and phase models by Fisher (1970) and Levine (1979) provide an understanding of the development of group process and dynamics.

Tuckman and Jensen

Tuckman and Jensen (1977) developed four stages, later added a fifth. They viewed 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.

Forming (inclusion)

> Discomfort of ego
>
> Caution
>
> ISSUE: In or out of group
>
> Usually a time of primary tension

Storming (control)

> Reacts to demands of what is to be done
>
> Questions authority, feels increasingly comfortable among group members
>
> ISSUE: Top or bottom
>
> A transition from primary tension to secondary tension

Norming (affection)

> Rules of behavior are appropriate and necessary
>
> Greater degree of order
>
> ISSUE: For or against

Performing (functional)

> Focuses energies on tasks, working through issues of membership, orientation
>
> leadership, roles, the climate of support
>
> ISSUE: Work or play

Adjourning

> Closure to task
>
> Changing relationships
>
> ISSUE: Fulfillment or bitterness

Tuckman and Jenson later added for each stage group behavior associated with interpersonal relationships and tasks.

Interpersonal Relationships

> Forming: Testing and dependency
>
> Storming: Tension and conflict
>
> Norming: Cohesion
>
> Performing: Functional role relationship

Task

    Forming: Task definition, boundaries, exchange of functional information

    Storming: Natural emotional response to task

    Norming: Shared interpretations and perspectives

    Performing: Emergent solutions

Gerald Corey

Corey et al. (2014) outlined four stages groups progress through and characterized them 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 an identity in a group and determining 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, and 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 the leader, and formulates trust and mistrust.

Stage 2: Transition and Resistance

Characterized: Cohesiveness (prime therapeutic factor in groups) and intimacy. Secondary tension is intragroup tension where member differences are felt and expressed. Typical dynamics are self-disclosure, confrontation, and feedback.

Tasks:

    the working stage for behavior change

    conflict and struggle for control

Leader: reinforcement, caring, confrontation

Member:

    interacts openly and directly

    expresses some amount of risk with knowledge; respect will be forthcoming

    resolves difficulties with sensitivity, not judgment

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:

cohesion development

risk-sharing

Leader:

reinforcement

search for common themes

interpretation, modeling

aware of therapeutic factors

Members:

share issues

provide feedback to others

challenge and support members

Stage 4: Final – Consolidation and Termination

Characterized: Depending on whether the group is open or closed the tasks may not be the same. Transferring what they learned in the group to their outside environment, consolidation of learning, summarizing, integrating, and interpreting the group experience.

Tasks:

separation anxiety

unfinished business

Leader:

termination issues unresolved

reinforce changes

feedback to others

applied learning

Members:

feelings of separation

generalize new learning

provide feedback

In conclusion, Corey, et al. (2014) suggested that termination of group experiences is a time to deal with separation, compare early and later perceptions, deal with unfinished business, review group experiences, practice behavioral change, carry out further learning, and to give and receive feedback.

Recurring Phase Models

Fisher's Model

Fisher's (1970) model is a phase model. These phases are as follows:

Phase 1: Orientation

    establish a common basis for the functioning

    communication oriented to each other

    task dimension approached

Phase 2: Conflict

    form opinions about their position in the group

    compete for status within the group

    assert individuality

    persuasive attempts at changing other's opinions

Phase 3: Emergence

    the group settles on norms

    moves toward consensus via ambiguity

    conflict continues

Phase 4: Reinforcement

    the sense of direction

    the consensus of opinion

    group identity

    a genuine sense of accomplishment

    reinforcement of group decisions

Levine's Recurring Phases

Levine (1979) proposed a phase model solving integrated conflicts.

PARALLEL: This phase drawn from the play of young children where they play next to one another but not with each other. Members show increasing levels of trust in the therapist, other members, and the group situation to free their autonomous strivings and actions.

    1. Authority Crisis: A challenge to the centrality and political power of the therapist.

INCLUSION: Inclusion is a decrease in the centrality of the therapist in group relationships and an increase in member relationships. There is an affiliation of pairings and subgrouping (conflicts/power struggles).

2. Intimacy Crisis: Pair and subgroup (empathy becomes important dimension in cohesion).

MUTUALITY: The mutuality phase reveals the capacity for intimate relationships and a deepening of relationships.

3. Separation Crisis: Any phase. Inherent in authority and intimacy. Deal with loss or potential loss.

TERMINATION: Disengage

Phases

Bennis and Shepard (1956) combined their work on group process with Bales (1955) and Bales and Strodtbeck (1951) and developed six developmental phases for groups. These are:

Dependence	flight
Counterdependence	fight
Resolution	catharsis
Enchantment	flight
Disenchantment	fight
Consensus	validation

Themes

Cohen and Smith (1976) envisioned 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:

Anxiety

Power

Norms

Personal Growth

Interpersonal Relationships

These themes may occur at any time and require a solution if the group is to mature. Leader and members need to explore issues underlying these themes. Cohen and Smith believed that these themes are good for growth, self-study, and task groups.

Cybernetic Hierarchy

Cybernetics is the science of control mechanisms and their associated communications systems (Chaplin, 1968). Cybernetics adapted to group work suggests that communication between input and

output is feedback to members. This behavior is what allows or permits group members to change or adjust their behavior as a result of new information.

Hare (1976) identified four factors necessary for any group to survive. These factors are:

1. Develop a sense of common identity with values and purposes that are consistent.
2. Membership must be composed of members with skills and resources necessary to meet goals.
3. Rules and procedures developed to coordinate activities and permit feelings of interdependence and task effectiveness.
4. Leadership is 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 generate energy to do the activity.

OBJECTIVE 6C: THERAPEUTIC FACTORS

Objective 6c. therapeutic factors and how they contribute to group effectiveness (CACREP, 2015, p. 12)

Functioning groups are those where members meet one another and develop a working relationship to accomplish group and individual goals. In meeting one another in a group Heider (1958) defined attribution as a process when members try to understand and predict the behavior of another to achieve balance and harmony. An individual will link another person's behavior to attributes belonging to that person or the environment. That is, an individual will attribute a person's behavior to internal personality characteristics or to external, environmental conditions to understand, explain, or predict that person's future behavior. Attribution theory is a collection of ideas about when and how people develop 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 behavior. That is, an individual is more likely to attribute situational variables to his or her 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 another person, and expectations of performing the observed behavior in the future. Attributes a person develops are out of respect to better interact with a member of a group.

According to Milgram (1963, 1969), social influence is the psychological mechanism that links individual action to the political purpose or a group goal. The person entering an authority system no longer views himself or herself as acting out his or her purpose but instead sees actions as accomplishing the purposes of the authority or the group. 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.

Turner and Killian (1987) indicated that a social norm emerges that is unique to a situation (Emergent Norm Theory-Collective Behavior). The crowd or group can get caught up in the emotion of the situation and sanctions "positive" or "deviant" behaviors consistent with the group norm. In the process, the "deviant" behavior becomes normative and to behave otherwise is seen by the group as deviant (as cited

in Albrecht, et al., 1980; Forsyth, 2013). This theory can be used to explain different acts such as lynching, looting, bullying, etc.

Question 6-13:
The classical studies conducted to determine how obedience was related to authority and paid subjects to shock other subjects were:

a. Milgram studies.
b. Bandura's division.
c. Festinger's conflicts.
d. Kelly's constructs.

Answer: a. Milgram studies. These were the studies that inflicted pain on peers when told to do so with minimal financial payments and laid the groundwork for additional studies on authority and conformity.

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. Togetherness is referred to as a "we" feeling. Burlingame, Duheiman, and Johnson (2002) defined cohesion as a feeling of attachment to group members composed of group acceptance, emotional well-being, self-disclosure, interpersonal liking, and tolerance for space. Burlingame, McClendon, and Alonso (2011) in a meta-analysis review of 40 studies theorized that cohesion involved structure (member-leader and member-member) and quality (positive bond, positive work, and negative relationship).

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).

a. "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 the group from those forces pointing toward group membership, and the result is cohesiveness.

b. "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 a conflict, and the establishment of a frame of reference whereby diverse opinions are tolerated" (Lakin, 1972, p. 42).

c. "Involves group's attractiveness to the participants and a sense of belonging, inclusion, and solidarity" (Corey et al., 2014). 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, 2000).

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), Yalom and Leszcz (2005) 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):

a.   group size
b.   physical proximity of members
c.   boundary permeability
d.   role differentiation
e.   role compartmentalization
f.   information flow

Cohesion Factors (Yalom)

a.   interpersonal
b.   group size
c.   group environment

Yalom further divides the three factors into specific parts: interpersonal, factors, and environment. The vital interpersonal factors are attractiveness of members, homogeneity of members, interdependence, and atmosphere. Important group factors are size, goals, activity, history, and leadership. Factors for the group environment are intergroup conflict and group status.

How cohesiveness unifies a group:

a.   assists group maintenance
b.   increases group influence over the members
c.   increases group productivity
d.   increases group identification
e.   has desirable effects on members
f.   "fosters action-oriented behaviors such as self-disclosure, immediacy, mutuality, confrontation, risk-taking, and insight" (Corey, 2000, 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) suggested that cohesion is more likely to take place in the present orientations, rather than in theories focusing on the future or the past.

Self-Disclosure

Self-disclosure is a complex social act framed in the context of the group experience. Corey et al. (2014) referred to two levels of self-disclosure. The first involves sharing reactions to what is happening in the group. The second involved relevant and unresolved personal issues, goals, aspirations, fears, strengths, weaknesses, and matched with the purpose of the group. Self-disclosure is best conducted at the pace of the members and progresses as the group matures. It is a subjective act and usually highly personal. Some individuals reveal secrets never shared with others. Yalom and Leszcz (2005) suggested that members and leaders should exercise caution 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 suggested that leaders and members may need to shift from vertical to horizontal responding when a disclosure takes place.

Corey et al. (2014) pointed 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 takes place as the group undergoes cohesion. Some members may exercise maladaptive self-disclosure. Some examples are as follows:

> 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.
>
> Nondisclosers: These members may fear to be alone and vulnerable.
>
> Too much: These members may fail to discriminate between intimate friends and distant acquaintances.

Pierce and Baldwin (1990) developed a scale from one to ten to help leaders guide self-disclosure. The scale ranges from defensiveness, withholding, inadequate risk, and inadequate skill to lack of restraint, provocation, domination, questionable judgment, and questionable skill. The middle of the scale represents appropriate self-disclosure.

One technique that reflects how communication of self-disclosure can flow in a group is the Johari Window technique, developed by Joe Luft and Harry Ingram (Luft, 1969). The concept of self-disclosure was developed by Sidney Jourard.

Here and Now

Yalom (1985) is best known for his interactional experience of the "Here and Now." The "Here and Now" has two components. The first is member awareness to his/her feelings and responses to other members of the group. The second is the "illumination process." This process occurs when the group can reflect upon itself and understand its process. Yalom calls this the self-reflective loop. The self-reflective loop occurs through the usage of self-disclosure, catharsis, and feedback. Sklare, Keener, and Mas (1990) pointed out that "you" language, questioning, speaking in the 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 attention to nonverbals (paralanguage, proxemics, kinesics), 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. Also, 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 (2013) offered three reasons why conformity comes about in a group. These influences are normative, informational, and interpersonal.

> Normative: Norms are pressures that bring about changes in our thinking, feeling, and acting (Forsyth, 2013). A few quick examples of these standards are roundabout, four-way stop signs, 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 to establish their orderly patterns.

> Informational: Members join groups to gain information. In groups, they acquire information as to how others respond to events of interest to them. The Social Comparison Theory (Festinger, 1950, 1954), suggested that each person gains feedback as to the accuracy of his/her perceptions and beliefs.

> Interpersonal: When an individual differs from the majority, the majority will attempt to influence this person. Schachter (1951) conducted a study regarding group cohesiveness, attraction, and opinion conformity that confirmed the initial hypothesis of rejection for the deviant. Also, 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) defined 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 power as an influence in group interaction. They listed six sources of power or power bases. These are:

Reward Power: French and Raven (1968) described reward power when "the member can distribute both positive and 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.

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). One positive attribute of the use of coercive power is when it is used to bring out into the open a conflict.

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 believe it is their duty to follow these people. This type of power is used to arbitrate or mediate a conflict.

Referent Power: Referent power "is derived from the members who desire an identification with this group. The attraction and respect for the power holder is a key element" (p. 266).

Expert Power: Expert power occurs 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 the leader looked upon as a very trustworthy person. Goldstein and Myers' (1986) research revealed that people are more attracted to high-status people or those perceived to be experts.

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 can exercise and maintain control of the group. Some of these tactics are the promise, reward, threat, request, punishment, discussion, instruction, persuasion, persistence, manipulation, evasion, and disengagement (Forsyth, 2013). Falbo (1977) and Kipnis (1984) categorized power tactics as falling into one or more of three methods of application. These methods are as follows:

Directness: Overt methods such as threats, demands, and indirect methods such as evasion

Rationality: Tactics that employ bargaining, reasoning, and persuasion, while the nonrational ones utilize misinformation and emotional responses

Bilaterality: Tactics whereby both parties are involved in the negotiation. Unilateral tactics are one way, such as demands or disengagement.

In summary, Schultz (1986) concluded that emerging leader attributes and behaviors demonstrated consisted of four characteristics; self-assuredness, formulated goals, gave directions and provided summaries.

Group Roles

The different positions a group member occupies during the process are known as group roles. A role is defined as "a set of expectations defining the appropriate behavior of an occupant of a position toward other related positions." (Johnson & Johnson, 1997, p. 20). Role differentiation occurs when the group progresses toward maturity or incompleteness, and different member roles emerge. When the expectations of different obligations for roles conflict, a role conflict is noted. There is a need for different roles at different group stages, and different members will meet these positions. Benne and Sheats (1948) identified two sets of roles, task and socioemotional. The task roles are those that focus on the performance of the group as it does its work and can be sources of stress and tension in the group. Socioemotional roles are those that ease the strain and stress of the group interaction. Bales (1955) hypothesized that very few group members could 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 happens when a member is playing one or more roles that are at odds with each other. Role ambiguity occurs when the person is unsure of the behavioral requirements.

Lifton (1967) and Benne and Sheats (1948) provided a list of roles associated with the categories of task, growth, and anti group. For a more detailed description of the functions, refer to pages 20-21 of Lifton (1967). Gladding (2015) 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 anti group.

Task Roles

Initiator contributor: suggests new ideas

Information seeker: requests factual data

Opinion seeker: clarifies value premises

Information giver: brings own experience

Opinion giver: expresses own beliefs, which might be relevant

Elaborator: gives examples/rationale

Orienter: summarizes, questions direction

Evaluator: compares standards to group activity

Energizer: stimulates group to activity

Recorder: keeps record of content/action

Growth-Vitalizing Roles

Encourager: praises, agrees, accepts

Harmonizer: mediates and relieves tension

Compromiser: comes halfway, yields to move

Gatekeeper: facilitates participation

Standard setter: expresses standards for group

Observer: records group process

Follower: goes along

Anti Group Roles

Aggressor: deflates status

Blocker: negativistic

Recognition Seeker: calls attention to self

Self-confessor: expresses personal thoughts, feelings, actions

Playboy: lacks involvement

Dominator: asserts authority/ manipulates

Help Seeker: gets sympathy

Group Norms

Group norms are intended to integrate the actions of the group members. Norms are rules that are designed to govern the behavior of the members. Norms are to reflect the appropriate behavior, attitudes, and perceptions of the members (Johnson & Johnson, 1997). Conformity and compliance are two intended purposes of instituting norms in a group. Several definitions of norms are listed below:

structure individual's behavior and judgments in group settings (Forsyth, 2013)

social standards that describe what behaviors should and should not be performed in any social setting (Rossi & Berk, 1985)

what is expected and allowed in the group (Gazda, 1989)

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) described 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) described three characteristics of norms to be 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 so that future members are aware of effects.

Schein (1981) had two types of norms, pivotal and peripheral. With pivotal norms, members use reason and logic in treating other members politely. With peripheral norms, members are simply not rude to one another. These are desirable norms but not crucial to the functioning of the group.

Douglas (1991) described norms as explicit and implicit. Explicit or formal norms are standards or guidelines of which all members have awareness. Implicit or informal norms evolve from prior standards

of which members endorse. This type of norm can cause intense pressure and stress in the group and can be negative or positive. Conformity may be a concern with informal norms.

Question 6-14:

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

    a. dynamics

    b. norms

    c. feedback

    d. roles

Answer: b. norms

Curative Factors in Groups

Bloch (1986) described therapeutic factors as those elements that have an impact on the general condition of improvement for a client. Some studies attempted to isolate the factors or elements contributing to client improvement or healing for those members who participated 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 of the group. These nine variables, as well as the six elements developed by Hill (1957) listed below, were shared and derived by group leaders:

    a. catharsis

    b. feelings of belonging

    c. spectator therapy

    d. insight

    e. peer agency

    f. socialization

The common therapeutic factors in these early publications were:

a. belonging (acceptance)

b. catharsis (ventilation)

c. spectator therapy

d. insight (intellectualization)

e. 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 the 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

Yalom and Leszcz (2005) summarized curative agents in the group experience. The group experiences consisted of 29 studies, more than 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:

a. Interpersonal Input: Interpersonal input refers to the individual learning how other people perceive him or her. It is the first step in interpersonal learning.

b. Catharsis: Catharsis is a sense of liberation, of acquiring skills for another time. The history of psychopathology provides the reference to the effort to cleanse, from confessions to bloodletting. 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. Cohesiveness: Yalom and Leszcz (2005) 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 inner world, and then the acceptance by other members of the group. Cohesion provides the safety and support that allows members to explore themselves, to request interpersonal feedback, and to experiment with new behavior.

c. 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 previously dissociated parts.

d. 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.

e. Existential: The existential nature of a group fosters responsibility, basic isolation, contingency, and recognition of mortality, consequences, and how to conduct personal lives.

f. Universality: Individuals learn that their problems are not unique. Others have similar concerns. Members learn that they have unacceptable thoughts, problems, impulses, and fantasies similar to others. Yalom and Leszcz (2005) indicated that members in T-groups share secrets and that usually take one of three avenues: basic inadequacy, interpersonal alienation, and sexual secrets.

g. Instillation of Hope: The instillation of hope is a reflection of faith in a treatment mode (faith, optimism, placebo, etc.). People observe others improving and it is helpful to draw attention to this behavior. Yalom and Leszcz (2005), Corey et al. (2014), and Couch and Childers (1987) suggested 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.

h. Altruism: Several philosophers viewed altruism as a reflection of 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 and Leszcz (2005) 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

i. Family Reenactment: Yalom asserts that individuals who come to the group do so because of an unsuccessful first family experience. Those unsuccessful experiences can be a corrective experience of the primary family and can provide a sense of belonging. The family haunts the group.

j. Guidance: In the early life of a group, providing direction takes precedence. Guidance serves to function as an initial binding until other therapeutic factors become operative.

k. Identification: Individuals can learn and change from observing and watching the process.

Yalom and Leszcz (2005) thought that the process of curing could take other forms. They 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

Kellerman (1979) listed personality traits of simplicity, honesty, straightforwardness, tolerance, authenticity, trust, empathy, warmth, acceptance, understanding, spontaneity, maintaining distance, and sense of humor.

Counselors and group members exercising an external locus of control rather than an internal locus of control are prone to use excuse strategies of consensus-raising, distinctiveness-raising, and consistency-lowering attributions when confronted with a threat to self-esteem (Basal & Synder, 1988; Snyder & Harris, 1987).

Group

Member's ability and adjustment

Groups composed of friendly, expressive, and people-oriented members (Jacobs, Masson, & Harvill, 2002)

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 of the effectiveness of groups.

OBJECTIVE 6D: Characteristics and Functions of Leaders

Objective 6 d. characteristics and functions of effective leaders (CACREP, 2015, p. 12)

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. Also, leaders do not always work alone; they have a co-leader.

Co-Leaders

A co-leader is usually a professional who will share the leadership and frequently utilized when the group exceeds 10 or 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 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 suggested that if a male and female are co-leading gender concerns might be easier handled. Corey et al. (2014),

Gladding (2015), Kottler and Engler-Carlson (2015), and Posthuma (2001) described similar characteristics and beliefs regarding the advantages and disadvantages in co-leading groups. Some of these advantages and disadvantages are:

Advantages

  a. better group coverage
  b. compatibility
  c. pragmatic considerations
  d. sharing responsibilities
  e. differences in personality
  f. support for low-functioning members
  g. continuity of care
  h. role-modeling and role-playing
  i. feedback
  j. training
  k. shared knowledge

Disadvantages: mainly relational difficulties (Luke & Hackney, 2007)

  a. lack of coordinated efforts
  b. interpersonal conflict
  c. too leader-focused
  d. competition
  e. collusion (informal alliance)
  f. pacing (equivalent)
  g. leaders can act as rivals
  h. triangulation

In summary Gladding (2015) highlighted the advantages in co-leaders from other group writers (Carroll, Bates, & Johnson, 1997; Corey et al., 2014; Jacobs, Masson, & Harvill, 2002) regarding ease in handling difficult situations, use of modeling, feedback, shared specialized knowledge, and pragmatic considerations.

Some disadvantages were the lack of coordinated efforts, too leader-focused, competition, and collusion. Posthuma (2001) added better group coverage, sharing responsibilities, support, continuity of care, role-modeling, and training. The disadvantages are competitiveness, need for control, dominant personalities, pacing, and a relationship between the two.

When leaders emerge from within groups such as self-help groups, Beck, Dugo, Eng, Lewis, and Peters (1983) identified 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 difficult to manage.

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 downside is he/she may make a group uncomfortable if it has not reached that stage of development.

4. Task: He/she becomes the authority of the group, sets norms, facilitates equitable interaction, clarifies goals, and will keep the discussion focused (p. 163).

Leadership

Trained leaders meet the qualifications and standards established by ASGW. Also, leader attributes consist of self-confidence, responsibility, ability to listen, objectivity, genuineness, empathy, warmth and caring, respect, flexibility, creativity, enthusiasm, humor, clinical reasoning, and the capacity to use self (Posthuma, 2001).

Forsyth (2013) 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).

a. Reciprocal: The leader, group, and setting all influence each other.

b. Transactional: Social interchange takes place between the leader and the member.

c. Transformational: The leader reinforces the change process by uniting members and changing their values, beliefs, and needs through the members' motivation, confidence, and satisfaction.

d. Cooperative: A legitimate use of power given by membership.

e. 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 provided some understanding of how leadership will emerge in a group. First, the silent members are rejected, followed by the overly talkative and aggressive members. Approximately half of the group will eliminate themselves because of various reasons, and 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 the basis of leadership resides on 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:

a. drive for responsibility and task completion
b. vigor and persistence in pursuit of goals
c. venturesome and originality in problem-solving
d. drive to exercise initiative in a social situation
e. self-confidence and sense of personal identity
f. willingness to accept consequences of decisions and actions
g. readiness to absorb interpersonal stress
h. readiness to tolerate frustrations and delay
i. ability to influence the behavior of others
j. capacity to structure social systems according to the purpose at hand

Forsyth (2013) 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:

a. Physical characteristics: Group members appear to associate leadership with height and weight. Leaders are larger and heavier, thus giving an appearance of power.
b. Gender: Men outnumber women as leaders in small groups and unstructured groups.
c. Intelligence: Groups tend to prefer leaders who are more intelligent.
d. Personality traits: Stogdill (1974) found leaders to be higher in achievement orientation, adaptability, ascendancy, energy level, responsibility taking, self-confidence, and sociability.
e. Task abilities: Stogdill (1974) found groups prefer leaders possessing skills and abilities valued by the group and enhancing their chances of achieving success.
f. 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 on the task and interpersonal dimensions. The theory suggests that the best leader is one who meets the needs of the group and 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's focus is the concern for people and concern for results (Blake & Mouton, 1964). This model utilizes a rating scale (1-9) along both dimensions. The evaluation 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. 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, relationship and task (Halpin & Winer, 1952). Some descriptors of each category are as follows:

1. Relationship:
    a. relationship-oriented
    b. socioemotional
    c. relation-skilled
    d. supportive
    e. employee-centered
    f. group maintenance
2. Task:
    a. task-oriented
    b. work-facilitative
    c. administratively skilled
    d. goal-oriented
    e. production-centered
    f. 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 supports the contention that the personal characteristics of the leader and the nature of the group situation determines effectiveness (Fiedler, 1978).

Styles Approach

Kurt Lewin, Ronald Lippitt, and Ralph White (1939) conducted the classic study on participatory leadership styles with 10- and 11-year-old boys who worked on hobbies. The three participatory 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 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.

AUTOCRATIC: Self-centered "I" and a need for power and prestige. This type of leader often fosters hostility and dependence. Where a critical and quick decision is needed, the autocratic method would be the most effective. This autocratic leader desires to control and to be in charge. Members in this type of group tend to be unaware of behavioral expectations. Goal attainment for this leader is for the group and not necessarily the individual members.

DEMOCRATIC: This is a problem-solving style. A "We" concept in the development of a group that leads to better decisions because of a desire to serve the group. Power is derived within the group, while responsibility and authority shared and the leader is motivated by persuasion and tolerance. The process is to create a safe environment and to involve all members. The leader will guide rather than direct, be receptive to member participation and ideas, leave decision-making to the membership and occasionally offer suggestions.

LAISSEZ-FAIRE: This is a non-leader style with complete freedom. Rarely does the leader interact with the members. Members make all decisions. This type is a passive or anarchy-type leader, an active listener. This leadership method may be effective if all members are committed to a plan. In therapy groups, this type of leadership will surface increased anxiety among the members.

DIPLOMATIC: This leader is interested in personal gain and will manipulate the members to achieve that end. Some descriptors of this method are the manipulator, personal gain, recognition, and hidden agenda.

BUREAUCRATIC: Social groups are often led by bureaucratic leaders. The leader will use a fixed set of rules and tends to be impersonal and rule-centered and will avoid interacting with the members, yet demands loyalty.

Question 6-15:
What leadership style is associated with a small interaction group and member satisfaction?

    a.   autocratic

    b.   bureaucratic

    c.   democratic

d.   laissez-faire

Answer: c. democratic. Democratic style of leadership tends to be highest in satisfaction in small, interaction groups.

Question 6-16:
A group with a laissez-faire style of leadership will find members experiencing:

a.   increased anxiety level

b.   increased individual power

c.   identification with the leader

d.   personalized problem attention

Answer: a. increased anxiety levels

Leader Techniques for Problem Situations

Possible questions regarding problem situations in a group 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 that 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 a situation, the leader is to take control. Different group situations warrant different responses and some suggestions are included for leader techniques. Gladding (2015), in researching problem members for groups, combined the work of several writers and listed six common problem members. These are:

MANIPULATOR: The manipulator attempts to use his/her feelings and behaviors to weaken the leader's function. Gladding (2015) pointed out that 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 to most manipulation that continues.

RESISTER: The resister attempts to remain out of exercises or involvement of the group. He/she will stand in the way of the group forming.

Leader Technique: Affirm these members, confront and interpret what is happening, invite him/her to participate

MONOPOLIZER: The monopolizer attempts to capture the group's attention. Gladding (2015) suggests this person may have underlying anxiety. Kottler and Engler-Carlson (2015) uses the term "entitled member" to refer to the monopolizer and overly talkative one. He views this member as attempting to control and keep the focus on him/ herself. He/she is frequently rigid and will sabotage help. He/she will come late or miss sessions and is needy and demanding.

Leader Technique: Confront this behavior and interpret how this behavior affects interpersonal behavior within the group and is self-defeating. Cutting off is appropriate.

SILENT MEMBER: The silent member may be nonassertive, reflective, and shy. Or the silence may represent some underlying behavior such as hostility. This member usually lacks trust in the leader, or the behavior is an inadvertent style based on an inadvertent state of mind. Silence may represent a cultural value or even a disciplined behavior.

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 and Engler-Carlson (2015) and Corey et al. (2014) suggested at times confront, create a structure which is more conducive to working with a silent member, and even pursue an individual session.

SARCASM: The sarcastic member utilizes sarcasm in an attempt to hide anger and finds it difficult to express his/her feelings.

Leader Technique: The leader can interpret what is happening (how the sarcasm is used) and encourage members to promote feedback. The task is to help the person recognize and effectively deal with his/her masked feelings.

FOCUSING ON OTHERS: The focuser focuses on others in an attempt to take on the leader's role. This member will ask questions, give advice, and remain out of the helping process as though he/she is not one of the group members. This member may also have difficulty with self-disclosure.

Leader Technique: The leader can help teach the person that personal involvement through some level of self-disclosure is more helpful than the role of leader.

There is some consistency in terminology regarding problem members, yet some response differences exist. So, several different lists will be presented. Yalom and Leszcz (2005) 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 and Engler-Carlson (2015) listed 14 difficult group member types, mostly similar to the debilitated listing of 17 problem members by Ohlsen, Horne, and Lawe (1988). The lists did not necessarily use similar names but did include avoiders, withdrawers, alienators, naiveté, Pollyannas, dependents, harmonizers, coordinators, problem solvers, poor me, special interest pleaders, attackers, resisters, and super-helpers. Ohlsen et al. (1988) identified several specific behavioral problems exhibited by different group members. These are:

1. Emotionally Debilitated: Those who fear the intensity of emotional expression
2. Chronic Suppression: A group member does not understand the depth of difficulties or hurt (hopelessness)
3. Emotional Episode: When a client has a debilitating emotion such as anger, hate, grief, etc., and wants to blame others for this condition.
4. Griever: The individual is obsessed with a love object.

5. Anxious Client: When a person doubts his/her ability or coping skills and interferes with effective action.

6. Hostile: Ohlsen, et al. (1988) suggested that this member may have been badgered, over-disciplined, and abandoned. He/she often reveals hostile feelings in a group.

7. 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.

8. Learning Disabled: This individual member has a disorder or is developmentally delayed.

OTHER-CONTROLLED: This member makes an undue effort to meet the needs of others. This member tends to go with what other members deem important. As a result, the other-controlled member often feels used and thus resentful (Ohlsen et al., 1988). Assertiveness training is a recommended treatment. These authors describe other-controlled as the silent or withdrawn (empathic silence, slow-moving, hostile silence, observer), scapegoat, socializer, dependent, and the advice giver.

RELUCTANT MEMBER: Reluctance may be an aspect of the counseling process and, as such, fear of the unknown and suspicion are common behaviors of the 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 (2001) cited a prepared list by Dyer and Vriend's of problem members in a group. The below list is a combination of their list and Corey et al. (2014), and Jacobs, Schimmel, Masson and Harvill (2016).

a. Noncontributor: Seek a smaller group. Ask questions about strengths. Give time and play it safe.

b. 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.

c. 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 useful sharing.

d. Rambling: The talkative person will use long and drawn-out tales. Once the rambler has shared, the leader can request him/her to paraphrase and reduce what he/she related.

e. 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.

f. Non-contributor-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.

g. 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."

h. Slow to learn: Often lacks the 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. The structure is required.

i. Rescuer: Smooths out or over negative feelings and prevents members from resolving problems. As the group progresses, draw this behavior to the attention of the member. Train the group members how to be therapeutic.

j. Fighter: Enjoys the disruption. The peer group is the most effective behavior adjustment. Allow the group members to solidify and encourage members to talk to each other. Norm setting is another effective way to handle the fighter.

k. Negativist: The negative member complains about the group or displays disagreements. Attitudes and behaviors run counter to the leader and group goals. Do not confront head-on. Talk outside of the group and ask for help from the member. Identify allies and avoid eye contact when the member is negative. Later, through emphatic responding, reflect on the behavior. It is usually an error to confront the negative member about his/her negativistic behavior. Recommended by several authors is to avoid making direct eye contact with a negative person. Sometimes this behavior will intensify the feelings and behavior.

l. Resistant: Let member to 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. (2002) recommend encouraging the resistant member to share his/her feelings in the group. If there is no progress, then talk with the member after a group meeting. Identify allies and direct questions to them. Recommended by several authors is to avoid making direct eye contact with a person exhibiting resistive characteristics or behaviors.

m. "Get the leader:" This behavior is 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, Harvill & Masson, 2002).

n. Silent: Corey suggested modeling respect for the silent member. Allow the group to initiate interest in the silent member and their 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 with the silent member the importance and impact his/her silence has on those who have shared.

o. Monopolizer: Cutting off and shifting the focus are helpful techniques and Corey suggested that giving feedback in the form of humor can be effective. Let the group struggle with the monopolizer.

p. Sarcastic: Elicit feedback from other members. Teach members how to be emotionally honest and present with one another.

q. Focuses on others: Encourage members to get something from the group for him/her.

The first time a behavior occurs for a leader and 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 and Engler-Carlson (2015) identified some 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 and Engler-Carlson (2015) cited Brown's (1992) suggestions as to the importance that the leader get these behaviors out in the open to all members, so that members can learn to hear non-defensively, learn to interpret accurately, develop skills in the practice of giving feedback, become more perceptive in his/her cognitions, collect data about one another, and learn to become accepting and flexible in his/her perceptions.

Question 6-17:

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 round type of activity in that everyone was giving a brief history of his/her origin. Nothing shared at this point appeared to be of an emotional magnitude to prompt such a response. What should the leader do?

    a.   ignore the behavior out of respect and continue with the rounds

    b.   suggest to the person to take a break for some water and return when he/she is ready

    c.   create a break for the group and take the person aside privately and speak to him/her

    d.   do not focus on the person; create dyads with an assignment such as what group experiences each has had in the past and what his/her reaction was to the experience

Answer: c. create a break for the group and take the person aside privately and speak to him/her. Of the options available this choice might be preferred because this is the second session and members are not that well acquainted. Thus, members might be reluctant or uncertain of group behaviors to move toward the member. Also, cohesion, according to theory, would not be established whereby membership would likely take control and members would seek to support with sensitivity and respect. To avoid focusing on the member (option d) could intensify the uncomfortableness in the group as well as the member. What was disturbing to the client to evoke the crying could be something recent that took place before the group or something from the rounds that triggered her/his response.

Question 6-18:

Group interaction occurs on two levels. The first is an interaction that is conscious, and the purpose is known (public) in the group and is public agenda. The second is hidden agenda. All are signs for the leader when hidden agenda might exist in a group except:

    a.   emotions overtake logical thinking

    b.   personal attacks, scapegoating, grumbling

    c.   withdrawal into silence

    d.   lack of coalitions and cliques

Answer: d. lack of coalitions and cliques. Hidden agendas may not exist in some groups but when they do hidden agenda refers to aims of some members to achieve or accomplish personal goals but not make them known to the group. The individual hidden agenda may be conscious or unconscious but likely to impede group process. The group as a whole can also have hidden agenda.

Question 6-19:

In the previous question (hidden agenda) assuming the hidden agenda is a group hidden agenda what strategy might the leader utilize to understand and move through the hidden agenda?

    a.   challenge the group regarding the resistance

    b.   use a specific technique to bring the hidden agenda to the surface

    c.   maintain control of the group, or it is likely to dissolve

    d.   leader ask self-questions such as "what does this mean", "am I pushing too hard", "is this about me"

Answer: d. leader ask self-questions such as "what does this mean", "am I pushing too hard", "is this about me." The leader may want to assess whether the hidden agenda is conscious or unconscious in the outcome thus the response is likely to be different dependent upon that assessment.

Specific Techniques

Leader techniques and skill development, for the most part, involve timing and effective communication for dealing with membership involvement, conflicts, and client issues. Some areas for leader or client work involve breaking eye contact, redirecting, last-minute input, monopolistic behaviors, recognition and gatekeeping, taking turns, nonverbal contact, confrontation, apathy, tension, nonparticipation, eye contact, agreements (dis), asking for opinions, direct questions, silence, disturbed individuals, and termination.

Cutting Off

The goal of 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 (2002) indicated 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. the session is nearing the end (p. 161)

Timing is crucial for intervention. It must be optimal. That is, action or interventions too early may cut off communication and involvement. If cutting off is too late a behavior may have generated its energy and take on dynamics calling for leader involvement.   Cutting off can be used when the leader wants to shift the focus. Jacobs et al. (2016) indicated that cutting off could proceed in three directions: cut and stay with the person, cut and stay on the topic, and cut and leave the topic and person. Cutting off can be efficiently carried out through the use of voice, clarifying the interruption, nonverbal expressions, and the refocusing method.

Question 6-20:

A personal growth group has been ongoing for four sessions. One of the nine members has been monopolizing much of the time for most of the four sessions. The two leaders were concerned because it appears as the sessions have progressed more members seem to be involved less, are not listening, and some degree of apathy exists when the monopolistic member starts to talk. The group has not reached cohesion yet, and cohesion appears to be slowing down. The co-leaders have decided that they should do something before charging the membership to deal with the spacing for everyone in the group. What might be a positive step for the co-leaders to take to begin the process without alienating that member?

a. one of the co-leaders to sit beside the monopolistic member

b. take the member aside and ask him/her to help the leadership involve more members to participate

c. ask the group what they think of everyone's involvement

d. open up a topic about how much involvement each member might want in the group

Answer: a. one of the co-leaders to sit by the monopolistic member. This technique is good for someone (member) struggling with impulse control or reality. A few non-verbal behaviors can be associated with the proximity of sitting next to the member. The co-leader may not want to solicit a leadership request from this member because it may set a precedent for this member to be apart (separate) from the rest of the group especially if he is not considered a leader by the members.

Question 6-21:

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. (2016) stated that arguments can only be harmful to a group as they affect cohesion and should only be allowed to continue if they in some way are productive for the group. Shifting focus to the group to reflect on the interacting can be feedback for the two arguing members.

Question 6-22:

A member appears to be rambling, and it has gone on for an extended period. In fact, the leader has noticed this in previous sessions. What is one of the cues that may be an indication for the leader to recognize that he or she should cut off the member?

a. when redundancy begins to set in with the member

b. when other members start to argue with the rambler

c. when silence becomes noticeable within the group

d. rely on the leader's experience and feedback from other members

Answer: a. when redundancy begins to set in with the member. From an informational standpoint, redundancy is a good cue that cutting off is in order. Letter d. is also an effective behavior; however, the leader can create new and effective behaviors if he or she cuts off.

Pacing

Jacobs et al. (2002) referred to pacing as the rate at which the group moves. Pacing influenced by the leader or members can exist because of the rate of speech and pattern. This pattern includes tone, pitch, volume, and rate. If a group moves too slowly, members will lose interest, become bored and frustrated, and tend to wander. The voice is the key to pacing.

Setting Tone

Setting the tone is conveying and setting a mood for the members, creating a disposition 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) identified several possible tones to be serious, social, confrontive, supportive, formal and on-task.

Linking

Nelson-Jones (1992) described linking as the connecting of the meaning of what one member says or contributes in a session to what another member shares in a session. Linking is an insightful gathering of common themes and feelings that different members are demonstrating.

Question 6-23:
A member of a growth group has been silent from the beginning and for the better part of several sessions. The leader wants to draw the person into the group. What action might the leader take to bring this person into the group?

   a. call on two or three members and through the use of the leader's eyes determine if the silent member will speak, but the leader should keep in mind to always provide an out for the member

   b. ask the silent member what he or she thought about the topic that another member just shared

   c. look directly at the person you would like to see share more (subtle non-verbal shift)

   d. speak to the person saying that the group would like to hear more from him or her; stress that the group is interested and would like for the person to feel a part of the group

Answer: b. ask the silent member what he or she thought about the topic that another member just shared. The silent member may be more comfortable speaking or reflecting outward before he or she reflects from within. This freedom to speak or reflecting outward allows the member to receive validation from the other members as to how they evaluate what is presently occurring, thus increasing his/her acceptance and confidence level. If the statement had indicated that in the early part of the group, the person had spoken perhaps a different answer would be suggested.

Focus

Jacobs et al. (2002) highlighted two other group leader skills: 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:

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). Also, 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, determine 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.

How long to hold the focus: This depends on the type of group or content of the focus, but the upper limit is 30 minutes (Jacobs et al., 2002).

How to hold the focus: The primary 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. (2002) believed that the essential behavior is to act quickly, not to wait.

When to shift the focus: Jacobs et al. (2002) recommended shifting the focus when the focus has been on one person, topic, or activity for too long. Also, 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 a topic to a person, topic to an exercise, person to person, person to a topic, or from a person to an activity (p. 109). Observing membership involvement is another form as members withdraw from the interaction or more become involved (interest).

Question 6-24:
When a member is rescuing another member, he or she is:

a.   providing answers for the focused person, who is unable to provide the answers.
b.   smoothing over negative emotions that someone else is experiencing.
c.   creating a situation where a focused member will have to deal with a real-life situation within the group.
d.   cutting off the focused member from the exploratory phase of the process.

Answer: b. smoothing over negative emotions that someone else is experiencing. Rescuing is not a behavior that the leader should reinforce. At the same time, a leader wants to exercise caution in cutting off a member. Rescuing occurs most often in mutual support, self-help, and growth groups. Some of the dangers of inappropriately cutting a member off are likely to diminish sharing by all members, not clarify why the interruption has occurred, shift the focus away from the topic, and shift the focus away from the person to a topic.

Drawing Out

Jacobs et al. (2002) described drawing out as a specific technique for the leader. Drawing out is "skill to elicit group members' comments" or involvement (Jacobs et al., 2002, p. 170). The reasons to draw out a member are varied. However, the group goal is to elicit more involvement. More involvement will generate more ideas, information, 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 et al. (2014) suggested the use of rounds, direct and indirect methods. Rounds are short stimulus statements/questions in which each member responds. These can be specific words, phrases, homework, adjectives, feelings about how they are at this time in the group, and feelings about a topic. The direct method uses direct questions, while the indirect

method can come about through the use of dyads, rounds, written expressions, and role-playing. Jacobs et al. (2002) suggested that a skillful method is to use the leader's tone of voice and caring, accepting attitude as vehicles for inviting and giving permission to speak.

Question 6-25:

You are a leader in a personal growth group. There are nine members in the group committed to their own group goal(s) and in the sixth two-hour session covering ten weeks. One of the members begins to cry silently 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 tears

    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 and assess what has troubled the member

Answer: b. exercise patience and allow the group to respond to the member. This group is in the 12th hour of the process and likely in the working stage where cohesiveness is established. If the leader has shifted the responsibility to the group, members will likely attend to the affected member with sensitivity and support.

Rounds

A useful and versatile technique to involve participation in the group process for the leader is rounds. To conduct rounds as an exercise is to request that each person reflects 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) cited 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, phrases, and comments are three types of rounds commonly used to reflect the here and now (Jacobs et al., 2002). Communicating in the here and now gives the group members a sense of where they are about everyone else. A word or a phrase used in another form of rounds can be 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

OBJECTIVE 6 E: Group Formation, Screening, Selecting

Objective 6e. Approaches to group formation, including screening, and selecting members (ACA, 2015, p. 12)

Yalom and Leszcz (2005) believed that the size of a functional group to be seven to eight members, but anywhere from five to ten members is acceptable. They stated that three to four members are too small to constitute a group because a critical mass will not occur. The 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) believed 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) considered four couples the maximum number in conducting a group for couples. Corey et al. (2014) recommended eight as an optimal size for college students or adults. Adolescent size groups can be in the range of six to eight and for elementary age students three-five.

Gazda (1989), considering different theories of groups and specific populations, made the following suggestions:

a. Elderly, six to eight
b. Substance abusers, 12 to 20
c. Alcohol abusers and adolescents, eight to 12
d. Alcohol and adult inpatients, five to six; psychotherapy theme, six to eight
e. Psychoeducational theme, ten to 14
f. Insight and personal change, eight to 12; self-help, ten to 20
g. Preschool, five or less
h. Preadolescent, five to seven
i. Adolescent, short duration five to seven, longer duration seven to ten
j. Existential, problem solving eight to 12; under medical care three to four
k. Person-centered, eight to 12
l. Adlerian, ten to 12
m. Multimodal, four to 10
n. Gestalt, eight
o. 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 some variables, such as interaction, type of leadership, themes, and settings. 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 distinct 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 different dysfunctions. The purpose of the group will sometimes divide the group into a 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 the reorganization of character

Therefore, heterogeneity is better suited for conflict areas and coping, and homogeneity for ego strength, patient vulnerability, and capacity to tolerate anxiety.

In summary, identification groups (age, gender, issue) provide the group with a feeling of solidarity (Donohue, 1982). Homogeneous groups operate at a more superficial level and are less prone to making a permanent change. This type of group does tend to be more cohesive, have better attendance, fewer conflicts, and faster relief of symptoms (Hansen, Warner, & Smith, 1980).

Question 6-26:
Homogeneous as opposed to heterogeneous groups tend to reflect all of the following except:

a. greater success in changing permanent behaviors.
b. are more cohesive.
c. are better-attended.
d. have fewer conflicts.

Answer: a. greater success in changing permanent behaviors. In homogeneity membership there is a tendency to experience less success in changing permanent behaviors (Hansen, Warner, & Smith, 1980). Homogeneous groups tend to have faster relief of symptoms from the mutual support.

Question 6-27:
Forming groups by age, gender, or issues tend to generate a group feeling of:

    a. individualism

    b. solidarity

    c. immunity

    d. confidentiality

Answer: b. solidarity - a feeling of relative comfort and security.

Why people join groups

There are many reasons why people seek group experiences. Therapists and friends have referred some individuals. Earlier it was noted that five types of problems are typically brought to a group setting (Ohlsen et al., 1988). Below is a list of reasons for joining a group keeping in mind the type of growth, task, support or event developed. The outcome of group formation often eliminates or adds different dynamics to the time spent in a group.

Motivation: Individuals have specific reasons, such as learning to meet others. Yalom believed that many join groups to re-experience an unsuccessful experience with their primary family. They learn to renegotiate and become successful.

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).

Other reasons typical of growth groups:

    a. a sense of something missing in life

    b. feelings of meaninglessness

    c. to diffuse anxiety

    d. anhedonia

    e. identity confusion

    f. mild depression

    g. self-derogation/self-destruction

    h. compulsive workaholic

    i. fear of success

    j. critical incidents

Forsyth (2013), in reviewing group research (objective 6c-research), summarized the work of Mackie, Goethals, and Moreland. From this research Forysth isolated two major reasons groups form: a functional perspective and interpersonal attraction. The functional perspective considers 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 (2013), 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 (2013) isolated several concepts to explain the interpersonal function. The attraction members have for one another, if strong enough to form a group, is explained by several factors or hypotheses. Some of these are as follows (objective 6b):

Similarity/attraction effect. Newcomb (1961) reported that there are four forces acting to cause a similar attraction effect. The fact that people like others who are similar to them is reinforced by the values and attitudes in others that serve to reinforce that their perceptions and beliefs are accurate.

a. Interaction at a future time is more likely and will be free of conflict.
b. People feel unity with those like them.
c. To dislike someone similar is distressing.
d. People like others who are similar to them.
e. Complementarily-of-needs hypothesis. People are attracted to those who are dissimilar in that they fulfill or complement their needs.
f. Proximity/attraction effect. This closeness concept is one of "mere exposure" where people tend to like those who 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.
g. Self-evaluation maintenance model. Tessar and Campbell (as cited in Forsyth, 2013) suggested 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 crucial.
h. Cialdini, Borden, Thorne, Freeman, and Sloane (1976) coined the term birging (self-serving, basking in glory) 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.
i. Comparison Level (CL) and Comparison Level for Alternatives (Clalt). Thibault and Kelley (as cited in Forsyth, 2013) believed that people join groups according to CL, which is the standard used to judge the desirability of group members. The Clalt is an evaluated choice for the greatest reward/cost. The individual will utilize a balance sheet when alternative groups are available.
j. Buffering hypothesis. Cohen and Willis (as cited in Forsyth, 2013) in researching stress, offer the hypothesis that people who belong to groups experience fewer psychological and physical problems than those who do not belong to groups.

Reasons Members Drop Out of Groups

As with individual therapy, a member may drop out of the group for reasons unknown to the therapist. However, in group there is usually a member aware of what caused the individual to drop out. Below are several common reasons for dropping out:

1. external factors: These are factors outside of the group.

2. physical, such as moving, scheduling, illness, etc.

3. external stress, such as disruption of a significant member of his/her life.

4. group deviancy: Member does not fit in, and every group has the potential to have a member (youngest, unmarried, student, clown, hostile) who acts out. A deviant member by definition often:

    a. lacks psychological sophistication

    b. lacks interpersonal sensitivity

    c. lacks personal psychological insight

    d. remains on the symptom level

    e. is unable to participate in the group task

    f. find that his/her contributions fail to match high group standards

    g. does not value or desire personal change

    h. intimacy: A member who has difficulty with self-disclosure usually has:

    i. maladaptive self-disclosure (too much/little)

    j. unrealistic demands for instant intimacy

    k. 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 emotional reactions.

    a. fear of emotional contagion: Examples of a contagion are:

    b. fear of hearing the problems of other members. A sign of permeable (penetrate) ego boundaries and inability to differentiate oneself from significant others.

    c. intolerable fear of being alone and an irrational sense that one does not exist unless one is being observed and attended by others.

    d. 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 another therapy, 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 taking place in the session. The reasons can be external and internal. Example: A member

may have planned to b on 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, subgrouping gives rise to factions not resolved, and consequently, one or more members may quit the group under the pretense that the group is not right for them.

Pre-Interview

The ACA and the Association for Specialists in Group Work (ASGW) emphasize the ethical considerations of the pre-interview. The 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 the 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 a person to a self-esteem group. A person 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 that will increase 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. Inform consents are procedures to inform members of the risks, pros, and cons of group work, misconceptions, history of the group, confidentiality, release of information, and working with minors.

5. What are the leader qualifications? The leader is to share leadership experience, style of leadership, expectations, and theoretical orientation.

In summary, the pre-interview serves as an informed-consent procedure so that each member becomes aware of expectations and what takes place in this type of group before it begins.

How to Begin a Group

There are numerous suggestions about how to start a group. It is the contention of several group authors that one should start with what attracted the members to the group such as what was advertised. Starting a task group may be very different from a personal growth group. Member introduction and the members goals shared for attending the group are a part of the initial process. 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.

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 again during the first meeting and includes ethical obligations, rules of conduct, research possibilities, releases, scheduling, disturbances, risks, history of the group, curative factors, and leader qualification. Several of these actions may not be important for a task group as it is for a therapeutic group.

The leader starts with an opening statement regarding the identity of the group, 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), techniques will vary. In therapy groups, trust frequently is an issue, which needs to be introduced early. The second topic for a first session is a statement of an initial goal of or reason for being in the group.

In therapy groups, leaders will often utilize rounds to check in with the group members. Rounds 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.

Evaluation

Planning the evaluation is critical for goal assessments throughout the life of the group. There is to be evaluation plan for the entire group as well as the individual members. The evaluation can take the form of written goals assessed with a rating scale or instruments. Suggestions for process note taking during the group experiences will assist in memory recall for smaller details to emerge and become a part of the outcome. A follow-up will provide feedback should the membership be homogeneous or heterogeneous.

The best practice guidelines 2007 revision within the scope of practice (A.3. C.3) specifies assessment to include group workers assessing their knowledge, skills and ecological awareness. Ecological assessment refers to the needs of the community, agency or organization resources, organization mission, staff competency, attitudes regarding group work, professional training levels of group leaders, client attitudes regarding group work, and multicultural and diversity considerations (Thomas & Pender, 2008). Section C.3 evaluation and follow-up state that group workers evaluate process and outcomes and to conduct follow-up contact with group members.

Interaction process analysis is a method of observation developed by Bales (1950, 1955) although later identified as a system for the multiple level observation of groups (SYMOG; Bales, Cohen & Williamson, 1979). In this system, observations are conducted for positive social/emotional areas, negative social/emotional areas and neutral task areas. A formal method of evaluation is to use forms for group development or diagrams that include topics of unity, self-direction, climate, leadership distribution, responsibility, problem-solving, methods for resolving disagreements, basic needs, activities,

depth of activities, leader-member rapport, role of leader, and stability. Depending on the type of group and group goals items can be deleted or added.

OBJECTIVE 6F: CONDUCTING GROUP TYPE

Objective 6 f. Types of groups and other considerations in conducting groups in varied settings (CACREP, 2015, p. 12)

Types of Groups and Characteristics

A group has a special type of focus and resembles a task-work emphasis, guidance-psychoeducational direction, counseling-interpersonal problem-solving, and psychotherapy-personality reconstruction (Gladding, 2015). Capuzzi and Gross (2001) summarized group type according to common writings by several group authors such as:

a.   group psychotherapy
b.   therapeutic groups
c.   human development and training groups
d.   self-help groups

Each of 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 may be overlapping.

a.   Psychotherapy Group: 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), pointed out that emotional attachments between members in a psychotherapy 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 regarding Stein and Kibel's three concepts of emotional attachment: interpersonal, intrapersonal, and integral.

b.   Interpersonal: Individual therapy within a group wherein individual theories and practices of treatment are applied to the individual.

c.   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.

d.   Integral: Emotions that are integral emphasize the group as a whole where the individual is seen in interaction with the group entity.

e.   Primary Group: Charles Cooley defined a primary group as a face-to-face experience where close 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).

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f. Sensitivity Group: A sensitivity group was first a laboratory training using an educational method that emphasized experience based upon learning activities, a learning by doing (Eddy & Lubin, 1989).

g. Encounter Group: 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).

h. Structured Group: Social skills training with structure. Drum and Knott (1989) defined 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).

i. Parents without Partners: This type of group as well as Alcoholics Anonymous, Overeaters Anonymous, and others are voluntary groups of people 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:

a. Reference Group: "Any group to which an individual relates his attitudes and 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 regarding the degree of conformity to certain standards of behavior or attitude (Kelley, 1952).

b. 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 when achieving the goal will dissolve.

c. Self-Help Group: Self-help groups meet two needs, a basic need for help when in crisis and serious difficulties. A second need is for independence and autonomy that self-help groups foster. A self-help support-system type of group is one in which individuals with common problems and life dilemmas bind together and create a protective environment from psychological stress. The purpose of this type of group is to provide a safe shelter so that members will feel motivated to begin a change in their lives. These groups are frequently created by the members with similar concerns and are not usually serviced by professionals. Personal responsibility and action are two main themes.

d. Balint Group: A Balint group was named after the founders 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 interns, residents, or physicians learned about when and how they did or did not respond empathetically to patients. Also, the members learned about the psychosocial dynamics that were the basis of the patient's complaint.

e. Closed Group: This type of group begins with a set number of members and no new members throughout their commitment of time together.

f.   Open Group, frequently found in hospital settings, admits new members at any time during the duration of the commitment. There are advantages and disadvantages to both open and closed groups.

This brief presentation suggests the existence of many types of groups, and it is easy to recognize that additional group knowledge is necessary to understand all aspects of them. The purpose of a group will often dictate the membership, composition, structure, leadership, dynamics, and process.

CONFLICT: FACTORS THAT AFFECT CONDUCTING GROUPS

Conflicts are common in group experiences consisting of interpersonal conflict between and among members, goal differences, leadership issues and dynamics that induce stress among members.

According to Forsyth (2013), conflict is disagreement, discord, and friction among members. The behavior is one of resistance by one or more members of beliefs, emotions, and 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 (2013) quoted 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 the several forms. Forsyth cited several of these behavioral forms to be attribution, entrapment, arousal and aggression, and reciprocity.

a. Attribution: Individuals make assumptions about causes of behavior and situations. Heider (1958) suggested that group members will make an intuitive hunch about some particular situation or event. Conflict may result if stubborness fosters other member's lack of competence and personality characteristics.

b. 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).

c. Arousal and Aggression: If members are unable to reach their goal frustration results and may lead to the motivation to act, often in an aggressive manner. Should the situation continue to escalate often the outcome is a display of hostility.

d. Reciprocity: Reciprocity is a type of sustaining conflict in that the members believe in fair play. If some members treated another unfairly, that person feels that he or she is deserving of unfairness and allows the conflict to persist.

Bion (1985) indicated that there are three conflicts that will affect group function. These are:

1. The first is a 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. The second conflict exists between the group and the member who desires a goal that is contrary to the group goal or group need.

3. The third conflict is between the problem-oriented work group and the basic growth-oriented group.

Social interdependency theory explains conflict factors as cooperation and competition. 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, 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 an 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 the 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 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:

a. physical flight (absences or lateness to session)
b. non-participation (silence and withdrawal by members)
c. extended focus (blaming and gossiping)
d. ventilation (grievances and anger)
e. monopolizing (attention-seeking and rambling)
f. intimidation (emotional blackmail and verbal abuse)
g. seduction (helplessness and eroticism)
h. red crossing (rescuing and avoiding conflict)
i. intolerance (peer pressure and prejudices)

Rose (1989) cited a list of common problems for adults that include both members and process. They are:

a. low cohesion
b. overly-dominant member
c. member withdrawal
d. excessive off-task behavior
e. destructive coalitions
f. over-dependence on the leader
g. active conflict
h. problematic group norms

Because conflict is common in most groups, a leader function is to manage this conflict. According to Simpson (1977), conflict can be managed by one of the following five actions:

1. withdrawal
2. suppression
3. integration
4. compromise
5. power

Question 6-28:

Different group processes can lead to an attack on the leader. Which one of the following does not foster an attack on the leader?

a. risk-taking and sharing

b. subgrouping

c. fear of intimacy

d. extra-group socializing

Answer: a. risk-taking and sharing

Question 6-29:

Which of the following is recommended if a group leader should find himself/herself under attack?

a. play devil's advocate.

b. ignore the attack.

c. view 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. view it as an opportunity to shape new norms and promote group movement. Answer d. is a viable option; however, without more information, this behavior may be premature.

Question 6-30:

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 some conflicts with the partial resolution to issues in varying intensity and importance to the group members. A critical issue has recently required a resolution so that the group can continue movement. Marian urges the members to reexamine the issues and locate points of agreement in the conflicts. Marian is using which technique of Simpson's to manage this conflict?

a. suppression

b. integration

c. compromise

d. power

Answer: c. compromise. The consensus is the core behavior for integration, while suppression plays down the conflict, compromise is giving up a part of what one wants, and power is to impose one's will on another.

Question 6-31:

Mary has decided to enlist the services of a co-leader for a small-group experience in self-esteem. Which one of the following reasons would justify her decision?

a. collusion

b. competition

c. feedback

d. too leader-focused

Answer: c. feedback. Leaders stimulate each other, assist in avoiding burnout, and provide twice the feedback. Collusion, competition, and too leader-focused are limitations of co-led groups.

OBJECTIVE 6G: GROUP ETHICS

Objective 6 g. ethical and culturally relevant strategies for designing and facilitating groups (CACREP, 2015, p. 12)

Ethics in Group

Corey et al. (2014) and Gladding (2015) each devoted 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).

OBJECTIVE 6H: Group Leadership Standards

Objective 6h. direct experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term (CACREP, 2015, p. 12)

In 1992, ASGW published standards for leader qualifications. These standards were revised in 2000 for at least one group course at the master level training. However, one course may not be enough when that course includes both content and experience (ASGW, 2000). The 2000 revision specified the content and clinical instruction for the course work objectives in knowledge and clinical instruction for experiential requirements and skill objectives. The 2000 standards are similar to the CACREP objectives for this unit of study regarding knowledge and skill requirements (Wilson, Rapin, Haley-Banez, Conyne, & Ward, 2000).

ASGW standards specify two levels of training. The first level is core knowledge and skill competencies. There are nine knowledge competencies, 17 skill competencies, and specified supervised hours of group work in group counseling. The skill acquisition mandates learning how to open and close

session work, appropriate model 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 et al., 2014). During skill acquisition, the standards recommend 20 hours of core supervised experiences with a minimum of 10 hours for supervised experiences. The second level, advanced specialization, is to specialize in one of four types of group psychoeducation, task/work group, group counseling, and group psychotherapy. Task/workgroup requires a minimum of 30 clock hours of supervised practice, group psychoeducation 30 minimum clock hours, group counseling 45 clock hours, and group psychotherapy 45 clock hours.

Multicultural and social justice competencies include three categories, awareness of self and group members, strategies and skills, and social justice advocacy. Social justice competencies include respecting worldviews, language development, specific knowledge and information, understandings of race, ethnicity, gender, culture, sexual identity, age, social economic status (SES) and shared cultural experiences, model relationships, group needs and goals, and target populations. If groups should be culture-specific, communication styles, pre-group screening, time impact and communication, and referring are important (Singh et al., 2012).

Group supervision is essential for effective feedback for the leaders and in accomplishing clinical goals for the group members. Supervision can include blind supervision (leaders describe session work), one-way mirror (observation behind a mirror), videotape (review verbal and non-verbal work together), and audio tape (verbal reporting with leader input). In each situation, ethical requirements include permission requests for each situation where the client is a part of the taping, video, and mirror experience and under informed consent, the leader is to inform members of supervision involvement.

Question 6-32:

The recommended group type for a person with a specific eating disorder is:

    a. Gestalt.

    b. person-centered.

    c. cognitive-behavioral.

    d. psychoanalysis.

Answer: c. cognitive-behavioral

Question 6-33:

Research by Elizabeth (1983) in comparing group treatment methods found which therapy to generate higher levels of anxiety among group members?

    a. psychoanalytic

    b. person-centered

    c. rational-emotive

    d. Gestalt

Answer: a. psychoanalytic

Question 6-34:

The term that Janis (1972) described as a deterioration of mental efficiency, reality testing, and moral judgment that results from in-group pressures is:

    a. groupthink.

    b. emotional contagion.

    c. deindividuation.

    d. SYMLOG.

Answer: a. groupthink (see terms for definition)

Question 6-35:

A research-based personality and group dynamic which allows a rating on three dimensions (dominance vs. submissiveness, friendliness vs. unfriendliness, and instrumentally vs. emotionally expressive) and 26 roles found in groups is:

    a. NGT.

    b. SYMLOG.

    c. synectics.

    d. cohesion.

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

Unit 6 - Terms

AUTOCRATIC LEADERSHIP:
A form of leadership in which the leader uses directive forms of group therapy and maintains control of the group. This type of leadership will usually inhibit the process of differentiation and recapitulation. This leader usually demands conformity and obedience, gives advice and sees himself/herself as an 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). Also, 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 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 et al. (2014) indicated 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 represent blocking behaviors. Blocking is not to be confused with the blocker role, which is the tendency to be negativistic and socialization groups.

CAPPING:

A term used to denote the easing away from emotional interaction and toward cognitive reflection. Gladding (2015) 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 appropriate modeling of 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. Gladding (2015) and Vander Kolk (1985) indicated 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 a unique study on group pressures.

CONTAGION:

A contagion is the transmission of cues triggering behaviors in others that may be similar to the one transmitting. It often causes members to follow suit and spontaneously pickup imitation (Redl, 1949).

CRITICAL INCIDENTS:

Gladding (2015) 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 and Engler-Carlson (2015) 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 events 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 that convey a sense of urgency transmitted through a crowd using 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) described 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 to the choice.

ENCOUNTER:

The 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 people 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, 2013) suggested 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.

FIDELITY:

A group ethic and ethical principle involving loyalty, faithfulness, and fulfilling obligations to a group.

FIRO:

Fundamental Interpersonal Relations Orientation (FIRO). William Schutz (1958, 1973) developed the FIRO-B and FIRO-F on the basis that people orient themselves toward people or away from them.

FISHBOWL:

One method of the fishbowl is to form subgroups to monitor each other's behavior. The leader matches each member of the inside circle with a member of the outside circle. The outside member will be observing to provide feedback, to conduct interchanges, serve as an auxiliary fishbowl used to increase the awareness of group members to the process of the group.

GROUP MIND:

Gustave LeBon, in publishing his study, *The Crow*, referred 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. Convergence theory, emergent-norm theory, and deindividuation theory also define a group mind (LeBon, 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 believed 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, 1972, 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 allow for 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 and details 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 with authority when he/she feels the power of the group support (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 actions 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 standard suggesting that the payoffs should equal the amount of input to the task.

POWER:

Power refers to the amount of influence or forces 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 a term used with leadership type and style. Forsyth (2013) refers to the basic power types as referent, expert, coercive, and legitimate and each has associated power tactics.

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 Jacob Moreno describing a technique for measuring the social relationships linking group members. Responses or actions of group members in studying group dynamics can be charged to form a sociogram (Forsyth, 2013).

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 laboratory for group dynamics and process.

TASK ROLE:

Task roles are performed by group members to assist in accomplishing the goal of the group. These role functions are more interested in the task accomplished than the emotional aspects of the interactions.

UNIVERSALITY:

Universality is one of the curative agents identified by Yalom that is important in the early phases of a group. Individuals learn they are not unique in the sense that they are the only ones to have a problem, which problem is or is not as severe as another, and that people do get better.

Unit 6 - References

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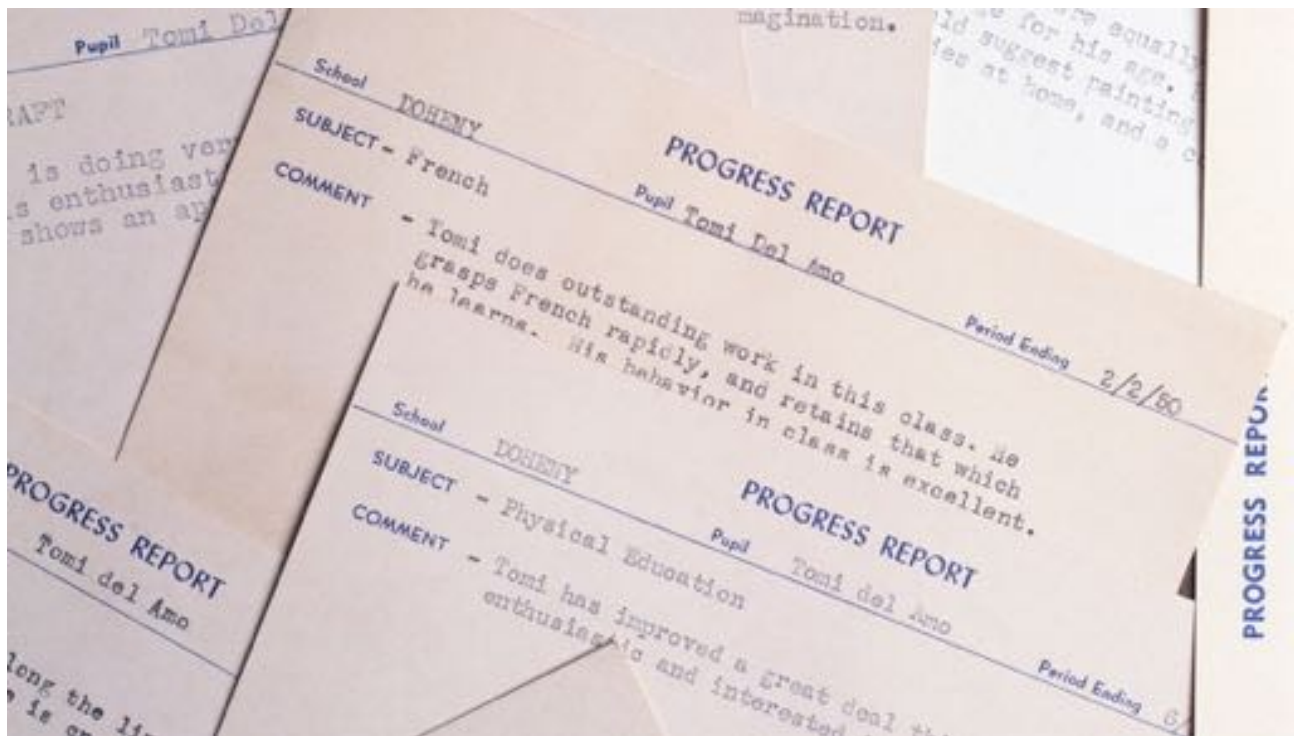
UNIT 7 - Assessment and Testing

Introduction

It is important for all counselors to understand the importance of assessing individuals. Client information acquired through different forms of assessment and evaluation involves understanding different theories of testing, instrument construction, testing procedures, and interpretation practices (Newsome & Gladding, 2014). Developing a foundation in mental measurement and assessment does include terminology, understanding and applying information about test administration and scoring, standardization methods, measurement error, and statistical techniques.

A reasonable approach to acquiring this understanding is, to begin with, the functions and usability of test and non-test data in measurement and assessment. Understanding distinct similarities and differences, historically, has been used as the basis for determining human functioning. Historically, these differences have been studied and interpreted using 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. Gathering data include interviewing techniques such as the social intake, mental status examination, and sociometric.

Basic principles of assessing emphasized in the CACREP objectives and throughout the examination include reliability, validity, norming, variability, and a variety of correlations. Computer technology 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 2014 Code of Ethics).

Finally, in preparing for questions from this chapter, be aware that approximately 25 test questions, of which 20 counts toward your total score, come from the core area of individual assessment.

CACREP Objectives

Assessment objectives have been abbreviated to serve as an over-view, and the full objectives for CACREP standards 2016 are to be located at www.cacrep.org. (CACREP, 2015, pp. 7-8).

a.   historical perspective and meaning of assessment;

b.   methods of preparing and conducting initial assessment

c.   procedures for assessing the risk of aggression or danger to others, self-inflicted harm, or suicide

d.   procedures for identifying trauma and abuse and reporting

e.   use of assessments for diagnostic and intervention planning

f.   concepts of standardized, non-standardized, norm-referenced, criterion-referenced, group and individual assessment

g.   scales of measurement, statistical concepts, central tendency, variability, shapes, and correlations

h.   reliability and validity

i.   use of assessments for academic/career, personal, and social development

j.   environmental assessments

k.   use of symptom checklists, personality/psychological testing

l.   use of assessment results to diagnose developmental, behavioral, and mental disorders

m.   ethical and cultural strategies for selecting, administering, and interpreting results

Question 7-1: (Objective A.)
Sir Francis Galton was credited for several constructs, terms, and evaluative tools. Which one of the following did he make a partial contribution used for interpreting test scores?

a.   correlation

b.   normal curve

c.   ratio IQ

d.   descriptive statistics

Answer: b. normal curve. The normal curve (bell curve) is referred to as the Gaussian curve and named for Carl Gauss.

Question 7-2: (Objective B.)
The technique most closely associated with behavioral observations of a social nature of individuals in a group task is:

a.   round robin.

b. sociometric.

c. social observation.

d. t-test.

Answer: b. sociometric. A sociometric is a qualitative method to measure social relationships (alliances, hidden beliefs, agendas, stars, isolates of a group).

Question 7-3 (Objective C.)

The DSM-5 uses criteria of symptoms to diagnose a disorder. Dimensional assessment regarding measuring symptoms is an effort to consider all except:

a. speed.

b. frequency.

c. duration.

d. severity.

Answer: a. speed

Question 7-4: (Objective D.)

Which instrument is used for assessing an assault of the brain?

a. Stanford Binet

b. Bender Gestalt

c. Halstead-Reitan

d. Rorschach

Answer: b. Bender Gestalt. After the Korean War, the Bender Gestalt was used for treating and diagnosing brain damage and as a screening tool for brain damage for ages 4-85. Errors are calculated for rotation, overlapping, difficulty, simplification, fragmentation, retrogression, preservation, collision, impotence, closure difficulty, angulation, and cohesion, time (15"). Error rate from 9-12 is considered substantial evidence.

Question 7-5: (Objective E.)

A client met minimum symptom criteria for a major depressive disorder, single episode with anxious mood. The counselor developed a treatment plan composed of a case conceptualization with matching treatment and techniques for specific symptoms. What technique would be appropriate for session intervention?

a. scripting

b. relaxation exercises

c. systematic desensitization

d. in-vivo

Answer: b. relaxation exercises

Question 7-6: (Objective F.)

It is important when using achievement instruments with specific populations to:

a. secure signed releases

b. use norm included instruments

c. use age-adjusted norms

d. use only raw scores

Answer: b. use norm included instruments

Question 7-7: (Objective G.)

The distribution of a set of scores with a mean of 58 and a median of 61 is a:

a. perfect distribution.

b. positively skewed distribution.

c. negatively skewed distribution.

d. t-distribution.

Answer: c. negatively skewed distribution. Mean is to the left of the median.

Question 7-8: (Objective H.)

What model of reliability is administered twice but with different but equal forms?

a. construct

b. test-retest

c. coefficient alpha

d. parallel

Answer: d. parallel (or alternate)

Question 7-9: (Objective H.)

Reliability is to the standard error of measure as validity is to the standard error of:

a. consistency.

b. criterion.

c. estimate.

d. relevance.

Answer: c. estimate

Question 7-10: (Objective I.)

A 12-year-old boy met minimum symptoms for a conduct disorder. His symptoms included behaviors such bullying, intimidation, physical fights, carrying a weapon, physical cruelty and assaultive behaviors, destruction of property, theft, and repeated serious violations of school rules. If this behavior persisted into adulthood and the client entered a treatment center at that time the same type of behaviors as an adult would be classified as:

a. conduct disorder.

b. oppositional defiant disorder.

c. antisocial personality disorder.

d. impulse disorder.

Answer: c. antisocial personality disorder

Question 7-11: (Objective I.)

When you know something about an individual's academic ability, the best estimate of his or her academic ability should be based on the:

    a.   mean.

    b.   z-score.

    c.   criterion.

    d.   correlation.

Answer: a. mean

Question 7-12: (Objective J.)

The technique that can be used to observe and measure interpersonal preferences among members of a group is a:

    a.   Q-sort.

    b.   sociometric.

    c.   semantic differential.

    d.   Likert scale.

Answer: b. sociometric

Question 7-13: (Objective K.)

In psychological testing, skewed distributions usually signify that the test developer has:

    a.   a bias that favors one or more subgroups of persons.

    b.   purposely set out to produce a test with a skew.

    c.   underestimated the ability for some subjects.

    d.   included too few easy items or too few difficult items.

Answer: d. included too few easy items or too few difficult times

Question 7-14: (Objective L)

During a full clinical interview, a client expressed that for several years she has been concerned about her weight and body shape. She knows that she eats a large quantity of food and eats in spurts and has been told that she uses inappropriate compensatory methods to prevent weight gain. She fears that her self-control and self-esteem or lack of one and her inability to maintain control is a significant part of her reason for coming to therapy. The client is most likely experiencing a:

    a.   factitious disorder

    b.   bulimia nervosa disorder

    c.   anorexia nervosa disorder

    d.   binge eating disorder

Answer: b. bulimia nervosa disorder. The client meets criteria A, B, C, and D.

Question 7-15: (Objective M.)

The resource guide most useful for technical information when selecting an assessment instrument is the:

    a. Test in Print.

    b. Test Manual.

    c. Technical Test Manual.

    d. Buros Mental Measurement Yearbook.

Answer: d. Buros Mental Measurement Yearbook. A minimum of three experts review and comment on the research, validity, reliability, usefulness, strengths, weaknesses, age usage, and other specifics of the instruments.

Question 7-16: (Objective M.)

When administering and interpreting test results it is important that a:

    a. manual is to be present

    b. supervisor is present

    c. code of ethics is present

    d. user's guide to test development is present

Answer: a. a manual is to be present

Terms

Several terms relating to individual analysis and testing are listed and defined at the conclusion of this chapter.

Coefficient Alpha	Item Response Theory (IRT)
Constant Error	Likert Scale
Convergent Validity	Maltreatment
Criterion Referenced	Measurement Scales
Cultural Equivalence	Omnibus
Discriminant Validity	Psychache
Efficacious Research	Public Law 94-142
Expectancy Table	Q-Sort
Factor Analysis	Regression
Flynn Effect	Semantic Differential
Forced Choice	Sociometry
Guttman Scale	Standard Error Measurement
Halo Effect	Stem and Leaf
Ipsative	Summative Evaluation
Item Analysis	Wilhelm Wundt

OBJECTIVE 7A: The History of Assessment

CACREP objective for assessment 7.a. identifies the need to understand the historical perspectives concerning the nature and meaning of assessment (CACREP, 2015, p. 12).

Drummond and Jones (2010) use the definition for assessment offered by the American Educational Research Association that is a systematic procedure for collecting information that is used to make inferences or decisions about the characteristics of a person. Testing is often a single act requiring an interview, a test, an observation or a self-report. The complete task is to integrate the information from a multitude of data collecting tools or methods. The methods represent three groups: interviews, tests, and observations. It is the purpose of the assessment that determines the method, screening, diagnosis, intervention, and monitoring for the outcome. Interview methods include data gathering styles using open, structured, motivational, unstructured, and semi-structured types. Tests are standardized, inventories, checklists, questionnaires, projective, work samples, environmental, and monitoring. Observation includes rating scales, event and duration recording, time sampling, raw notes, and anecdotal records (Drummonds & Jones, 2006).

Currently testing and assessment has added another approach and tool to gather data. Some of these advancements are computer-based which include automated test scoring, computer-generated reports and narratives, computer-adaptive tests, and simulations. With these innovations, new ethical dilemmas have emerged regarding confidentiality, examiner expertise in the use of test format, and packaged reports are taken at face value. Internet-based assessments have opened up different pros and cons, and there are immediate availability and scoring, cost efficiency, and for some assessments, an administrator is not required. The limitations include receiving feedback at face-value without a counselor to assist in the understanding of results.

Though the history of testing can be traced to the ancient Chinese, it was during the late 1800s that interest in measuring individual differences became pronounced. With the rise of scientific psychology in Germany and the writings of Charles Darwin in England, the field of mental measurement became a new frontier to be explored. Early test development contributors included Wilhelm Wundt, Francis Galton, Carl Brigham, James McKeen Cattell, Charles Spearman, Lewis Terman, Robert Woodworth, Edward Thorndike, and Alfred Binet (Aiken & Groth-Marnat, 2005). 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 genetic basis for 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.

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, 1996; Newsome & Gladding, 2014). The decades of the 1970s and 1980s was an "anti-testing" era that led to a critical review of the use of tests. There were extensive revisions and improvements of instruments, 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 and similarities. From its initial purpose to identify the developmentally disabled, 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. The uses of tests tended to vary, and generally, they are selected for purposes of classification, diagnosis, self-knowledge, program evaluation, and research (Gregory, 2013, 2015).

The following section identifies some of the basic concepts in the appraisal that are common to all of these types of tests.

OBJECTIVE 7 B: ASSESSMENT METHODS-Interviewing

Objective 7 b. methods of effectively preparing for and conducting initial assessment meetings (CACREP, 2015, p. 12)

The Interview

Interviewing is a process in which one or more individuals interact with another individual with a structured or unstructured set of stimuli to secure information. If the data are objective or scoreable, they are often called biodata (Gregory, 2013). Frequently, the data is not objective but more so in the form of attitudes or subjective in nature. Numerous researchers have studied whether two or more individuals possess the exact skill to secure the same information. Just as training two people 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 individuals 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 an 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 on 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 the evaluation factors that are not part of the person's job. Interviews include verbal and nonverbal assessment. An example of a test to assess the non-verbal skill of the evaluator is known as the Profile of Nonverbal Sensitivity (PONS).

When counselors engage in the process of counseling the first step is to conduct a clinical or a biosocial interview. Some agencies develop a clinical interview set of questions to fit their particular

practice; however, most organizations use a clinical interview that will elicit responses to similar questions. Some agencies such as a feeding and eating disorder clinic, no doubt, would expand and focus clinical questions that are directly related to the eating disorder.

The interview is the main ingredient of the assessment, and good interviewing skills are critical for the evaluation process, as a number of authors have described: Lazare, Putnam, and Lipkin (1995) suggest three functions of the interview: 1) determine and monitor the problem, 2) develop, maintain, and conclude the therapeutic relationship, and 3) provide client education and implement a treatment plan. The interviewer collects data for diagnostic purposes, responds to the client's emotions, and provides a means to educate and modify or cure symptoms. Truant (1998) described the assessment process as consisting of three components: 1) a diagnostic interview comprised 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 and include all pertinent information.

Phase I: The first phase is to determine the purpose of the interview derived from the presenting client statement. The foundation of the interview data gathering consists of the specific nature of the presenting issue, career, academic, social, environmental, psychological and physical. A career issue may need a historical set of questions about previous work, interests, skills, aptitudes, and training while a psychological problem may require a mental status examination, specific questions for symptoms to determine the disorder and treatment plans. In most cases, additional tools may be helpful such as an interest inventory or a psychological diagnostic test such as the MMPI-2. The presenting issue may require different interviewing skills and tools.

During the initial interview for diagnostic assessment, the interviewer may need to look for the major personality characteristics, traits, and chronic symptoms typical of the client's long-term functioning. However, it is sometimes difficult to tell the difference because of abnormalities in cognition, affect, behavior, and motor activity may be manifestations of more than one disorder. In other words, personality related cognitive impairment, affective dysfunction, and personality or behavioral abnormalities also could be symptoms of clinical depression, anxiety, or panic disorder. Most personality disorders are readily apparent. For example, emotional distress and physiological manifestations of stress (i.e., cardiovascular and gastrointestinal symptoms) are prevalent in anxiety disorders, mood disorders, and somatization symptom disorders than in personality disorders (Everly, 1989). On the other hand, personality disorders typically manifest a lack of overt distress. Thus, the interviewer can clarify the difference by determining if subjective distress is present or absent and if modulation of affect is acute or long-standing.

Phase II: Typically, personality-disordered clients maintain an attitude of denial about their disturbing character traits, finding it much easier to blame other people or external factors for their problems (arrests, job losses, broken relationships) than to be honest and acknowledge any faults. Thus, the interviewer's task is to look for symptoms and behavioral characteristics that may not be obvious. To bring these to awareness (attention), the interviewer will need to confront or bypass the client's defensiveness, denial, avoidance, projection, and distortion. Widiger, Frances, and Trull (1989) recommend indirect questioning techniques that can bypass the client's defenses and tendencies toward dishonesty or evasiveness to elicit honest and accurate information the disordered client would rather hide.

Preparing for the initial client session can include a variety of approaches and interns are taught the clinical or biosocial interview. Also, checklists, pre-interview rating scales, and specific interview question formatting are other tools for the interview. These types of interviews may also include motivational, open-ended, and structured styles of interviewing.

The DSM-5 included four pre-interview rating scales designed to be administered as a pre-interview for identification of domains to focus the interview (APA, 2013; Jones, 2012). The purpose of the pre-interview symptom cross-cutting rating scales is to differentiate symptoms with more clarity for the frequency, duration, and severity of symptoms. Many disorders have symptoms that are similar (comorbidity) therefore the rating scales are constructed on an ordinal measurement and referred to as a dimensional assessment.

The DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult, is a 23-item rating on an l-5 point Likert scale for duration, frequency, and severity (ordinal scale) categorized in 13 domains (depression, anger, mania, etc.). The DSM-5 Parent/Guardian-Rated DSM-5 Level 1 Cross-Cutting Symptom Measure-Child Age 6-17 is a 25-item, 12 domain pre-assessment like the adult version. A third rating scale is the Clinician-Rated Dimensions of Psychosis Symptom Severity, assessing eight domains (hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired recognition, depression, and mania) and is like the other pre-interview rating scales. Also, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) is a 36-item rating to assess for communication, getting around, self-care, life activities, school/work, and participation in society. These ratings based on an ordinal system indicate that if a client is rated mild or greater on a category domain, the interviewer is to focus the interview inquiry specific to those areas. Also, if the rating is mild or greater, a Level II instrument may be administered that is longer and provides additional feedback (APA, 2013). The DSM-5 psychological disorders and z-codes are cross-listed with the International Classification of Diseases (ICD-10) and the International Classification of Medicine (ICM-10).

Unstructured Clinical Interview:

When used for purposes of a diagnosis, the clinical interview is known as the diagnostic interview. The unstructured clinical interview is the most common assessment interview among psychiatrists, psychologists, and counselors (Craig, 2003). Clinical interviews do contain structured, semi-structured, and unstructured formats. Summerfeldt and Antony (2002) described that the unstructured interview has no standardization of questions rather the counselor determines what questions for the interview. Prior knowledge of DSM-5 symptoms is necessary to arrive at a correct diagnosis. The structured interview has a list of questions that is standardized with a sequence of questions and follow-up with a systematic rating of client responses (Bagby, Wild, & Turner, 2003). The semi-structured interview has a less formal approach yet has some flexibility (Craig, 2003). Basco (2003) reported that assessing diagnostic accuracy is supported by the semi-structured or structured interview. Jones (2010) provided an outline for an unstructured interview for diagnostic questioning to include recognizing signs, symptoms, and behaviors for a particular disorder. The chief complaint is a description of symptoms that brought the client to seek help, symptom intensity and duration, duration of existence, cause for concern, when most affected, and changes in quality or quantity. Presenting illness is another statement that represents the onset of symptoms, precipitating factors and modifying factors, the extent of disability, degree of worsening, effect on job, social relationships and family, efforts taken to modify or control, and when first noticed. Jones (2010) outline includes:

a. identifying information-diagnostic clues are evident from referral sources and predispositions provided during the data gathering such as literature support frequency, duration, and severity of use (substance/males) or gender (depression/females) that is helpful in questioning format.

b. chief complaint or presenting problem-identifying diagnostic clues is through careful listening for symptoms, patterns of dysfunction, stressors, and interpersonal conflicts. Predispositions or known family functioning that is based on genetic or environmental blockers is helpful to enlist additional questions for the frequency, duration, and severity of the symptoms or maladjustment.

c. history of presenting problem-three areas of question are to include (1) onset/course of the problem chronologically for severity of the symptoms in different domains such as work, social, academic, relationships and other areas of functioning. Duration in symptoms such as acute stress disorder is three days to one month following the trauma (APA, 2013).

d. family history-developing family psychiatric history is helpful because of previous experiences and associated behaviors with family interactions and follow-up questions regarding first-degree relatives, parents and siblings, childhood and adolescence, medical history of the family, quality of relationship with family members, child abuse, substance abuse, trauma, and suicide or violent behavior.

e. relationship history-current living situation, marital and non-marital relationships, and the nature of any social relationships are important help to describe the problem. The assessment is to determine if a lack of or change in a relationship is associated with a mental condition (avoiding situations, people, or separations).

f. developmental history-Rutter, Kim-Cohen, & Maugham (2006) reported that psychopathology is often preceded by a childhood mental disorder or psychosocial risk factors. Developmental history includes questions pertaining to risk factors, cultural issues, and system variables. Attention areas include behavior problems, school performance, childhood diagnosis, abuse, traumas, and hyperactivity.

g. educational history-achievement has linkage to substance abuse, antisocial behaviors and onset usually is early and with poor academic performance.

h. work history-current employment, length of work for each work setting, job losses, and injuries related to work, relationships with peers/managers often are associated with impulse-control, oppression, mood disorders, and unemployment.

i. medical history-questions are directed at previous and current medical problems, hospitalization, medications, and disabilities. Thyroid disorders, head traumas, neurological disorders, circulatory disorders, hepatitis, seizure disorders, lupus, electrolyte disturbances, and B-vitamin deficiencies are known medical conditions that are or can be associated with a psychological problem. Clues observed during the interview might include altered state of consciousness, fluctuations in alertness and attention, disorientation, confusion, short-term memory loss, hallucinations, and changes in motor function, unsteady gait, tremor, or problems with coordination (Pollak, Levy, & Breitholtz, 1999).

j. substance use-questions about present or former use or involvement with substance or drug use is purposeful to rule out substance use problems.   Knowledge about what may be normal use of substances (alcohol) is necessary and for gender. Dawson, Gant and Li (2005) reported that men who drink five or more standard drinks in a day and women who drink four or more standard drinks a day are at risk for alcohol-use related diagnosis. In addition to a standard list of questions for substance or drug usage the CAGE, MAST, and SASSI may be used for pre-screening. A drug analysis may be recommended.

k.   legal history-questions may surface involvements with warrants, arrests, detentions, convictions, probation, parole, and repeated offenses (DUI's, larceny, indecent exposure, etc.) that will suggest frequency, duration, and severity symptoms for a mental condition such as aggressive behaviors, antisocial personality disorder, and manic episodes (bipolar I/II).

l.   previous counseling-questions include receptivity to counseling, helpful or not, medication compliance, referrals, hospitalization, suicide attempt or self-harm.

m. Mental Status Examination (MSE)-the MSE is not necessary for all clients rather those with increasing psychopathology (Polanski & Hinkle, 2000). The MSE is frequently administered simultaneously during routine diagnostic questioning with both observation clues, cognitive, and affective responding. If a full MSE is necessary, this will entail another session to cover cognitive, affective, speech, and language, thought process and content, mood and affect, and cognitive functioning.

Example of Unstructured Interview

When the interviewer suspects a personality issue when the client is behaving or expressing pathologically narcissistic behaviors and avoiding responsibility for a failed marriage, the counselor might ask open-ended questions about the client's family and other matters that are important to the client, follow up with more specific questions, pay attention to the counselor's own "counter-transference feelings," and wait until there is an opportunity to confront gently.

Q.   "Tell me about your relationship with 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-aleck 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 unsafe that you had to retaliate and strike her?" (gentle confrontation)

A. "I didn't feel unsafe 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 (Vacc & Juhnke, 1997). It is very appropriate in certain circumstances to use a structured interview to assess specific issues, including those that 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) recommended 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 center of attention?"

Lanyon and Goodson (1982) recommended semi-structured interviews for several reasons because: they are more flexible than paper-and-pencil assessments, clarify unclear answers, establish rapport, 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 on 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 presenting 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 well conducted mental status examination 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.

There are specific intake interviews and questions for specific therapies such as solution-focused. Examples of solution-focused questions are what brought you here, how can I help, the miracle question, relationship questions, exception questions, scaling questions, and is there anything else? Each type of interview may have several questions to accompany the first question for expansion. One example is the scaling question with four or five sub-sections with responses ranked on a scale of 1-10 (where are you now? confidence scale, motivation scale, risk scale and resiliency scale).

After a completed interview for the initial gathering of data, the assessor may desire to validate the interview with another source of the problem or a disorder. The counselor is aware of comorbidity where symptoms are also present in other disorders such as conduct disorder and oppositional defiant disorder requiring a differentiated questioning. If a diagnosis is to be confirmed the assessor will adhere to the criteria within the DSM-5. If a disorder is not confirmed but is diagnosed as a Z-code the treatment plan can be described for that clinical issue. A Z-code classification is often specific although there are categories referred to as problems and several fall within education and literacy, employment and

unemployment, risk factors, housing and economic circumstances, primary support group, family circumstances, psychosocial circumstances, personal risk factors, nonmedical substance allergy, noncompliance with medical treatment, psychological trauma, personal history of adult abuse, and other personal history of self-harm. Crime victimization and terrorism may be psychosocial circumstances (APA, 2013).

There are a variety of clinical interview formats, and most are designed specifically for the treatment agency or site. A clinical interview schedule provides categories for data gathering in areas of personal information, regarding current risk factors (suicidality, homicidal, impulse control, medical risks, and a risk history), education, history taking (medical, psychological, medication, family history, hospitalizations) counseling, social involvements, substance use, mental status rating (affect, mood, appearance, motor activity, thought process, hallucination, memory, judgment, orientation, speech), a symptom checklist rated on a severity scale of none, mild, moderate, severe, and severe with agitation, and an interview based on the criteria of a specific disorder.

A Biopsychosocial Interview:

The biosocial interview, previously the social intake, has a history dating back to pre-1900. A biopsychosocial interview accounts for broader influences on the overall health of individuals. Normal or not normal experiences are compared to a developmental model and may be milestones or markers. The DSM-5 rearranged the category disorders regarding environmental and genetic markers. The interview is composed of psychological, biological, and social development factors that include:

a. Psychological: learning, thinking, personality, behaviors, life choices, decision-making, cognitions, knowledge, emotion/affect, mental health, experiences that promote pain, beliefs, feelings

b. Biological: neural communication, endocrine system, nervous system, brain, sense organs, genetics, hereditary, trauma, mental illness

c. Social: social examples include primary groups, the presence of behavior of other's social influence, family stress, job stress, community, availability of resources, SES, gender, ethnicity, race, age, accidents, the death of loved one, transitions bring stress into our lives.

Motivational Interview

According to Chanut, Brown, and Dongier (2005) the four basic principles of a motivational interview (MI) are to express empathy, develop discrepancy, support self-efficacy, and roll with the resistance. This type of interview is designed to assess the ambivalence many clients come into treatment with regarding change and what it will cost them to make a change. Cost are behaviors the client has to give up, an encounter with others, and to manage self-discipline and accountability in order to change. Motivational interviewing is a modern form of interviewing in the addiction field (substances, diet, exercise, gambling, etc.) as well as other behavior problems. Motivational interviewing focuses on the goals of the client to increase internal motivation through exploring and resolving ambivalence about a change (Miller & Rollnick, 2002). Two important terms within motivational interviewing are ambivalence and resistance. One way to deal with resistance is rolling with resistance. Some examples are to state the reasons to change and the reasons not to change in the same sentence (double-sided reflection) and state the reasons to change so the client takes the opposite stance and hopefully makes a commitment to change.

Strategies for implementing a motivational interview are through the utilization of (O) open-ended questions, (A) affirming the client's self-efficacy and support, (R) reflections, and (S) summaries (complex reflections, organize resolving ambivalence, promote change). The acronym is OARS.

Prochaska's six stages of readiness for change can be utilized to manage the ambivalence. The Motivational Interviewing Treatment Integrity (MITI) Code, an instrument in research developed by Moyers, Martin, Manuel, and Miller (2005) codes the interview for competencies in pausing utterances, giving information and open/closed questions, reflections, affirming, emphasizing control, support, advising, confronting, directing, empathy, and spirit to name a number of the indices. Prochaska's six stages of readiness for change are precontemplation, contemplation, preparation, action, maintenance, and termination (Prochaska, DiClemente, & Norcross, 1992).

Question 7-17:

Discrepancy is one of the four guiding principles for effective interviewing and treatment. The counselor attempts to develop discrepancy through:

    a. increased cognitive dissonance.

    b. confrontation.

    c. past behaviors.

    d. narratives.

Answer: a. increased cognitive dissonance. To increase cognitive dissonance is to examine this discrepancy between the client's present behavior and core values.

Question 7-18:

Motivational interviewing skill is to roll with resistance, that is, to avoid confronting the client. MI interviewers use what technique to roll with resistance and to avoid an argument?

    a. empathy

    b. support self-efficacy

    c. ignore the resistance

    d. reflective listening

Answer: d. reflective listening. MI does not view resistance as a client characteristic rather as the health of the collaborative relationship and therapeutic rapport between the client and counselor.

Question 7-19:

All of the following are strategies to roll with resistance when the intervention suggested by the counselor is incompatible with the client's level of recognition. Which one is an exception to that strategy?

    a. avoid recommending change and advocate for the client to recommend change.

    b. negotiate with the client to identify a first target to change among several targets.

    c. recognize that motivation to change is permanent.

    d. state reasons to change and not to change in the same sentence.

Answer: c. recognize that motivation to change is permanent. MI believes that motivation to change is not stable rather modifiable and in a stage of fluctuation.

In addition to motivational interviews, three additional communication methods to obtain diagnostic information are unstructured, structured, and semi-structured types. In most cases, the preferred interview is the structured or semi-structured interview. 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.

Mental Status Examination Assessment

During the initial interview or at some later time it may be necessary to administer the mini-mental status or the full mental status examination (MSE). The MSE is not a psychometric instrument rather a set of cognitive, affective, behavioral, and observation diagnostic interviewing probes. This interview requires observations of subtle and detailed wording and behavior that accompany a client's thoughts, mannerisms, and non-verbal behavior. The full MSE is an interview to gather data for objective and subjective information including cognitive ability, appearance, emotional mood, and speech and thought patterns at the time of evaluation. It is one part of a full examination that includes the client's attitude and cooperativeness. The clinician administers the MSE when a client appears disoriented and presents confusing communication. The MSE assesses five areas consisting of orientation to time, place, and person followed by questions concerning registration, attention, calculation, recall, and language. The examination is administered to clients experiencing symptoms of schizophrenia, psychotic behavior, dementia, Alzheimer's disease, and possible organicity (head injuries) and those under the influence of drugs and unable to effectively communicate. A complete evaluation includes ten areas of functioning.

The assessment can take many forms such as a social intake, problem identification, structured interview, referral sourcing, and a diagnostic evaluation based on the DSM-5™ diagnostic criteria. The full interview is not complete until a mental status examination has been conducted that includes a detailed profile of a client's:

   a.   appearance, attitude, and activity.
   b.   mood and affect.
   c.   speech and language.
   d.   the thought process, thought content and perception.
   e.   cognition.
   f.   insight and judgment (Trzepacz & Baker, 1993).

Abnormal results include signs of organic brain damage, evidence of thought disorder, a mood or affect that is clearly inappropriate to context, thoughts of suicide, disturbed speech patterns, dissociative symptoms, and delusions or hallucinations. Possible organicity signs may include: (a) recent head injury, (b) headaches, (c) vomiting, (d) memory loss, (e) history or recent development of seizures, (f) sensory loss, (g) loss of motor function, (h) grossly impaired judgment, (i) concrete thinking, (j) perseveration, (k) history of learning deficits, (l) extreme personality changes of a sudden onset, and (m) change in eating, sleeping habits.

In many cases, this information is readily available without systematic questioning. On the other hand, information necessary for the diagnosis of conditions such as neurocognitive disorders, delirium,

Alzheimer's, or head injury may require a structured mental status examination. An effective interviewer has learned how to weave pertinent questions into the interview, which will allow for a more fluid assessment. When conducting a mental status examination, the interviewer should consider dividing it into two components: observation of behavior and cognitions (Morrison, 1993). The behavioral or observational part includes attitudes, appearance and demeanor, mood, psychomotor behavior, and flow of thought, while the cognitive portion contains content of thought, perception, cognition, insight and judgment. Another method is to categorize according to appearance and demeanor, orientation/ attention/ cognition, speech and language, mood and affect, thought content and process, and judgment and insight (Culleri, 2010).

Mental Status Categories: Cognitive Functioning

Orientation: The individual is aware of the time (day, month, and year) place (exact location at the time—office, city, and state), the person (awareness of his/her name), and purpose (the reason why the interview is taking place).

Fund of Knowledge: Questions are usually based upon or taken from individualized intelligence tests such as the Wechsler Adult Intelligence Scale (WAIS) or Wechsler Intelligence Scale Children (WISCR). The interviewer 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.

Concentration: Attention span and concentration assessed in some ways limited only by the examiner's creativity. A typical example is to have the person count backward in serials of nine or six.

Memory: Long-term, intermediate, and immediate memory can take several forms. The interviewer can recite a string of numbers forward and backward, identify some objects in the room, and request the client to repeat these objects immediately and again later in the interview. Acquiring this type of feedback is important in the assessment of such disorders as senile dementia, amnesia, or healthy aging.

Abstraction: Typically, the client is asked to provide his or her understanding of the meaning of a proverb.

Judgment: This portion of the assessment reflects the capacity to make sound decisions. The interviewer will ask the client to indicate what he or she would do in a situation.

Mental Status Categories: Observational

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.

Speech: Does the client speak coherently, normally, in progression, spontaneously, and understandably? The counselor observes 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? Also, 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.

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 dysfunction. Speech is assessed along with the thought processes as the client responds to questions from the interviewer. Another set of observations 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. The 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. Association Loss: the client will lose point, fragments and has disjointed thoughts that remain logically unconnected and 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.

Psychomotor Movements: Observe any unusual movements, mannerisms, or levels of physical activity. Some examples might be pacing, slowed responses, stiffness, tics, tremors, uncontrolled body parts, hyperactivity, disconnected, Parkinson, etc.

a. Athetotic: slow, recurring, weaving motion of arms and legs/facial grimaces

b. Choreatic: jerky, involuntary movement, spasms (muscles)

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 client's subjective expression of how he or she is feeling. This statement can include words or manifestations 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, euphoria, hyperphoric, inappropriate, and depressed.

OBJECTIVE 7C: ASSESSMENT FOR RISK

Objective 7c. procedures for assessing the risk of aggression or danger to others, self-inflicted harm or suicide (CACREP, 2015, p. 12)

Counselors who counsel clients with behavior associated with aggression, suicide, self-inflicted harm, homicidal tendencies and physical acts need to acquire sufficient background information to assist in the assessment phase of an interview. It is important when counseling suicidal and self-harm clients to be knowledgeable about risk symptoms, types of suicide (cluster, contagious), mental health illness with histories of ideation/attempts, nuances and factors that often precipitate ideation or self-harm, and timelines are known to exist for best counseling help or pre-post hospitalization reactions.

Arie, Haruvi-Catalan, and Apter (2015) reported that a first step is to acquire a definitional understanding of different terms regarding suicide and self-harm (p. 37).

TERMS:

Deliberate self-harm is a willful self-inflicting of painful, destructive, or injurious acts without intent to die.

Suicidal ideation involves thoughts of performing actions to produce one's death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent.

Suicide threat is a verbalization of intent to perform a suicidal action or a precursor action which, if fully carried out, could lead to suicide.

Suicide gesture is a threat accompanied by a suicidal act of low lethality.

Suicide attempt is self-injurious behavior with a nonfatal outcome that is accompanied by evidence that the person intended to die.

Interrupted suicide is an attempt that the client interrupts before any physical damage takes place.

An aborted suicide attempt is one that is stopped by the presence of another person before any physical damage takes place.

Parasuicide is an act that is not related to the actual suicide (Kreitman, 1977). Parasuicide is akin to suicidal gesture such as wrist slashing or a sublethal drug use.

Also, the counselor should recognize different methods for committing suicide. During the year 2010, there were recorded 38,000 suicides. The National Action Alliance Suicide Prevention Task Force (2014)

reported methods and deaths included: firearms (51%-19,391), motor vehicle poisoning death (735), jail and prison inmates (500), military veterans (8360), active duty military (300), accessed healthcare within 30 days of death (17,200) and seen in emergency departments for suicide attempt in past year (7800) (NAASP, 2014).

Suicide is the third largest cause of death in youth and adolescents, and each year 16% consider killing themselves, 13% will make a suicide plan, and 8% will attempt suicide (Centers for Disease Control and Prevention, 2012; Nock et al., 2013). Depression is the most frequently indicated (80 to 90%) clinical disorder associated with suicide and suicide attempts Clayton (1985). Craigen et al. (2010) reported that self-injurious behavior occurs in 4% to 39% of adolescents and young adults.

Irwin and Austin (2013) reported suicide data from the Lesbian Social Life study, a survey focusing on white lesbians living in the southern United States, and found that more than 40% of participants had considered suicide and more than 15% attempted suicide. Berk, Grosjean, and Warnick (2009) reported a suicide rate of 3.8% in a sample of borderline personality disorder (BPD) clients in a six-year follow-up study completed suicide. In past years that rate was between 8% to 10%. BPD is the only personality disorder that has DSM-5 criteria of suicidality or self-injury of the personality disorders. Risk factors categories include behavioral factors, cognitive/emotional factors, comorbid diagnoses, and psychosocial and psychiatric history.

Nonsuicidal Self-Injury (NSSI)

Nonsuicidal self-injury (NSSI) and suicidal behaviors overlap in the range of 10% to 37% (Asarnow et al., 2011). Irwin and Austin (2013) found that 40% of white southern lesbians considered suicide and more than 15% had attempted suicide.

Hamza, Stewart, and Willoughby (2012) developed an integrated model that is a combination of NSSI engagement, severity and familial (connectedness) factors that are pathways to suicidal behaviors. However, Wester et al. (2016) research indicated there are nuances to be taken into consideration that include the relationship between suicidal behaviors and lifetime NSSI, number and type of methods used, and lifetime engagement or a history of engagement when compared to recent engagement that may be the stronger predictor (Joiner, 2005).

There are differences in the prevalence, function, and severity for suicidal and nonsuicidal (self-injurious thoughts and behaviors) terms and practices (Nock, 2010). Suicide includes suicide ideation, plans, and attempts with any intent to die. Nonsuicidal or self-injurious thoughts and behaviors include suicide gestures and threats. Turp (2003, 2007) defined self-harm from a multifaceted set of behaviors (hidden, omission):

> that result, whether by commission or omission, in avoidable physical harm to self, and
>
> that breaches the limits of acceptable behavior, as they apply at the place and time of enactment, and hence elicit a strong emotional response (p. 36).

Rates of suicide for Native Americans are significantly higher than other racial/ethnic groups (CDC, 2005). The Alaska Native (AN) and American Indian (AI, New Mexico Indian tribe) young adults (10-24 years) suicide rate is nine times higher than other U.S. population same age youth (USDHS, 2014). The report also indicated that young female AI/AN in Alaska die by suicide 11 times more often than all U.S.

females in the same age group. A similar rate is evident in New Mexico (AI). The NCHS study reported evidence for suicide clusters and contagions for AI/AN. Point and Mass were the two types of identified clusters. Point clusters are close in location and in time and occur in small communities. Mass clusters involve a temporary increase in whole populations, close in time but not necessarily location. Suicide increases and media appear to be associated (Gould, 2001). Stimulating factors to suicide behaviors are contagions that are transmitted from one person to another through social or interpersonal connections (Cox et al., 2012). Suicide factors include an individual with a history of mental illness, a friend or relative who died by suicide, and poor mental health (Haw, Hawton, Niedzwiedz, & Platt, 2013). Risk factors frequently are referred to as psychological mechanisms for clusters and involve a circle of vulnerabilities that include geographical and psychosocial proximity, and several populations at risk (mental illness, history of trauma, substance misuse, and history of suicidal thoughts and behaviors (Zenere, 2009). Individual risks for AI/AN include alcohol use, depression, and death of a family member or friends by suicide.

The social, ecological model is useful to understand risk and protective factors. The four levels of this model include individual, relationship, community, and societal (NAASP, 2014). Often factors at the individual level transcend the person and influence the larger community, thus outside of the person. The community and societal levels consist of cultural community and social disorganization, culture loss, and collective suffering (Wexler & Gone, 2012).

Theoretical models provide an understanding of suicide theory (Laux, 2002). These models are:

1. Overlap Model (Blumenthal & Kufer, 1986)-greater the overlap in domains the greater the risk of suicide

2. Three-element Model (Jacobs, Brewer, & Klein-Benham, 1999)-predisposing factors, family history, social environment, personality, life situation and availability of means

3. Suicide Trajectory Model (Stillion, McDowell, & May, 1989)-interactive influences of risk factors associated with premature exits

4. Cubic Model (Shneidman, 1987)-that people reach a point of hopelessness and suicide is the only exit

5. Interpersonal Theory of Suicide (Van Orden et al., 2010). There is a simultaneous presence of perceived burdensomeness and belongingness that contribute to suicidal actions. For some clients, a third factor is the capability to engage in suicidal behavior that is separate from the desire to engage in suicidal behavior (p. 575)

6. Automatic Negative Reinforcement (ANR), a functional model. Negative feelings influence emotion regulation functions to suppress negative affect or self-threatening cognitions for those engaging in nonsuicidal self-injury (Chapman, Gratz, & Brown, 2006; Printein, 2008). Feelings from these automatic negative affect of numbness is an attempt to generate positive feelings (Nock & Prinstein, 2005)

7. Interpersonal-psychological theory of adult suicidal behavior (Joiner, 2005; Van Orden, Witte, Gordon, Bender, & Joiner, 2008).   Suicide is an interaction for some individuals among (a) interpersonal loss or loneliness/isolation/thwarted belongingness, (b) burdensome to others, and (c) an acquired capability to engage in self-injury enduring the painful and provocative situations.

Each of these models identifies risk factors, predisposing factors, family history, social environment, personality, life situations, suicide methods, and response by a professional.

RISK FACTORS

Nock and Mendes (2008) reported that for adolescents an association existed between exposure to stress and lower levels of distress tolerance, possessed poorer social problem-solving skills.

Goldstein, Bridge, and Brent (2008) reported that a warning sign for suicide completers was significant sleep difficulties and insomnia or hypersomnia the week prior to suicide completion when compared to a control group. Prinstein (2008) reviewing numerous suicide and nonsuicide self-harm reports found repeated references to emotion regulation or dysregulation to be a common factor in both suicide and non-suicidal self-harm.

Wester et al. (2016) found family connectedness, a locus of control, NSSI, and suicidal ideation to be factors in those who attempt suicide.

Arie et al. (2005) found in their study of personality related suicide three sets of constellations that may underlie suicide. These factors include:

1. Impulsive and aggressive characteristics combined with an over-sensitivity to minor life events. Behaviors often associated include a history of substance abuse or alcohol, physical and sexual abuse and a possible genetic connection. Regression, splitting, dissociation and displacement are often the defense mechanisms.
2. Narcissism, perfectionism and an inability to tolerate failure. The individual has difficulty asking for help and denies comforts of intimacy.
3. Hopelessness associated with depression and other associated disorders such as affective types, schizophrenia, anxiety disorders, and anorexia nervosa.

King and Apter (2003) summarized impulsive and suicidal behaviors to involve accidents, impulsivity, reckless lifestyles, tobacco and drug use, unprotected sex, fighting, reckless driving, weapon-caring, and homicide. The psychiatric association includes mood, disruptive behaviors, substance use, mood, increasing negativity and interactions, truancy delinquency, and environmental influences such as family, peers, and neighborhood.

Aries et al. (2005) pointed out that Cluster B (impulsive, dramatic), avoidant personality and personality traits may be a factor and should not be overlooked. Specific behaviors include impulsivity, aggressiveness, self-criticism, hostility, sensation seeking, and deficits in coping, social skills, and problem-solving.

Jessor (1998) coined contrasting risk factor terms of conventionality-unconventionality. Unconventionally included individuals who associated with deviant peer to peer orientation rather than parental values, and parental tolerance of deviance. Conventionality protective factors included placing value on academics, achievement, intolerance of deviance, involvement with church or community organizations, compatibility of parent and peer values.

The second set of narcissism, perfectionism, schizoid traits and impaired or low self-disclosure may be factors. Impaired self-disclosure may affect social networking and increase isolation and loneliness and suffering.

Suicide dynamics may be 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 explained the sociological approach to suicide as a reaction to societal pressures and influences (as cited in James & Gilliland, 1997). Durkheim identified 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) listed myths considered to be false that include:

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 previous attempts
b. family history of suicide
c. involved drug or alcohol use
d. history of psychiatric disorder
e. history of severe trauma
f. emotional regulation
g. exposure to painful and provocative events
h. thwarted belongingness and burdensomeness
i. isolation from others
j. radical shifts in behavior or mood
k. expression of hopelessness or helplessness
l. chronic medical illness
m. suicidal ideation or a plan and means
n. living alone or divorced
o. relationship instability
p. the poor support system
q. childhood trauma
r. physical illness
s. financial stress

In summary, warning signs include changes in behavior and personality, recent family changes, recent loss, suicide statements or acts, difficulty concentrating, preoccupation with death, withdrawing behaviors with silence.

Therapist Tasks

Dacey and Travers (1994) reported the warning signs for therapist assessment of clients with potential suicide to be:

a. withdrawal or moodiness.
b. accident proneness.
c. change in eating or sleeping habits.
d. other significant changes in usual behavior.
e. talking about killing oneself.
f. talking about "not being" or having any future.
g. giving away prized possessions.

Blumenthal and Kupfer (1986) indicated that risk signs are:

a. history of the previous attempt.
b. the family history of suicidal behavior and affective disorders associated with substance abuse.
c. associated with conduct disorders (impulsive disorders).
d. associated with affective disorders.
e. precipitating humiliating events.

Moursund (1985) recommended the following guidelines for counseling with the suicidal client:

a. take threats and attempts seriously
b. recognize ambivalence about living and ally with the healthier part that wants to live
c. some are depressed, but not all; may appear agitated, anxious, psychotic, organically impaired
d. most suicides involve another significant person in the client's life
e. ask directly about suicidal intent; this may minimize anxiety and act as a deterrent

Assess danger with direct questions for:

a. has a method been chosen?
b. is the method available?
c. how specific is the plan?
d. how lethal is the method?
e. a previous attempt is the best indicator of future attempts; the first three days after an unsuccessful attempt are the riskiest

Actions may include:

a. hospitalization if in clear danger

b.   psychiatric evaluation for medication and consultation

c.   enlist the help of the client's support network; know all potential community resources

d.   discuss suicide and death and all of the ramifications with the client

e.   develop a safety contract with the client

f.   utilize consultation and supervision when working with a client

In summary, Gutheil and Applebaum (2000) suggested that while conducting an interview the counselor should determine the following:

a.   the presence of severe depression or the lifting of a depression

b.   the presence of psychosis (with hallucinations to commit suicide)

c.   history of substance abuse and poor impulse control

d.   loss of a loved one, job, residence, or academic or social standing

e.   history of marginal adaptations and few accomplishments or recognition

f.   lack or presence of social support and living in a hostile environment

g.   thoughts and fantasies with destructive content (revenge and "resting in peace")

All conditions should be elements of the interview in addition to determining suicide intent, specific plan, means to commit the suicide and previous attempts.

Assessment:

During the initial interviewing session, a formal and informal approach for assessment of self-harm is recommended (Buser & Buser, 2013; Rutt, Buser, & Buser, 2016).

Buser, Buser, and Rutt (2015) reported that the deliberate attempt in harm to body tissue is often unintentional. One-fifth of young adults who perform NSSI have at least one time harmed themselves more severely than intended. A relationship exists between alcohol and drug use and unintentional injury. This unintentional injury is often associated with alcohol or drug use. Moderate to severe acts involve cutting, scraping, self-tattooing, and burning and need medical attention. Minor actions often involve picking at oneself to draw blood, hitting self, biting self, or hair pulling. Dissociation and impulsivity are symptoms of escalating injury. Impulsivity consists of four domains: (a) actions are taken to quell negative emotions; (b) acting without considering potential consequences; (c) difficulty completing tedious or complicated duties; and (d) being drawn to novel potentially dangerous, and stimulating activities (Whiteside, Lyman, Miller, Reynolds, 2005).

The authors evaluated the HIRE model, an informal training model for nonsuicidal self-injury as an evidence-informed model for teaching assessment. This model assesses for history (H), interest in change (I), reasons for engaging in the behavior (R), and exposure to risk (E). The training in assessment for nonsuicidal self-injury assessment includes assessing and teaching with confidence and skill. The effectiveness of the HIRE model was evaluated using two independent variables, the self-efficacy (NSSI-ASE) and nonsuicidal self-injury assessment for skill acquisition (NSSI-ASA). The NSSI-ASE focuses on confidence in conducting the session and the NSSI-ASA for skill.

Formal assessments may involve the usage of data gathering inventories to include: the Inventory of Statements About Self-Injury (Glenn & Konsky, 2011), the Deliberate Self-Harm Inventory (Gratz, 2001), and the Functional Assessment of Self-Mutilation (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007).

Several behavioral symptoms may differ in intensity and actions for self-injury and suicide regarding the intent, means, frequency, severity, and emotional components before the act and the consequences following the injury (Whisenhunt et al., 2014). Whisenhunt et al. (2014) grounded theory listed six categories for conceptualizing self-injury. The six include: (a) external factors to self-injury, (b) defining self-injury, (c) potential for harm, (d) conditions for treatment, (e) counselors' reactions to working with clients who self-injure, and (f) clients' response to treatment.

It is important to differentiate non-lethally motivated self-harm from real suicidal intention, because of the lifetime risk of suicide in clients. Craigen, Healey, Walley, Byrd, and Schuster (2010) recommended a formal and informal assessment for self-injury. Formal assessment includes a self-injury assessment/ inventory, suicidality protocol inventory, trauma inventory, Beck Depression Inventory, and anxiety scales. An informal assessment is on-going and includes observations, and interviews to include a background check, familial history, peer support, social support, negative/positive influences, emotional capacity, verbal ability to express emotions, and coping strategies.

Hom, Stanley, and Joiner (2016) conducted a web-based on-line suicide and suicide-related symptoms for disclosing information for compensation study. The authors identified some instruments that cut across several of the risk factors associated with suicide and suicide self-injurious acts. Key factors assessed include suicide capability, an involvement of alcohol, depressive severity symptoms, emotion regulation, suicidal symptoms, the fearlessness of death and attitudes toward individuals who die by suicide, exposure to painful and provocative experiences, lifetime and past-year suicidal ideation, stigma barriers for care, and thwarted belongingness, and burdensomeness. Troister, D'Agata, and Holden (2015) identified three screeners for preexisting risk factors to be the Beck Depression Inventory-II, Beck Hopelessness Scale, and Psychache Scale in a study of 7, 522 undergraduate students. The Psychache Scale was superior to the Beck Depression Inventory and Beck Hopelessness Scale in indicating suicide ideation, single and multiple suicide attempts, and a recent suicide attempt.

The instruments identified as screeners by Hom et al. (2016) to assess for several of the risk factors include:

1. Acquired Capability for Suicide Scale: The Acquired Capability for Suicide Scale (ACSS; Ribeiro et al., 2014) is a 7-item self-report scale that assesses an individual's perceived fearlessness about death.
2. Alcohol Use Disorders Identification Test (AUDIT–C; Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998) is a 3-item self-report questionnaire used to screen for an alcohol use disorder,
3. Center for Epidemiologic Studies Depression Scale is a 20-item self-report depression scale (CES–D; Lewinsohn, Seeley, Roberts, & Allen, 1997) designed to assess depression symptom severity.
4. The Depressive Symptom Inventory–Suicidality Subscale (DSI-SS; Joiner, Pfaff, & Acres, 2002) is a 4-item self-report assessment of suicidal symptoms.
5. The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is a 36-item self-report measure designed to assess emotion regulation difficulties across six distinct domains.

6. The Stigma of Suicide Scale–Short Form (SOSS–SF; Batterham, Calear, & Christensen, 2013) is a 16-item self-report measure used to assess attitudes toward individuals who die by suicide.

7. The Painful and Provocative Events Scale (PPES; Bender, Gordon, Bresin, & Joiner, 2011) is a 26-item self-report scale designed to assess the frequency with which an individual is exposed to a range of painful and provocative experiences (e.g., physical abuse, car accidents, injuries requiring medical attention).

8. The Suicidal Behaviors Questionnaire–Revised (SBQ–R; Osman et al., 2001) is a 4-item self-report measure of lifetime and past-year suicidal ideation and future likelihood of suicidal behavior.

9. The Perceived Stigma and Barriers to Care for Psychological Problems Scale (PSS; Britt et al., 2008) is an 11-item self-report assessment used to investigate the degree to which various structural and stigma barriers for physical and psychological care might prevent an individual from seeking mental health treatment.

10. The Self-Injurious Thoughts and Behaviors Interview–Short Form (SITBI-SF; Nock, Holmberg, Photos, & Michel, 2007) is a 72-item interview assessment used to capture information regarding the nature and timing of past and current suicidal ideation and behaviors as well as NSS

11. The Interpersonal Needs Questionnaire (INQ; Van Orden, Cukrowicz, Witte, & Joiner, 2012) is a 15-item self-report measure of thwarted belongingness (INQ–TB; 7 items) and perceived burdensomeness (INQ–PB; 8 items).

Instruments (Suicide Self-Harm Injury or nonsuicidal self-injury):

1. Deliberate Self-Harm Inventory (DSHI; Gratz, 2001)

2. Self-Harm Inventory (SHI; Sansone, Wiederman & Sansone, 1998)

3. Self-Injurious Thoughts and Behaviors Interview (Nock, Holmberg, Photos, & Michels, 2007)

4. Self-Injurious Thoughts and Behavior Interview (SITBI; Nock, Holmberg, Photos, & Michel, 2007)

5. Attitudinal Familism Scale (AFS; Steidel & Contreras, 2003)

In summary, assessment for suicide is to include risk factors, warning signs, and self-protective coping skills. Granello (2010) listed twelve global principles for suicide risk assessment:

1. that each person is unique

2. complex and changing

3. an ongoing process

4. to err on the suicide of caution

5. collaborative

6. relies on a criminal judgment

7. taking all threats, warning signals, and risk factors seriously

8. to ask the tough questions

9. treatment

10. to uncover the underlying message

11. conducted in a cultural context

12. is to document (pp.364-368)

Theories of Aggression:

Middlebrook (1980) defined aggression regarding primary drives as described by Sigmund Freud and Konrad Lorenz (instinct theories).

a. Freud: Aggression is a primary drive representative of the death instinct. In every person, there exists the drive to create and the drive to destroy.

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

c. 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 to brain damage and hormonal levels to aggression (Albrecht, Thomas, & Chadwick, 1980).

d. Social Learning Theory: Aggression is learned through reinforcement, punishment, modeling, and imitation. Research indicates that observation of aggression (including violence on television) is a form that contributes to aggressive behavior.

e. Frustration-Aggression Theory: Dollard, Miller, Doob, Mowrer, and Sears (1939) state that aggression is the outgrowth of frustrating experiences. Unresolved frustration stimulates factors demonstrated in aggression. Some examples of these influencing factors include:

   1. A personal attack will result in more aggressiveness than environmental blocking.

   2. A justifiable "reason" for the frustration will reduce the aggressive response.

   3. Expecting to be and experience being unpleasant reduces aggressive responding.

   4. People take cues from the environment when experiencing frustration. The presence of guns or watching others behave aggressively will likely elicit aggression.

   5. Expected rewards and punishment will determine how aggression is expressed. Aggression may be expressed indirectly or displaced when punished.

f. Social-ecological approach and perspective taking for aggression are to consider individual and group level influences (Swearer, Espelage, Vaillancourt, & Hymel, 2010). This approach takes into consideration the influence of group behavior such as bystander approval and encouragement (Salmivalli, 2010). Aggressive attitudes may be a factor of peer approval (popular) if one is aggressive and losing face or respect if one is not aggressive. Norms, goals, interpersonal relationships, teaching and learning practices reflect and are suggestive of a climate involving bullying, teasing, and fighting as an established pattern in the school life and the organizational structure (Huang, Cornell, & Konold, 2015).

OBJECTIVE 7D: IDENTIFYING AND REPORTING TRAUMA

Objective 7.d. procedures for identifying trauma and abuse and reporting abuse (CACREP, 2015, p. 12).

Violence, abuse, and maltreatment of adults and children are severe enough to be defined as traumatic events. Assessing sexual abuse trauma is difficult especially for children because of memory, cultural factors, ethnic differences, policies and standards, feelings of self-responsibility, and interviewer

knowledge for elements of sexual abuse and that the interviewer may apply Anglo-American standards of "good" parenting to judge the behaviors (Ferrari, 2002).

Trauma may be a result of violence, being physical, mental, environmental, familial, and verbal assaults. Trauma can have an effect on the lives of those who have witnessed violence (Geffner, Ingelman, & Zellner, 2003). The trauma may be over, but the person's reactions to it are not. What happened to the victim becomes the recognizable and unrecognizable symptoms of adaptation. The variables to consider for the psychological symptoms that result are intrusive memories, flashbacks, nightmares, or overwhelming emotional states. The impact of trauma on child sexual abuse can lead to depression, anxiety, substance use and abuse, poor self-esteem, suicidality, interpersonal isolation, and continued use of same adaptive coping strategies (Browne & Finkelhor, 1986).

Children developmentally are forming their individual personalities that encompass how they perceive the world and develop personal beliefs about everything. Symptoms and outcome behaviors after experiencing a trauma have been associated with the core mechanism of emotion dysregulation and later in adult life developing psychopathology (Silverman, Reinherz, & Giaconia, 1996; Weltz, Armeli, Ford, & Tennen, 2016). Emotional dysregulation differs according to trauma type (Van Dijke, Ford, Frank, Van Son, & Van den Hart, 2013). The literature supports a relationship exists between physical abuse and substance abuse, criminality, and antisocial behavior, and domestic violence (Logan, Leeb, & Barker, 2009). African American children are three times as likely as White children to die from child abuse (Children's Defense Fund, 1985). However, there is a paucity of research for emotional abuse. In all types of abuse related to trauma, stress-reactivity are a present and long-term memory for child sexual abuse. A longitudinal study researching surviving adult victims for long-term memory of sexual abuse was conducted by Alexander et al. (2005) regarding the accuracy of sexual abuse as children after 12-21 years. The memory of the factors associated with the trauma, emotions, cognitions, and behaviors was found to be intact and available to the victims. Anderson and Bang (2012) reported that resiliency was a major factor in adults recovering from childhood exposure to domestic violence and that short-and long-term memory was impacted (Geffner et al., 2003). The trauma events that are highly negative are remembered well (Berntsen, 2002). As the severity of the trauma increases so does the memory recall, and long-term feelings. An international review of sexual abuse for youth in residential child and youth centers from 1945-2011 identified factors that predisposed children to risk of sexual abuse and found institutional culture, sexual culture and gender, sexual abuse by professionals and peers, perpetrator's profiles, ethnicity, and responses to signals as prominent cues to establish residential control variables and policy for safety (Timmerman & Schreuder, 2014).

Trauma symptoms are similar to PTSD symptoms. The PTSD symptoms may trigger trauma symptoms of the distressing events and may affect children's adaptive abilities, emotional well-being, social functioning and physical health (Graham-Bermann & Edleson, 2001). Psychological issues for abused women included depression, anxiety, psychological distress, and lower self-esteem. A type of damage to the psyche that occurs as a result of a severely distressing event or the overwhelming amount of stress that exceeds one's ability to cope or integrate the emotions involved with that experience is a psychological trauma. The individual's ability to integrate emotional experience is overwhelming, or the person experiences, subjectively, a threat to life, body integrity, or sanity are elements of a psychological trauma (Pearlman & Saakvitne, 1995, p. 60).

Maltreatment is the abuse and neglect that occurs in children under 18 years of age. Maltreatment includes all types of physical and emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation that results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, and trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment (Herenkohi, 2005; World Health Organization, 2016). There were 872,000 substantiated cases reported in 2004 in one of four categories: (a) neglect, (b) physical abuse, (c) sexual abuse, and (d) psychological abuse (Department of Human Health Services, 2016). Maltreated children are at risk for anxiety, depression, somatic complaints, suicide, impulsivity, hyperactivity, interpersonal problems, intrusive thoughts, hyperarousal, and dissociation (Kolko, 2002).

Sexual Abuse (children):

The U. S. Department of Health and Human Services (2016) received over 3.5 million reports of child abuse and neglect requiring decisions for services. The Adverse Childhood Experiences (ACE) Study involving 17,000 U.S. adults examined the impact of childhood experience on adult mental and physical well-being (Felitti et al.,1998). Childhood exposure to multiple forms of trauma was found to be predictive of more pervasive, severe, and negative adult mental and physical outcomes and that individuals who were exposed to one childhood category have 86.5% chance they were likely to be exposed to at least one other abuse category (Dube et al., 2003). Mendoza, Rose, Geiger, and Cash (2016) in an actuarial and clinical study categorized types of abuse to be neglect, verbal/emotional abuse, physical abuse, intrafamilial sexual abuse, extrafamilial sexual abuse, any sexual abuse, and parental substance abuse.

Mendoza et al. (2016) found that during the clinical assessment that practical wisdom often lacks agreement by workers as to the intensity of maltreatment. Different instruments or inventories have been used to determine the level of risk. The Washington Risk Assessment Matrix (WRAM), the California Family Assessment Factor Analysis (CFAFA), the Child at Risk Field System (CARF), and the Child Emergency Response Assessment Protocol (CERAP) are clinical evidence-based instruments (Mendoza et al., 2016). An actuarial approach to assessing maltreatment classification informs the likelihood of future harm or risk (Brown & Packard, 2012). An actuarial evidence-based instrument is the CRC's Actuarial Models for Risk Assessment (Johnson, 2004). Sexual abuse assessment may be limited in accuracy to the professional's degree or level of forensic research knowledge and experience regarding childhood sexual abuse. Pelisoli, Herman, and Dell'Aglio (2015) surveyed a total of 645 U.S. and Brazil professionals (188 psychologists, social workers, nurses, medical doctors) and non-professionals (457 students) with a 32-item knowledge (correct answers) questionnaire to determine reliable judgments of childhood sexual abuse reporting (CSA). Herman (2005, 2009, 2010) reported that mental health professional assessments lack validity and accuracy and that judgment errors are common because of a lack of research knowledge with a biased 24% accuracy rate. Professional and non-professional survey results regarding knowledge pertinent for the clinical interview relating to a childhood sexual abuse revealed a 44 percent correct for nonprofessionals (similar to random guessing) and 55 percent for professionals. Judgment errors may be questioned because of attitudes, subjectivity, and skepticism (Everson & Sandoval, 2011) and at least 25% of all children who disclose sexual abuse will at some time recant their initial disclosure (Pelisoli et al., 2015). This study supported Mendosa, Rose, Gelger, and Cash (2016) findings that professionals and non-professionals were uninformed or misinformed about some of the research findings that are relevant for a forensic assessment.

Children rarely disclose sexual abuse (Goodman-Brown et al., 2003; Smith, Letourneau, Saunders, Kilpatrick, Retick, & Best, 2000). Childhood self-disclosure or in discussions with a mental health professional, children may share feelings regarding the abuse, impact on their well-being and health, sources of support, coping strategies, the context in which the abuse occurred, and compliance in the abuse (Jackson, Newalt, & Backett-Milburnt, 2015).

Forensic evaluations of childhood disclosures are limited in scope and accuracy because of evaluator's knowledge of sexual abuse, lack of confidentiality, denial of the trauma, and children's restraint in compliance. Also, ethical and legal considerations restrict access to accounts of children. Retrospective records from adults who experienced childhood sexual abuse have been helpful but may involve distorted recall or memory issues. Radford, Bradley, Fisher, Beutler, and Williams (2011) reported in the United Kingdom that 15.5% of 11-17-year-olds and 24.1% of 18-24-year-olds experienced contact and non-contact sexual abuse offenses during their childhood.

Jackson et al. (2015) conducted a narrative, qualitative study of 2986 sexual abuse cases (main reason for calling) from a data bank of 10,716 call-in cases. The study involved ages 5-18-year-old female children (66.4%) and male children (33.5%). Categories of abuse included: touching, contact with animals, harassment, indecency, organized abuse, rape, ritual abuse, and incest. Six percent of the cases included more than one category. Talk of the abuse was described as direct, indirect, explicit, and implied regarding the abuse. The majority of young children presented their abuse with direct communication and indirect as children were older. Study results included:

a. coping strategies most commonly included disclosure to others, avoidance, self-harm, suicidal thoughts/attempted suicide, running away, trying not to think about it and resistance.

b. when abuse was severe self-harm and suicide were described.

c. violence and physical abuse within sexual abuse was by male perpetration (threatened violence).

d. abuser strategies included force or coerce compliance, they were special or bribed, a game, loving, etc.

e. factors that the child thought contributed to the abuse included divorce, separation, bereavement, alcohol, and drug use.

f. factors that affected their health were physical, psychological, and social that included pain, sexual arousal and gratification, identity issues, depression, eating disorders, low self-esteem and relationship problems with friends, family and partners (p. 328).

In summary, responsibility was a common theme for barriers to disclose the abuse. Children expressed in a variety of ways that they felt responsible for the abuse. Ninety-three percent of the perpetrators were known to the victim, and many of those were family members and men. Children ages 5-8 used direct communication in describing the abuse; friends were an important source of support and factors that predisposed children to risk included divorce, separation, and parental alcohol misuse.

Assessment

Cook, Blaustein, Spinazzolo and van de Kolk (2003) reported that assessment information includes:

a. developmental history of the child, family, and trauma.

b. primary attachments.

c. involvement of child protective services.

d. illnesses, losses, separation/abandonment by parents.

e. family mental illness.

f. substance abuse.

g. legal history, child, and family coping skills and.

h. extra family stressors.

Question 7-20:

Considered to be the primary coping mechanism of sexual abuse is:

a. emotional dysregulation.

b. sleep deprivation.

c. abdominal pain.

d. social withdrawal.

Answer: a. emotional dysregulation

Reporting Abuse

When abuse is considered contact the National Society for the Prevention of Cruelty to Children (NSPCC) to report the concern or call directly to the nearest Family and Children's Service Department in the local city or state. The telephone number for adults is 0808.800.5000 and for children 0808.800.1111. Call 911 if the child is at immediate risk or call the police if a crime has been committed. Signs of child abuse reported include the type of abuse such as domestic violence, sexual abuse, online abuse, physical abuse, neglect, emotional abuse, child sexual exploitation, female genital mutilation, child trafficking, grooming, bullying and cyberbullying, and harmful sexual behavior. Signs and symptoms of each type of abuse are available at nspcs.org.uk. The person answering will gather information, ask a social worker to look into the allegation, and possibly contact the police. Confidentiality limits the responder to inform the caller of what takes place after the call.

OBJECTIVE 7 E: DIAGNOSTIC ASSESSMENT AND INTERVENTION PLANNING

Use of assessment for diagnostic and intervention planning purposes (CACREP, 2015, p. 12).

Data gathering during assessment is derived from multiple sources to include an interview, disorder criteria, client reports, client associates, family members, checklists, ratings, screeners, inventories, instruments, mental status examination, technology reports, and medical reports. Once the assessment is completed and goals established the counselor attends to different aspects of treatment.

TREATMENT PLANNING

Treatment planning takes into consideration the derived symptoms, client motivation, and commitment to the counseling. Treatment can include global treatment matched with the symptoms such as scientific evidence or non-scientific outcome evidence for effectiveness or efficacious research literature support. The 2014 Code of Ethics informs the counselor in the use of innovative theories and techniques (F.7.h.), harmful practices (C.7.c.), treatment modalities (C.7.a.), scientific basis for treatment, and monitor effectiveness (C.2.d.).

Outcome research for evidenced-based treatment is an orderly designed scientific study with significant findings. These outcome studies are referred to as effective and efficacious treatments for cognitive behavioral therapy (CBT), eye movement desensitization (EMDR), interpersonal psychological therapy (IPT), dialectical behavior therapy (DBT), and acceptance and commitment therapy (ACT) for specific disorders and self-harm and suicide ideation. Non-scientific approaches may also be helpful if grounded in theory, research, and experience of the counselor. Some of the global theories have specific techniques that the counselor implements with client treatment during session work.

Technique refers to specific intervention strategies utilized during therapy sessions. Techniques are matched to specific symptoms presented during intake that altered the normal course of functioning. The role of techniques may be to increase a symptom that decreased during the distress or to decrease a symptom that increased causing distress to the functioning level of the client. Techniques are specific to theories such as defusion and mindfulness associated with Acceptance and Commitment Therapy (ACT). Erford (2015) identified 40 techniques every counselor needs to know. His list includes the empty chair, in vivo, scripting, muscle relaxation, breath inhalation, bibliotherapy, journaling, systematic desensitization, etc. The counselor is to be aware of the strengths and limitations of each technique used in practice. Caution is to be taken with the use of relaxation exercise when used with a client experiencing generalized anxiety disorder or panic disorder. Relaxation may exacerbate a client into a panic attack that could be harmful (Lilienfeld, 2007). Possibly a client could re-experience symptoms of repressed childhood trauma if a counselor with no knowledge of the trauma seeks an early memory as a technique for Adlerian therapy.

Counselor benefits when using a technique may include energy (more active session), pace (session is too fast or too slow, and a technique can be an interruption), obstacles (facilitate the process and used when resistance is present), content (expand material), and clarification (when therapy is vague) (Gonzalez & Welch, 2001).

Client benefits may energize the client during a session, provide a newness (novelty), engage the client in participating, and integration (the client integrates what is learned).

OBJECTIVE 7F: Basic Concepts of Assessment

Objective 7 f. basic concepts of standardized and non-standardized testing, non-referenced and criterion-referenced assessments, and group and individual assessments (CACREP, 2015, p. 13)

The art and science of understanding, measuring, and making decisions about the psychological characteristics of people are the essence of this unit. Several major terms are important to begin this unit of study. These are:

CLASSICAL MEASUREMENT THEORY: The equation $x = T \pm e$ describes Classical Measurement Theory. The x represents a score attained by an examinee, T refers to a perfect score and e represents errors that influence a less than perfect score. Item Theory is another theory although is not likely to be a test question for the NCE examination.

MEASUREMENT: Ward and Murray-Ward (1999) defined measurement as a "process of determining the amount, extent, or another category of a variable" (p. 59). Variable is an important term in this definition because it is usually a characteristic. Mehrens and Lehmann (1984) briefly defined 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 (1991) definition of evaluation it involves decision-making as a judgment on 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: Gregory (2015) defined psychological assessment as a process of solving problems utilizing psychological tests as a method to collect information. The process of psychological assessment involves an accumulation of data and personal information collected to evaluate the person's psychological functioning in an area and to predict behavior. The critical elements of psychological assessment are the problem, data collection, and interpretation of the information. Sattler (2008) approached psychological assessment regarding the unique characteristics and circumstances of the person. This measurement is predicated on the idea that behavior can be assessed quantitatively. Therefore, some quantitative concepts are IQ, GPA, %, etc.

QUANTITATIVE: Quantitatively refers to how much of an attribute a person had in a segment of knowledge (algebra) and presented as 36 correct out of 50 items, or 72%.

QUALITATIVE: Qualitatively refers to how good are the 36 correct. Frequently the answer is conducted by comparing it to some standard (norm or criterion). The interpretation provides information that this person surpassed the criterion number correct to pass on to the next lesson or that this person ranked at the 50% level when compared to his eighth-grade classmates at his local school.

STANDARDIZED TESTS: Standardization is a uniform procedure in the administration and scoring of the test. There are many specific facets to be fulfilled for a test to be considered a standardized test. Therefore, a psychological test is an objective and standardized measure of a sample of behavior (Kaplan & Saccuzzo, 2013). The standardized sample 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.

Classification of Tests

The ACA 2014 Code of Ethics cautions users to be aware of the established procedures, relevant standards, and current professional knowledge for assessment, design development, publication, and utilization of assessment techniques (E.12., construction, ACA, 2014).

Aiken and Groth-Marnat (2005) listed methods to classify tests.

Standardized vs. Nonstandardized: A sample statistically drawn from a population of people is administered a test in a standardized procedure and norms computed representing the population for future test takes. A standardized test has set instructions for administration, scoring, interpretation and has been developed by professionals meeting standards. 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 items, but there is a limit on the time the examinee has to complete the questions. A power test has a generous time limit, but the items may be more difficult.

Objective vs. Subjective: An objective test has a set answer for each question and 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, Intelligence, 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 were developed.

A norm-referenced test compares the person's performance 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 using standard scores such as z or T scores to make comparisons (Gregory, 2013). Norm-referenced scores compare how well a person did when compared to a group score and interpreted as a ranking.

Anecdotal records are brief usually in a narrative form charted after the behavior has taken place. Anecdotal records often are of a single observation or event, objective, written in phrases and immediately after the event, listing sequences of behavior, direct quotes, and recording positive and negative statements (Drummond, Sheperis, & Jones, 2015).

A criterion-referenced test is designed to measure the outcomes of instruction and a student's performance is compared to a standard defined by the instruction. There is an absolute standard often characterized as a criterion level, cutting score, pass-fail, go no go, which is a passing standard (Glaser, 1963). The term domain-based is used with criterion-referenced tests and represents a universe of items. It is the core of criterion-referenced tests. In comparison to norm-referenced, criterion-referenced is a narrower interpretation such as mathematics (norm) and the criterion may be larger in scope (intelligence).

Criterion-referenced norms result from criterion-referenced tests with established norms and measure how well a person mastered a skill such as mathematics. An interpretation of a criterion reference test regarding a standard of performance uses percentiles, scale scores, and performance categories.

Testing is applied to different domains including cognitive, affective, psychomotor, nonverbal, and component behaviors and listed in a sophisticated hierarchy known as taxonomies. Depending on the purpose of assessment, one or more of these domains may be a unit of the test construction and interpretation. The parts or levels of the cognitive domain taxonomy are knowledge, comprehension, application, analysis, synthesis, and evaluation. The purpose of the test determines the selection of a norm-referenced or criterion-referenced test. If the purpose of testing is simply to rank order the examinees along some achievement continuum, norm-referenced is appropriate. If the scores are the basis for deciding whether to prescribe remedial work in a skill area or to pass the student along to the next unit of learning, a criterion-referenced test is appropriate.

Taxonomies for Testing

Test development is 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 assessment for rehabilitation and neurological testing is concerned 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 aspects of perceiving, thinking, and remembering. Cognitive domain levels are knowledge, comprehension, application, synthesis, analysis, and evaluation.

Knowledge is the ability to recall or recognize information in the presented form (remembering). Comprehension is the understanding and the ability to use the previously acquired information to solve a problem (translation and interpretation). Translation consists of the ability to paraphrase a communication or present it in a different form or to recognize the changes in symbolic form. Interpretation requires the ability to make an inference based on information, explain the meaning, or summarize the information.

The psychomotor or the kinesthetic domain emphasizes psychomotor developing as individual behavioral objectives. Harlow (1972) developed a taxonomy that utilized classification levels and subcategories to classify behaviors. Terms in the taxonomy include reflex movements, fundamental movements, perceptual abilities, physical abilities, skilled movements, and nondiscursive communication (posture, gestures, facial expressions, and creative movements like those in mime or ballet).

Norms

Tests can be norm-referenced or criterion-referenced. Norms are the average performance of the standardization sample and determined by testing a sample (random, stratified random, or cluster) of the target population for which the test is designed (Aiken & Groth-Marnat, 2005). 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. 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 are 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 (Whiston, 2017).

Test administration and interpretation manuals contain printed norm tables. These tables provide derived score equivalent for each possible raw score as well as a description of the specified group-based norms. Following is a list of different types of norms commonly used.

Types of Norms

Developmental norms include age and grade but can be misused because educational and psychological growth is not constant across grades and ages (Aiken & Groth-Marnat, 2005).

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.

Norm referencing: This 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:

Standard score norms—A standard score norm is a linear transformation of raw scores so that the same shape of the sample is maintained (example -z scores)

Normalized standard scores-A normalized standard is expressed regarding a distribution that has been transformed to fit a normal curve (examples—T scores, stens, stanines)

Criterion-referencing: An individual's score is compared to a performance standard rather than the "norm" obtained by others on the same test and is based on what the person knows, not how he/she compares to others.

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.

Expectancy referencing: relates a person's test result to expectancy information based on experience with test results. For instance, we might want to know how Sandra's typing score related to success in clerical jobs. Her score is compared with records (expectancy tables) kept on others who have already been working.

Self-referencing: A person's score can be compared with his or her performance at a different time or situation. If a person is repeatedly tested, 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 room by himself; or, Peggy's score on self-esteem has become progressively higher as she maintains attendance at the meetings.

An ipsative measurement is one in which an item 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. These types of comparisons are only intra-individual and not appropriate for normative comparisons. The response is reflected or measured against the self.

OBJECTIVE 7G: Statistical Concepts

CACREP objective 7.c. specifies different concepts for understanding and in applying the scales of measurement, central tendency, variability, shapes and types of distributions, and correlations (CACREP, 2015, P. 13).

Two broad areas of statistics are reviewed in this unit and the research unit.

DESCRIPTIVE: A summarizing of a set of data thus tabulating, depicting and describing a collection of data (Cohen & Swerdlik, 2009; Cohen, Swerdlik, & Sturman, 2013).

INFERENTIAL   Statistics to make inferences about a population from researching a sample (Cohen & Swerdlik, 2009).

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

Shapes and Distributions

Displaying data or scores in some ways reflects frequency distributions. Some of these are by frequency tables, histograms, polygons, symmetrical distributions (normal curve) and asymmetrical (skewed). Beginning with the normal curve a statistic known as kurtosis reflects peakedness or flatness of a normal curve. Thus, the distribution can be mesokurtic (similar in height to normal distribution), leptokurtic (more peaked than normal) or platykurtic (flatter than the normal curve).

Normal Curve

Before presenting the application of descriptive statistics, an understanding of the normal curve is necessary. The normal curve is useful in statistics because many distributions of standardized test scores closely resemble the normal curve (Whiston, 2017). Though the normal curve extends in both directions to infinity ($\pm \infty$), most scores fall between ± 3 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).

50% of scores fall above the median and 50% fall below the median ($z = 0$).

The mean, median, and mode are the same assuming there are a sufficient number of scores.

The farther away from the mean a score falls, the fewer the number of subjects who received that score.

The number of scores that fall one standard deviation (s.d.) above the mean is the same as the number of scores that fall one standard deviation (s.d.) 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 referred to as a reciprocal curve of distributions.
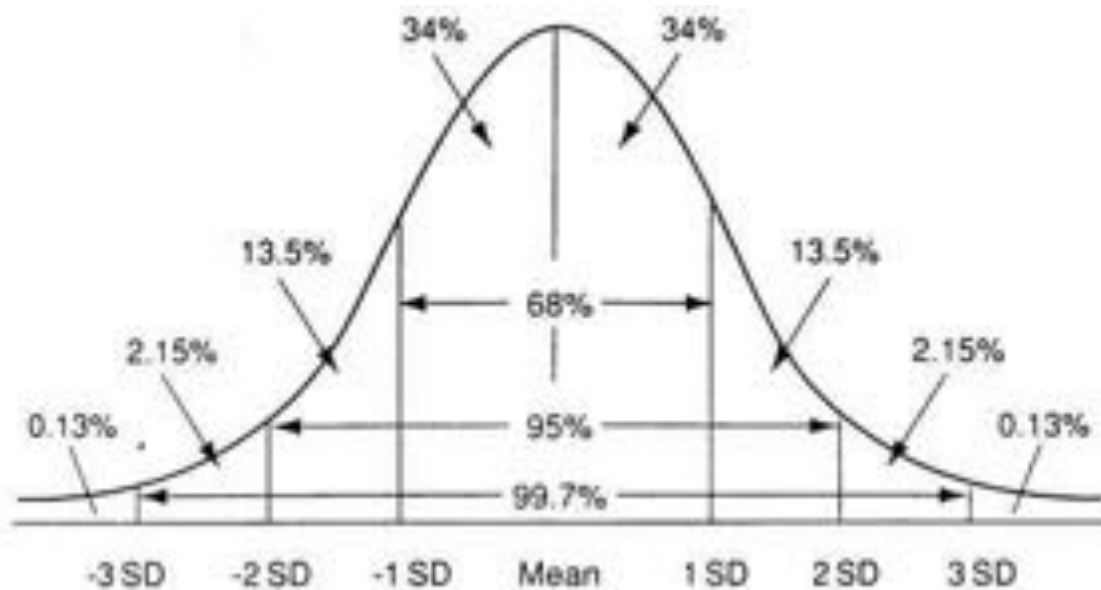
The curve for a distribution of scores is not always normal. Sometimes the distribution is skewed. In skewed distributions, the mean, the median, and the mode are different; and the mean is pulled in the direction of the extreme scores (curve is distorted). Retrieved from google.com November 12, 2013.

The normal curve is a means or method by which comparisons are made from different measures. The baseline of the curve is called a linear line and expressed in z scores with a mean of zero and a standard deviation of one. The bell-shaped curve is 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 standard deviation and 34.14% of the area of the curve lies between the mean (0) and -1.00 standard deviation. The same principle holds for each of the remaining standard deviation units, that is, +2 standard deviations = 13.59% of the area of the curve, +3 standard deviations = 2.14% of the area of the curve and +4 standard deviations 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 the skew. If the information groups itself on the right side of the normal curve, one can infer from the data, if interpreted as test results, the test contained deviant score(s). If the data are grouped on the left side of the curve, it can be inferred that the test contained deviant score(s). This can be interpreted by reviewing the central tendency figures, mean, median, and mode, or a scattergram. If the mean is to the right of the median, it is a positively skewed distribution, and if the mean is to the left, a negatively skewed distribution is likely. The mean will lead the skewness. Of the central tendencies the mean is the one most affected by extreme scores, thus is pulled toward the skewness.

A negatively skewed set of scores is evident when extreme score(s) pull the distribution out of shape and toward the left (-1 direction, tail of the curve). The skew might imply the test may be too easy or that it is a test with a relatively high easiness index. On the other hand, a positively skewed distribution of scores would have a few extreme scores to the right of the majority which would have scores gathered on the left of the curve. It might be assumed this would be too difficult or have an easiness index much lower. Indicating that a test is too easy or too difficult might be an overstatement because it is skewed and might reflect a value judgment at this point of our study. The shape of the curve initially is intended to give the researcher a picture of how the scores fall in relation to each other. To derive meaningful interpretive data researchers employ the use of descriptive statistics.

Other Distributions

Another way to review individual appraisal is through the use of two sets of data, for example, grade point average and a SAT score. A scatterplot or scattergram is a visual representation of the relationship of two sets of data. Each set of data represents 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 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 the direction and not to a value of good or bad, positive or negative.

Measurement Scales

Ary, Jacobs, Sorenson and Razavich (2010, 2014) stated that S. S. Stevenson developed a taxonomy of measurement to assign numbers to specific observations.

Nominal Scale

A nominal scale categorizes groups as male/female, freshmen/sophomores and 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 the 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, the rank of 50 states in friendliness.

Interval Scale

An interval scale has the equality of units and 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 after that (interval and ratio) adds another criterion to the qualifications, so that ratio, which adds the absolute zero, and ratio quality also include category and distance.

Question 7-21:
The mean is an arithmetic average and utilized at what beginning level of measurement scale?

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

Answer: c. interval

Question 7-22:
Which measurement scale provides a true zero point as well as equal intervals?

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

Answer: d. ratio

Question 7-23:
Which scale of measurement is the least sophisticated?

a. nominal
b. ordinal

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c. interval

d. ratio

Answer: a. nominal

Question 7-24:

Which measurement scale is typical of classroom tests?

a. nominal

b. ratio

c. interval

d. ordinal

Answer: c. interval

Nominal measurement involves placing people, objects, or things into categories. While an interval scale does provide equal intervals, there is an arbitrary point of origin for each interval; however, there is no true zero point.

Once the measurement scale has been identified and the raw data rated according to weights and summed, the data are then organized. Frequently, the first step to organizing data is to develop a frequency distribution and to illustrate the data in some graph form. Examples might be bar graphs, frequency polygons, and, when two variables introduced, the scattergram.

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 with single digits thus fewer opportunities for addition errors. A second question might focus on 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 divided by the number of test scores (5) that equals a mean score $(30 \div 5)$ equal to 6. Thus, a mean of 6.

To illustrate with a second set of numbers $(1 + 5 + 4 + 9 + 6)$ the formula and procedures to calculate the mean add the measures (x) or test scores and divide by the number (n) of test scores.

$$\bar{x} = \sum \frac{x}{n} \qquad \sum x = \frac{1+5+4+9+6}{5} \qquad \sum x = \frac{25}{5} \qquad \bar{x} = 5$$

Median: The median utilizes ordinal data. The median is the point above which 50% of the measures (scores) fall and below which 50% of the scores fall. 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.

Numerical order is a requirement, either low to high or high to low, before the middle number can be located. There are specific guidelines for an odd and even number of measures. Notice that if one had not rearranged the numbers in the example under mean; the median would appear to be 4 (incorrect) rather than 6 (correct) when the numbers are ordered.

Mode: The mode is the most frequently occurring measure or number and there can be one or more modes. A disadvantage is that the mode is not very reliable. From the above mean set of numbers, the digit 9 occurs two times, and no other number occurs that many or more times, thus 9 is the mode.

The following example will help in understanding the earlier statement regarding extreme scores and which central tendency is the preferred choice.

Five boys had the following number of professionally signed baseball cards: 11, 11, 14, 16, 38. The central tendency that would best describe or be representative of this group would be the median. If one were to conduct the three central tendencies (mean, median, mode) the mean would be 90÷ 5 or 18, which is a number above 4 of the boys. The median would be equal to 14 and is a score within or nearer to four of the five while the mode would be equal to 11.

Here is another example to determine the mode. 1, 4, 5, 6, 9—For this example, there is no repeating score so no mode or 5 single modes. If we look at 4, 5, 6, 6, 9 the digit of most frequency to represent the mode is 6 that is repeated two times, more than any other digit.

Assuming all criteria were met for a normal distribution of scores (normality) the three central tendencies of mean, median, and mode, if equal, would reflect a perfect distribution of scores.

If the three central tendencies—a mean, median, and mode were all equal to 5 this would meet one of the requirements for a perfectly normal distribution of scores and 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 in only five scores.

Question 7-25:
Which measure of central tendency is most appropriate to use with nominal data?

    a. mean

b. median

c. mode

d. quartile

Answer: c. mode

Question 7-26:

Which central tendency represents the most frequently occurring score?

a. mean

b. median

c. mode

d. quartile

Answer: c. mode

Question 7-27:

A local newspaper reporter requests the director of counseling to provide a salary that is representative of the majority of counselors in the local mental-health facility. Five counselors with the following salaries: $18,000, $19,950, $22,100, $24,400, and $49,000 were reviewed. Which central tendency would the director provide to the reporter?

a. mean

b. median

c. mode

d. all three

Answers: b. median. It is best to provide the median when using 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.

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. Calculate the range 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 et al., 2014). 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 quartile scores for Q3 which is the 75%, Q1 the 25%, and Q2 which is referred to as the semi-interquartile range the middle 50% between the 25th and 75th percentile. When the central tendency is the median, the semiquartile range is preferred and also the choice for extremely skewed distributions.

Standard Deviation: The standard deviation is the square root of the squared deviations from the mean. The standard deviation is used when the mean is reported as the best indicator of the average. This is the most reliable measure of variability for a sample. The application of the standard deviation requires the mean of the distribution. If the mean of a set of scores is 60 and the standard deviation is 5, this means that the normal curve distribution will depart from the mean in equal units of 5 both to the left and to the right of the mean (60 ± 5 or 55-65) that will represent the range of scores. Two standard deviations would be two sets of five or 2 x 5 or ten units to the left and ten 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 for each standard deviation. The standard deviation refers to the group data while the standard error of measurement refers to the individual variance.

Question 7-28:

A professor in the psychology department at a local college developed 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 extremely low scores. In examining the variation scores, which index of variability should the professor choose in order to minimize the effect of extremely low scores?

   a.   inter-quartile deviations

   b.   standard deviation

   c.   range

   d.   average deviation

Answer: a. inter-quartile deviations. The inter-quartile deviation is the most appropriate index of variability in this situation.

Standard Scores

Standard scores: Raw scores are converted using the normal curve to form standard scores. They are expressed as the distance a score is from the mean in terms of standard deviations. They are a measure of relative position when the test data are of <u>interval or ratio</u> measurement (Gay, 1996). Standard scores allow scores on different tests to be compared if the raw scores came from the same groups; once a score is converted to a standard score, a mathematical procedure is performed.

Z Scores: A Z score (portrayed as a small z) is the raw score minus the mean of the group divided by the standard deviation $z = x - x /s$ (x is the score, x is the mean and s is the standard deviation). Z score always has a mean of 0 and a standard deviation equal to 1. A z-score of 0 is equal to the mean (50%), a z-score of .5 is one-half of a standard deviation above the mean, and a z- score of -2 is two standard

deviations below the mean. The z score is the most basic standard score in that the calculations for other standard scores are often derived using z scores. A z-linear line is below.

_____	_____	_____	_____	_____	_____	_____	_____	_____
-4.00z	-3.00z	-2.00z	-1.00z	0.00	+1.00z	+2.00z	+3.00z	+4.00z
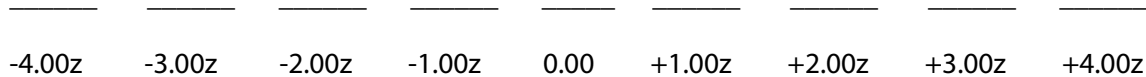
Question 7-29:

In a standard distribution with a mean of 100 and a standard deviation of 15, what is the z-score for a score of 115?

    a. +1.00

    b. - 1.00

    c. 0.00

    d. cannot be determined with given data

Answer: a. +1.00. The score (115) minus the mean (100), which is equal to 15, is divided by the standard deviation (15) and therefore this z-score is equal to +1.00.

    T-Scores: T scores are the same as z scores although have been multiplied by 10 and a constant 50 is added ($T = 10z + 50$). The development of the T scores made it easier to interpret scores to individuals because the T-score does not use negative numbers or decimals. It is easier to tell a person he or she has a T score of 40 than it is to explain a z score of - 1.00, though both scores have the same meaning. One difficulty with T scores is that individuals might confuse them with the procedure of school grading which has traditionally been 90-100 (A), 80-90 (B), and 70-75 (C).

Question 7-30:

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 given data

Answer: c. 70. Score (34) minus the mean (20), thus 14, which is divided by the standard deviation, (7) is therefore equal to a z score of +2.00. This is a z score. Converting the z score of 2 to an equivalent core requires multiplying the z score by 10 (2 x 10) and adding 50 thus 20 + 50 or 70T.

    CEEB Scores: College Entrance Examination Board (CEEB) scores have the advantage of not using decimals. This score is calculated by multiplying the z score by 100 and adding 500 ($CEEB = 100z + 500$).

Question 7-31:

In a normal distribution, what is the CEEB score for a raw score of 85 when the mean is 100, and the standard deviation is 15?

    a. 40

    b. 400

c. 4,000

d. cannot be determined with data given

Answer: b. 400. The raw score converted to a z-score would be: z = score minus mean (85-100) divided by standard deviation of 15. Thus, -15 ÷ 15 = -1.00. The z of -1.00 is to be entered into the above formula 100(-1.0) + 500 = -100 + 500 = 400.

Stanines-Standard nines: The stanine is not a true standard score because the first and last stanine are open-ended. Aiken and Groth-Marnat (2005) cited 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 stanines are not as exact as other standard scores. Stanines are based on the percentile rank and 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. Similar in type to the stanine with nine units, the stens has ten units. The normal curve of approximately 6 (±3, 34, 14, 2) percentage units consuming the curve (99+%) the stens has five reciprocal percentages of scores reflected throughout the curve (2%, 5%, 9%, 15%, 19%). 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 sten score is that each will reflect the margin of error in testing and will yield a band or range of scores or percentiles.

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 and 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.

Raw scores:
The actual number of raw points or accumulated valued points assigned to a question or stimulus statement.

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.

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 found on a taxonomy-based intelligence tests with advancing levels of knowledge and application. 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 set of 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.

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, and stens. These types of scores allow an individual to compare his/her score to scores of others who have taken the same instrument.

Tools for Interpreting Individual Analysis

All data, whether derived from a test or nontest means, are initially in raw form. To understand the information beyond a percentage correct score, the data are organized and translated into a form to perform a comparison.

Test Scores

Raw Scores:

The raw score is the actually tabulated number counted.

A TRUE SCORE is the average of all of the scores for a person upon retesting a number of times. Ary, Jacobs, and Razavieh (2010) described 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) indicated that the true score is a hypothetical score that could be attained if the assessment were perfectly reliable.

The OBSERVED or OBTAINED SCORE is the actual score, and the unsystematic error variance accounts for additional variance in the obtained score.

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.

Standard Scores Expressed:

Each standard score has an established standard deviation and mean

OBJECTIVE 7H: RELIABILITY

Objective 7h. Reliability and validity in the use of assessments (CACREP, 2015, p. 13).

Reliability can be understood from several perspectives (Gregory, 2013, 2015). Following are short descriptive excerpts from her work.

The same individual attains consistency of scores 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

e. "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).

f. by estimating what proportion of the total variance of the test score is error variance (p. 109)

g. the relative freedom from unsystematic error of measurement

h. 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 an UNSYSTEMATIC ERROR (positive or negative) and a TRUE SCORE (Gregory, 2013; Kaplan et al., 2013). In summary, since no test is considered perfect, nor is any testing situation perfect, some error of measurement is associated with each observed score. $X = T \pm e$ (Observed score = True score ± Error Variance)

Variance Accounted For is the square of the reliability. The unaccounted amount of variance is the variance accounted for subtracted from 100%. The Coefficient of Determination is another term for variance accounted for (Suter, 2012). This process determines the amount of variance (differences) in the variable accounted for by the other variables. In fact, it is the strength of the relationship.

Question 7-32:

Mark took the Canterbury Test for story-telling training. He scored 66 out of 100 questions on this cognitive examination. He retook the examination six weeks later and scored 72. The test mean was 50 with a standard deviation of 8. What was his true score?

a. 66

b. 72

c. 97

d. 99

e. unable to determine

Answer: e. unable to determine. The true score is a hypothetical construct.

Correlation (Reliability)

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. The best guess, then, is as good a guess as any regarding the relationship between the two variables. Correlation is viewed on a scattergram by plotting a bivariate distribution. Through the use of a scattergram, it is easy to visualize the direction of the relationship, positive or negative, and a lesser or greater degree of association.

Scatterplot (1), (2), and (3)

Scatterplot 1: A scattergram or scatterplot is a pictorial representation of two variables. Without performing the arithmetic operation of correlation, one can view the relationship between two variables, that is, more or less positive or negative.


(1) Positive r = +1.00
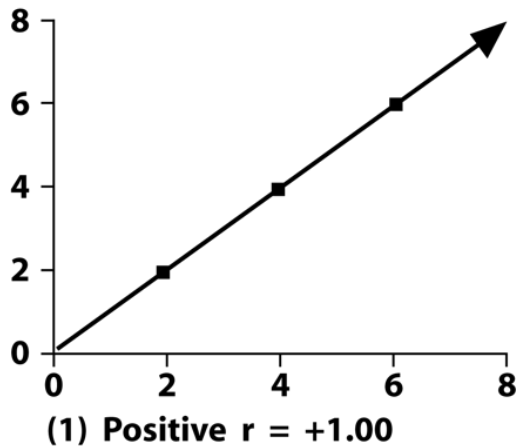
Scatterplot 1: Assuming the vertical line represents one set of test scores and the horizontal line represents a second set of scores, the student had a 2 on the first test had a 2 on the second test. Each subsequent student attained the same score and the same position for each testing. This is a perfect correlation of +1.00.

(2) Negative r = -1.00
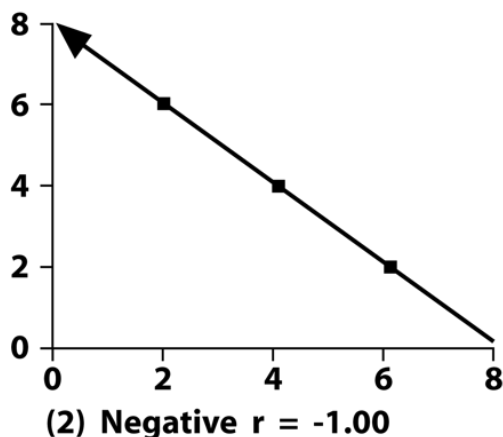
Scatterplot 2: Connecting the dots will illustrate the straight-line 45-degree angle for scattergrams one and two. The second one illustrates that the student who had the lowest score on the first test had the highest score on the second and so on. This scatterplot is a perfect negative correlation (-1.00).

The third scattergram reflects an extreme scatter (nearer to 0.00). The Left-to-Right and Right-to-Left orientations are visible on this scatterplot.

(3) Negligible = 0.00
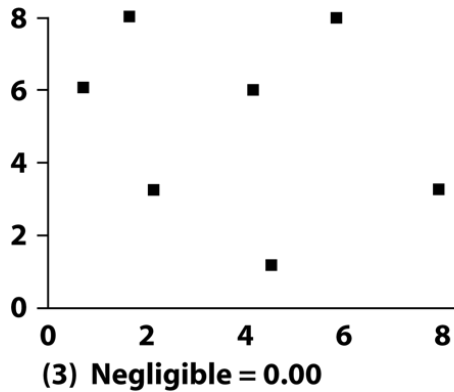
A correlation is a mathematically computed term that reveals the relationship between the two variables. This relationship is expressed as a linear relationship on the number line from -1.00 to and through 0 to +1.00. It is important to note that one variable does not cause the second.

(-)   as one variable increases the other variable decreases

(+)   as one variable increases the other variable increases

(0)   no relationship exists between the two variables

-1.00   0   +1.00

                                                             positive
negative (perfect)   (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.

Standard Error of Measurement

When applying reliability to a single score, the standard error of measurement 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 sufficient. 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 (sem), 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 like 99 times out of 100 and represented by ± 3 standard error of measurements (±6).

If an individual scored a raw correct score of 70 on a cognitive examination and wanted to know how he/she would score if he/she took the test again based upon the known unsystematic errors, this can be determined. What is required is the standard error of measurement, which is 3. The degree of confidence requested for a 95% confidence is 2 confidence bands (± 2). This is to indicate that if you took this examination 100 times or 20 times, what would be the observed score range (nearer to the true score) or confidence band (estimate)? The formula is:

2 units (or the 95% prediction) x (3 sem) or 2 x 3 = equals 6

The estimated observed range at 95% or 19 out of 20 times would be ± 6 (2 x 3) from the obtained score of 70 or a range of scores from 64-76. The counselor will be expected to interpret this score prediction to a client. 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 types of reliability measures are reported and serve different purposes:

Measure of Stability: A stability reliability requires two administrations and is a test-retest situation using the same test. Very often interest inventories utilize this type of reliability.

Measures of Equivalence: An equivalence 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 and is also called the parallel or alternate form measure.

Measure of Internal Consistency: A measure of internal consistency 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 is an inter-item consistency measure that attempts 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 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 (Cohen & Swerdlik, 2009). If the items are determined to have the same degree of difficulty the KR-21 is recommended over the KR-20.

Cronbach's 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) indicated that the Coefficient Alpha is the preferred method with the advent of computer technology. It is an all-purpose reliability because it can be applied to types of scales and internal consistency (Suter, 2012).

Scorer Reliability: Scorer reliability 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 utilized in projective administration and scoring responses. Depending on the type of test score measurement the Pearson r or Spearman rho is the preferred correlation technique to derive an index of consistency.

Assessment

Reliability can be understood and assessed in the following ways:

Standard Error of Measurement: Range of fluctuations of one's scores as a result of chance error

Correlation: Degree of agreement between two sets of scores

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 (1991) as instrumental in affecting the reliability. These are:

Test Length:	A long test is more reliable than a short test
Speed:	Faster test are problematic because not everyone completes the test
Group Homogeneity:	More homogeneous less reliable than heterogeneous test
Item Difficulty:	When there is less variability, too difficult or too easy are less reliable
Objectivity:	Objective tests are more reliable than subjective tests, Single scores more reliable
Variation	Testing situations vary errors mount because of sickness, noise level, and other extraneous factors
Test-retest interval:	Shorter interval between testing result in higher correlations.

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 the score 90% of the time.

Question 7-33:

A classroom teacher conducted a reliability study for a speeded test she gave to an algebra class. Which measure will provide an expectancy reliability?

    a. stability

    b. parallel

    c. split-half

    d. equivalent

Answer: c. split-half. Split-half measures are spuriously high because of the odd/even split and will approach 1.00

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 (Drummond, Sheperis, & Jones, 2015; Kaplan & Saccuzzo, 2013). 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

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, 2009; Kaplan & Saccuzzo, 2013). There is no correlation (r).

Content-related: Establishing content validity requires a thorough inspection of the test objectives matched across the individual test items. Different categories of tests include taxonomies for cognitive

affective, and psychomotor to test for levels of performance. A cognitive test utilizes a procedure called item analysis to determine easiness/difficult of each test item and for discrimination index. There is no correlation (r) to express the level of content validity. Whiston (2017) reported a content validity ratio is determined by a panel of experts who review test items for answers to the question regarding the skill or knowledge measured for each item and for the complete test.

Criterion-related: Criterion validity utilizes a criterion to measure the performance on a specific test. The two common criterion types are concurrent and predictive. Correlation (r) is the index to describe these validities. The preferred correlation is dependent upon the type of data, sample size, and the shape of the distribution.

Concurrent: This type is composed of two measures taken at one time. The objective of the testing is most important. It can be used for a determination now; does the grade point average predict the SAT score?

Examples: SAT and GPA.

Predictive: A longer time interval for prediction and often utilized for selection and classification. Diagnosis is for the future. Example: SAT score will predict success in college, completion of a degree. The criterion measure of prediction is successful completion of college.

Construct-related: This type of validity relates to theoretical constructs such as intelligence and fear. Construct validity is described with the use of correlation (r) and is most frequently associated with personality theory although it exists for all constructs.

There are other types of validity that will not be reviewed in this manual, such as incremental, differential, discriminant, and convergent. If you are competent with content, construct, and concurrent validities, it is recommended that you review discriminant and convergent validities in the terms section.

Describing Validity

Correlation: Used for criterion and construct-related validities.

Coefficient of Determination: The coefficient of determination is the squared correlation between the test and the criterion and is the proportion of criterion variance accounted for by the test. If the correlation between the ACT and successful completion of pre-college training is .70, then the coefficient of determination is the correlation of those two measures squared (r =. 70) or .49 and interpreted as a percentage. That is 49% of the variation in successful pre-college training is accounted from knowledge of the ACT.

Standard Error of Estimate: This term is similar to the standard error of measurement, as this term is to set the confidence limits of the true score. The standard error estimate is the margin of error in predicting the criterion score.

Expectancy Tables: Decision theory utilizes cutoff scores for personnel decisions. These tables are easy to read and interpret.

Multiple Regression: A mathematical combining of scores on several tests to assign weights and allows a high score on one test to offset a low score on another test.

Prediction

Prediction validity is an application of decision theory, and it affords one to subject the test scores to a scatterplot and make predictions. Four quadrants are developed on the axes of the ordinate and abscissa with two variables. Thus, one can establish the following predictions.

False Rejection: Rejecting the hypothesis when it is true referred to as a false negative in that one predicts the person to fail. This is referred to as a Type I or Alpha error.

Valid Acceptance: Accepting the hypothesis when the hypothesis is true

Valid Rejection: Rejecting hypothesis when the hypothesis is not true

False Acceptance: Accepting the hypothesis when the hypothesis is false or a false positive that is incorrectly predicting that one will succeed if succeeding 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.

The 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 when squared equals .64 subtracted from 1.00 equals .36, and the square root of .36 is .60. It is not important to memorize or perform this operation rather to understand the purpose and

$$\sqrt{1 - r^2}$$

what may be gained by performing the operation.

 The use of the standard error estimate enables counselors 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. The margin of error could be interpreted as 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 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 the unsystematic error.

Maximum Validity: To determine the maximum validity calculate the square root of the existing reliability. If the reliability of a test were .64, the square root would be .80 and the maximum validity.

OBJECTIVE 7I: EDUCATIONAL, CAREER, PERSONAL, SOCIAL

Objective 7i. use of assessment relevant to academic/educational, career, personal, and social development (CACREP, 2015, p. 13)

Categories of testing for development includes intelligence, aptitude, achievement, interest, values, and behavioral areas.

Cognitive 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 developmentally disabled 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 & Groth-Marnat, 2005). In America, the most important 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 intelligence testing was widely applied.

Intelligence Tests

Several definitions exist for intelligence tests; however, most include judgment, understanding, and reasoning capacity. Gregory (2015) reviewed thirteen definitions of intelligence by various theorists and found an agreement that intelligence is composed of the ability to learn from experiences and to adapt to one's environment. Scholars such as Thorndike, Otis, Guilford, Spearman, Cattell, Thurstone, Wechsler, and Binet have developed instruments to assess the aptitude for scholastic work and satisfactory 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 (2015) delineated 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, when mental age is divided by chronological age and multiplied by 100. Stern introduced this term in 1914 when he recognized that being mentally deficient (retarded was a term at that time) had different meanings at different ages. The basal age of a subject is

the highest year level at which all subjects pass, and the ceiling age is the lowest year level at which all subjects fail.

Another set of popular intelligence instruments are the Wechsler Intelligence Scales (WAIS-R, WISC-IIIR, and WPPSI-R). The Wechsler yields a deviation IQ, which is computed by multiplying the 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) include Verbal, Performance, and Full Scale.

Several tests yield scaled scores. For the most part, the Verbal Scale is likely to refer to functions of the left-brain hemisphere and the Performance Scale to right-brain hemisphere functioning. The left hemisphere components control for verbal functions, memory, language and logical-sequential learning while the right brain for expressive and creative tasks. The below list is not exhaustive, however, contains a majority of the functions.

Left Hemisphere	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	Humor
Sequential processing	Creative associative
Conceptual	Sound
Motor functions	Fluid thinking
Field-dependent	Field thinking
Crystallized thinking	Incidental learning
Speech-writing	Impersonal orientation

The above functions have been adapted from the work of Sattler (2008, 2014) and Berent (1981). The counselor respects special consideration when reporting of IQ scores. When interpreting intelligence scores to parents caution is exercised to ensure that appropriate meaning and expectations are not misinterpreted. Grade norms should not be used in counseling with parents (Sax, 1974), and methods of reporting student progress should be objective, continuous, reliable, and valid.

Models of Intelligence: An overview of a few select models of intelligence theories about efforts to measure intelligence (Galton, Cattell, Brigham).

Faculty Theory:
During the 18th century, the mind was made up of separate and distinct faculties, such as memory, concentration, and reasoning. These faculties functioned independently of one another and any of them

could be strengthened through appropriate kinds of exercise and was known as the doctrine of formal discipline.

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 some 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 (C)completion, (A) arithmetical reasoning, (V)vocabulary, and following (D)directions—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 things. They vary from person to person, and the quality determines the intelligence of each. Spearman believed that the differences in the g have to do with the apprehension of experience, determining relations, and determining correlations.

Group-Factor Theory:

L. L. Thurstone arrived at the conclusion that intelligence is composed of some 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 capacity 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 appears to decline with age while verbal comprehension; word fluency, and inductive reasoning do not (Gregory, 2013, 2015). 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 (1967):

This model is a multifactor approach to understanding intelligence known as a structure of intellect (SOI). Guilford (as cited in Drummond, 2000; Drummond & Jones, 2010) 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 refer 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 & Jones, 2010). Guilford's operations include:

a. cognition
b. memory
c. divergent thinking
d. convergent thinking
e. 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 bits of 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 that 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 & Groth-Marnat, 2005). Subtests on major individual intelligence tests assess crystallized intelligence though verbal comprehension and social relations (Whiston, 2017).

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 (1993) believed that there are several independent human intelligences. He referred to this as autonomous intelligence and isolated seven natural intelligences or forms. They are:

a. linguistic
b. logical mathematical
c. spatial

d.   musical

e.   bodily kinesthetic

f.   interpersonal

g.   intrapersonal

Personal intelligence is composed of both intra-and-interpersonal accessing of one's feelings as well as others. Bodily-kinesthetic refers to skills of the artistic environments such as athletes and dancers.

Confluence: Zajonc believed firstborn children were brighter than siblings. 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 comparing races. This prompted the genetic-environment issue of intelligence differences in races that prompted the genetic-environment controversy and dialogue.

Neurological Examinations:
When conducting a neurological assessment there is a need for a diagnosis or treatment for anyone suspect of a brain dysfunction. Neurological tests are different from other types of tests in that they attempt to derive inferences regarding the location (site), type, and degree of impairment in the brain. These impairments can be open-or close-head injuries. These impairments can be from birth, accidents, and diseases such as Alzheimer's. The function of a trained examiner is to understand the anatomy of the brain to include the central nervous system as well as the peripheral nervous system.

At times, counselors will refer individuals to a physician for a neurological examination. This referral is due to suspected or known brain dysfunction. This type of examination includes a clinical history, mental status, and an analysis of the cranial nerves, motor functions, coordination, sensory functions, and gait. Also, 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, 2008, 2014).

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 brain functioning.

Aptitude Testing

New statistical methods such as factor analysis were developed, new developments in trait theory, widespread use of intelligence tests and limitations of test use became evident with the advent of the Multiple Aptitude Test Battery. Charles Spearman, T. L. Kelly, and L. L. Thurstone were all influential in aptitude testing. This type of a test measured some traits and yielded a separate score for each trait, as

opposed to one global score such as the IQ. Nearly all aptitude batteries have been constructed since 1945 as a result of the intensive research by military psychologists during World War II. Today, multiple aptitude batteries are still used in the armed forces as well as educational and vocational counseling, personnel selection and classification. (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; Gregory, 2013, 2015).

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 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, 1996)

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 and Groth-Marnat (2005) identified the following instruments representing a match for the 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.

Noncognitive Tests

Noncognitive instruments are of different types and development. The following material will provide the reader a method in which to categorize type and makeup of tests.

Makeup:
Noncognitive tests or inventories can be structured or unstructured. Structured tests are those in which there are questions (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 16 Personality Factors (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:
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 period. Certain nonverbal behaviors are observed in elevators, such as nearness to one another as passengers enter the elevator.

Sociometry:
Sociometry is a form of evaluation in which others make ratings or judgments. Sociometry 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. 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 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:
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 theory of perception.

Homogeneity Construction:
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.

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Empirical Construction:

Empirical construction referred to as criterion construction, makes no assumptions about the assessed trait. The author attempts to create items and thus scales which will discriminate those who have the trait from those who do not. Faking is harder to achieve with this type of construction and keying.

Scaling Methods:

Assigning numbers to responses

Equal Appearing Intervals:

Equal appearing intervals are presented as many items that 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.

Absolute Scaling:

Scaling for absolute item difficulty for different age groups. Frequently this method is used for cognitive achievement and aptitude tests.

Expert Scaling:

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.

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, and strongly disagree.

Guttman Scale:

This type of scale differs from the Likert Scale in that when a respondent agrees with one statement the respondent is, in fact, agreeing with the other items, which are milder.

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).

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.

Interest Inventories

In 1927, E. K. Strong published the Strong Vocational Interest Blank (SVIB). There are several revisions of the SVIB and currently, 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 (Gregory, 2015). 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 examples of interest inventories are the Kuder series

(vocational, personal, and occupational), the Jackson Vocational Interest Survey, and the Vocational Preference Inventory.

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: Interest is thought to be 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 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.

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 (Whiston, 2017).

These tests give a composite of mental abilities, interests, and other variables that characterize a person's individuality (Kaplan & Saccuzzo, 2013). 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 share 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:

a.   what individuals say about themselves (self-report)

b.   what others say about the person (sociometric)

c.   what the individual does in a situation (observational)

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 referred to as response sets, response bias, response style, or suppressors. These styles represent either nonsubstantive or substantively irrelevant components of the 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.

The 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, concerning 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.

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).

The forced choice format is designed to reduce response styles. A forced choice is usually a yes/no, true/false with only two choices, in contrast to the Likert Scale, which allows for continuous scaling or answering.

Attitude Measures

An attitude is a "learned predisposition to respond positively or negatively to a certain object, situation, institution, or person" (Aiken & Groth-Marnat, 2005, p. 121). Attitudes are descriptions of how people feel about certain social statements or objects and 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 understand better 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 the milder responses. Attitudes can reflect response styles of deviancy, extreme, or guess (Drummond & Jones, 2010, 2012)

Values

Rokeach (as cited in Gregory, 2013), a psychologist, defined value as a shared, enduring belief about ideal modes of behavior or end-states of existence. Value is the "usefulness, importance, and worth attached to particular activities or objects" (Aiken & Groth-Marnat, 2005). Like attitude assessment, values are easier to define than assess. Some examples of values instruments are the Rokeach Value Survey, Gordon's Survey of Values, and Educational Values Inventory. Rating scales used for attitude and values assessment, however, are less precise but popular. Examples are in the form of numerical, graphic, standard, forced-choice, and behavioral-anchored types. Q-Sorts or card sorts are a method of sorting out a set of statements (adjectives) into piles of most to least characteristic. A final type of assessment is the checklist that is a self-report instrument. The subject checks words in a list that describes whatever or whoever is assessed on that value or attitude.

OBJECTIVE 7 J: ENVIRONMENTAL AND OBSERVATIONAL ASSESSMENT

Objective 7j. use of environmental assessments and systematic behavioral assessments (CACREP, 2015, p. 13)

Observational Testing

Behavioral instruments are employed to assess the behaviors of subjects who are about to undergo behavior assessment, modification to establish a baseline, to determine the antecedents and consequences of the target behaviors, and to get a social learning history (Aiken & Groth-Marnat, 2005). The observation baseline allows for monitoring at different phases of the treatment.

To measure behavior methods, include rating scales, checklists, behavioral charting, anecdotal records, and interviews. These observational techniques are subject to error in assessment. Some errors include lack of objectivity, 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 may be student demonstrations like classroom behaviors and is known as authentic or performance testing (Drummond & Jones, 2006). Observations that take place at work, play, school, and social settings are natural laboratory observations are analog assessment.

One example of an observational scale is The Vineland Adaptive Behavior Scale, which utilizes observational testing to assess intellectual disability. The Vineland consists of a diagnostic evaluation and program planning (Sattler 2008, 2014).

Method

Aiken and Groth-Marnat (2005) described several observation methods. They are:

Observational: Information about target behaviors that can be recorded by teachers, parents, and nurses. A few examples are the Attention Deficit Disorders Evaluation Scale, Connor's teacher/parent forms, Parent/Guardian-Rated DSM-5™ Level 1 Cross-Cutting Symptom Measure-Child Age 6-17 (APA, 2013), DSM-5™ Self-Rated Level 1 Cross-Cutting Symptom Measure-Adult, World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).

Self-Observational: The person is taught to monitor self-behavior that may affect the behavior. If smoking is the clinical issue the person charts the exact time of day he/she smoked, what happened just before he/she made a choice to smoke, and what occurred just after the smoking. Example: sleep log.

Behavioral Interviews: A clinical interview is a behavioral set of questions geared toward obtaining information 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: Laurence Frank was the pioneer for projective tests. Projective assessment techniques provide for unstructured or vague stimuli, such as pictures, music, or inkblots, and require the subject to respond by relating what he/she is thinking or feeling about the stimuli. Projective tests are developed in such a manner to seek deeper layers of personality functioning (unconscious desires, motives, conflicts, unexpressed or out of awareness). Instrument development is derived from the projective hypothesis or psychoanalytic theory. It is believed that when a client is presented ambiguous material, he or she will project hidden aspects of his or her personality onto the material by way of the response to a picture or inkblot. The typical response forms are categorized into five groups: inkblots or words, construction of stories or sequences, sentence completions or stories, arrangement or selection of pictures of verbal choices, and expressions with drawings or play (Gregory, 2013). The central theme of all five forms is freedom of expression. The Rorschach Inkblot Test and Thematic Apperception Test are examples of projective tests.

Naturalistic: This type of observation takes place in a formal or informal setting, (work or school); an analog assessment in a laboratory (Drummond & Jones, 2010)

Family Assessment: Includes diagnosis, treatment selection, and treatment in the 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 is reached.

OBJECTIVE 7K: SYMPTOM CHECKLISTS, PERSONALITY

The use of symptom checklists for personality and psychological testing (CACREP, 2015, p.13)

Checklists, inventories, and screeners are often used as a part of the initial information gathering for distressing symptoms for personality, intelligence/cognitive, career, clinical/behavioral, environmental/ interpersonal, and psychological problems. Checklists can be used to compare with non-clients and to validate a diagnostic or problem interview for normal and abnormal behaviors across different developmental domains. Professionals exercise expertise in determining the usefulness of different tools to describe, assess problem areas, and implement theories, techniques, treatments, and interventions.

Some standardized checklists include Children's Checklist, Achenbach System of Empirically Based Assessment, and the Symptom Checklist SCL-90-Revised (DeRogatis, 1994), The Children's Checklist includes three competency scales (activities, social, and school), eight syndrome scales, and six DSM-5 oriented scales. Syndrome scales include anxious/depressed, Ostrander, Weinfurt, Yarnold, & August, 1998).

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a rating scale and is more sophisticated than a checklist. A rating scale requires responses regarding an amount or degree of the problem such as frequency, duration, and severity. Some clients will rate themselves in the middle of a rating (1-5) when they are more or less in one of the opposite scale directions and is considered a central tendency error or a leniency error when the client resists indicating an unfavorable rating. The Conner's Rating Scales-Revised is a frequently used rating scale for attention deficit-hyperactivity disorder.

Screening inventories are not considered checklists and are typically employed to sort out problem areas.

Research and publications provide information in the form of validity and reliability studies, behavioral monitoring, and application for the different assessment tools and the frequency of use by professionals in different settings. A checklist can be standardized or developed by a professional as an informal checklist and is typically few in items. The purpose or function of a checklist is to gather initial information, is cost effective, and can be completed by a client or parent/guardian. Practitioners inform the profession regarding the frequency of use for different instruments through surveys that are developed and sent to counselors-in-practice for responses to their use of different assessment tools designed for different behaviors or disorders. These results appear in the different assessment journals for education, career, personality, developmental, counseling, personality, and an assortment of other counselor needs.

Surveys are conducted by professionals to determine the frequency of use by practitioners in a counseling practice and results are published in the different journals pertinent to specific children or adult services for education, career, personality, developmental, and specific areas of counselor expertise. Peterson, Lomas, Neukrug, and Bonner (2014) conducted a survey involving 174 commercial standardized assessment instruments selected from four textbooks used by counselor educators. Seven categories were assessed and included personality, projective, career, intelligence/cognitive, educational/ achievement, clinical/behavioral, and environmental/ interpersonal. Some 5,000 national certified counselors composed of school counselors, certified mental health counselors, and other counselors received the survey.

Rankings are determined for each of the three counseling groups. All three groups ranked the quality of the checklists, rating scales, and screeners. Results revealed that the Beck Depression Inventory ranked number one, Myers-Briggs Type Indicator ranked two, Strong Interest Inventory ranked three, ACT ranked

four, SAT/PSAT ranked five, Self-Directed Search ranked sixth, Wechsler Intelligence Scale for Children ranked seventh, Conners' Rating Scale ranked eighth, Beck Anxiety Inventory ranked ninth, and Substance Abuse Subtle Screen Inventory ranked tenth.

Some research examples published in the journals include:

Choosing assessment instruments for posttraumatic stress disorder screening and outcome research (Bardhoshi et al., 2016)

Choosing assessment instruments for depression based on outcome research with school-age youth (Muller, Erford, 2012).

Children's Depression Inventory (Kovacs, 2003)	40%
Beck Depression Inventory-II (Beck, Steer, & Brown, 1996)	31%
Hamilton Rating Scale for Children (Hamilton, 1960)	29%
Child Behavior Checklist Internalizing Scale and Anxious/Depressed subscale	24%
Center for Epidemiologic Studies Depression Scale	19%
Reynolds Adolescent Depression Scale-Second Edition	12%

Counseling outcomes for youth with oppositional behavior: A meta-analysis of the frequency of use for each measure (Erford, Paul, Oncken, Kress, & Erford, 2014).

The Child Behavior Checklist	58%
Eyberg Child Behavior Inventory (Eybert, 1990)	35%
Direct observations of oppositional symptoms	32%

Personality Assessment

The first phase of the interview may take or include a focused questioning regarding a personality issue. The DSM-5™ lists ten personality disorders that are symptomatic impairments in social and occupational functioning (APA, 2013). This diagnostic category uses a polythetic approach that utilizes taxonomy for diagnosis based on a clustering of traits. According to the DSM-5™, personality disorders are defined as "enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is inflexible and has onset in adolescence or early adulthood, is stable over time and leads to distress or impairment" (APA, 2013, p. 645). This maladaptive pattern of behavior is of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.

How does the interviewer make an assessment of a personality disorder? Fong (1993, 1995) described the clinical interview as a progression of steps: making initial broad observations and screening, looking for tentative symptom clustering, and asking focused, diagnosis-specific questions. While this process is pertinent for all disorders, the latter (e.g., a personality disorder) may take more than one interview to accurately diagnose, using techniques about which many counselors are untrained (Richie, Piazza, & Lewton, 1991).

To differentiate pathological from nonpathological personality traits, the interviewer may utilize a polythetic list of criteria of many types of symptoms, emotions, cognitions, and behaviors with threshold requirements for each personality disorder that differ from normal personality traits. For example, it is relatively normal for most individuals to maintain self-esteem by avoiding acknowledgment of their faults yet be willing to take constructive criticism from trustworthy friends.

In contrast, an individual with a narcissistic personality disorder maintains absolute denial of his or her shortcomings, is predictably self-absorbed, verbally denigrating or abusive, always blames others when things go wrong, and always denies his problem in the face of evidence to the contrary. One of the differentiating features of a personality disorder from other disorders is the degree of ego-synchronicity. For example, an individual with a clinical disorder other than a personality disorder may see the problem as egodystonic and unwanted ("I'm depressed, and I want help.").

An individual with a personality disorder has an egosyntonic "problem" which he or she is unable to perceive or take responsibility for, ("If I ever get angry, it's because she provokes me and deserves what she gets. It's not my problem, it's her problem.")

According to the DSM-5™, typical behaviors for individuals with a personality disorder are rigid, inflexible, repetitively nonfunctional, destructive or self-destructive, and tends to be the same coping behaviors over time. Individuals with personality disorders suffer from cross-situational maladaptive patterns of behavior, which have become stable over time (Fong, 1995). As a result, such individuals suffer from chronic difficulties, either directly or indirectly, caused by repeated destructive or nonfunctional coping behaviors, leading to impairment in occupational and social functioning.

Turkat (1990) estimates that at least 50% of clients who have a personality diagnosis concurrently have another disorder. In assessing a personality disorder, behaviors must be manifested by abnormalities in two or more of the following: a cognitive, interpersonal functioning, affect, or impulse control. Also, there is an inflexibility and pervasiveness to the disorder, which must cut across personal and social situations. Finally, a resulting impairment in functioning may occur in social, occupational, and other important areas of life. An important goal in assessing for a personality disorder is to determine whether the symptoms are a state (transitory feeling, i.e., fear or worry) or a trait-enduring characteristic, the way one individual differs from another (Gregory, 2013, 2015). Fong (1993, 1995) pointed out two other features necessary for the diagnosis of a personality disorder. The first is to determine if the client perceived the problem as egodystonic (not part of self) or egosyntonic (an integral part of self). The second feature is to determine if the personality disorder reveals a dysfunction in occupational or social functioning. Finally, Overholser (1989) notes that clients with personality disorders will repetitively utilize the same maladaptive coping skills.

PERSONALITY: According to the DSM-5™ (APA, 2013, pp. 649, 659, 672) personality disorders are organized into clusters based upon a descriptive similarity of traits. According to Bergin, Maynard, Prillaman, and Nadkarni (1997), Clusters A, B, and C are patterns of inner experiences and behaviors.

Cluster A (Individuals appear odd or eccentric)

    Paranoid – often argumentative, tense, and humorless; a pattern of distrust and suspiciousness
    Schizoid – detachment in social relationships and restricted range of emotional expression

Schizotypal – acute discomfort in social relationships, cognitive and perceptual distortions

Cluster B (Individuals appear dramatic, emotional, or erratic)

Antisocial – originates in childhood or early adolescence as a conduct disorder

Borderline – is characterized by instability in a variety of personality dimensions

Histrionic – draws attention to self, charming, warm, and viewed by others as shallow

Narcissistic – self-importance, self-absorbed

Cluster C (Individuals appear anxious or fearful)

Avoidant – shy and avoids new and old situations as well as people, feelings of inadequacy and hypersensitive to negative evaluation

Dependent – will allow others to make decisions, lacks self-esteem, submissive, and clinging behaviors

Obsessive-Compulsive – will strive for perfection, preoccupation with orderliness, and control

OBJECTIVE 7 L: Use of Assessment Results to Diagnose Developmental, Behavioral, and Mental Results

Objective 7l. Use of assessment results to diagnose developmental, behavioral, and mental disorders (CACREP, 2015, p. 13)

Use of assessment information is a consideration for clinical utility and user acceptability. DSM-5 disorders within the categories are organized on developmental and lifespan starting with childhood through the adult years. The age-specific disorders are based on internalizing (emotional and somatic) disorders to externalizing disorders (impulsive, disruptive conduct and substance use disorders), neurocognitive disorders, and other disorders (APA, 2013). For some disorders, the boundaries between normalcy and pathology across cultures require clinical attention regarding cultural norms if internalized by the individual and family. Thus, using assessment results to diagnose requires knowledge of cultural norms, coping strategies, alternate data gathering tools, environmental and genetic blockers, and collaborative services.

The use of assessment results can be framed in adaptive functioning and are based on a clinical evaluation which is culturally appropriate, and psychometrically sound measures when considering the intervention and treatment (APA, 2013, p. 37). The use of information gathered from educational, developmental, social judgment, risk, medical, mental health evaluations, self-management of behaviors, emotions, and interpersonal relationships are components of the overall understanding of the presenting issue.

Assessment results also include diagnostic markers that influence the findings. These markers include intellectual capacity, adaptive functioning, genetic and nongenetic causes, associated medical conditions, and co-occurring mental, emotional, and behavioral disorders.

Accurate assessment results are intended to match intervention and treatment specific to the developmental, behavioral, and mental disorders. The DSM-5 has established a minimum duration and

frequency of symptoms for a diagnostic disorder with severity ratings of mild, moderate, severe, and severe with agitation. The frequency, severity and duration assessment are helpful in documenting the symptom thresholds. The severity rating provides information for effective intervention and treatment planning.

OBJECTIVE 7M: Ethical Issues in Testing

Objective 7m. ethical and culturally relevant strategies for selecting, administering, and interpreting assessment and test results (CACREP, 2015, p. 13)

The ACA 2014 Code of Ethics for assessment has 13 subsections devoted to assessment, client welfare, competence, appropriate use of instruments, decisions based on results, informed consent, recipients of results, release of data, diagnosis, cultural sensitivity, social prejudices, refraining from diagnosis, instrument selection, referral, conditions for administration, favorable conditions, technological administration, unsupervised assessment, multicultural issues, scoring and interpretation, insufficient empirical data, services, security, obsolete assessment and data, construction, forensic evaluation, obligations, consent, evaluation prohibited, and potentially harmful relationships (ACA, 2014).

In addition to drawing attention to key critical ethical obligations in testing, information will appear with some of the constructs.

Ethical Factors to Consider in Assessment

Almost any textbook that has to do with psychological testing will systematically present the training needs and safeguards for the consumer because of score contamination, user qualifications, error variances, inadequacies in instrumentation sophistication, and ethical considerations in the application and interpretation of tests and test scores. A few such examples will be provided for review.

Invasion of privacy: Several court cases have evolved because the stimuli statements (test items) were found to be an invasion of human rights. The area of personality testing calls for improvement in a theoretical base (E.3.b., E.10. security).

Heredity vs. Environment: The controversial report by Dr. Arthur Jensen regarding the raising-lowering of IQ based on coaching and the differences in IQ in races have generated many questions yet unanswered. This debate continued with the publication of The Bell Curve by Richard Hernstein and Charles Murray.

Clinical vs. Statistical: Statistical predictions have proven to be more reliable than clinical predictions. Clinical judgment is based on experience, intuition, textbook knowledge, research-based formula (Gregory, 2013).

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 for generalization. Publications are old, however, do note that the biases or lack of data remain current. 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.

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. Messick (1988) concluded that SAT results could be enhanced by as much as 10 points with 8-10 hours of study. Research has reported that thirty-point differences with 260 hours of study for the SAT-V and 45 hours for the SAT-M because coaching has gone beyond teaching, and the Lake Wobegon effect has inflated test scores. Also, other reasons include 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).

Need for cultural and ethnic diversity (E.5.b., ACA, 2014):

Cultural and ethnic diversity differences include values, language, family interaction, nonverbal communication, 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 the 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?

Social and Cultural Issues

Section E.8 of the ACA Code of Ethics addresses multicultural issues/diversity in assessment emphasizing caution in the selection and use with assessment techniques and norms other than that of the client (p.13). This caution is extended to test administration and interpretation. It is critical in assessing clients representing minority populations that the counselor is knowledgeable about the impact of results when using instruments that may not be culturally appropriate (E.9.b., E.12.). The standards for Multicultural Assessment lists 68 standards separated into four tasks; a) selection of assessment instruments, b) norming, reliability, and validity, c) administration and scoring, and d) interpretation and application of results (Prediger, 1994; Whiston, 2013).

An ethical issue in multicultural testing is the civil rights of minorities. The first step in cross-cultural counseling should be to understand the values and worldview of the client before considering the use of testing. Because testing has historically been a dehumanizing experience used to discriminate against minorities, special care should be taken to explore the feelings and attitudes of a minority client concerning the taking of any test. These feelings and attitudes can have a significant impact on test results (Corey, Corey, Corey, & Callanan, 2015).

A factor that can influence test results is previous test-taking experiences. To combat the lack of test-taking experience of some minority clients, opportunities for practice should be provided, and the client should be retested with an alternate form (Anastasi, 1988). An example of pretest taking experience is evidenced by those taking the NCMHCE. Before the testing begins, examinees are provided a sample scenario. Test results can also be affected by the presence of item bias in the form of culturally restricted

test content, sexual stereotypes, and unfamiliar or alienating material. Test constructors are becoming increasingly sensitive to such content in instrument design (Anastasi, 1988). 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, 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 indicated "each regional, ethnic, the social group should be tested and scaled by the same operation in its idiom, in its 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 (1988) pointed 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, Aiken and Groth-Marnat (2005) reported many more minority "misplacements" would probably occur were it not for objective tests.

According to Constantine and Ladany (2001), multicultural competence has six dimensions: 1) self-awareness, 2) general multicultural knowledge, 3) multicultural counseling self-efficacy, 4) ability to understand unique client variables, 5) effect counseling alliance, and 6) multicultural counseling skills. If a counselor possesses these dimensions of competence, it is more likely good decisions will be evident in assessment procedures. Drummond and Jones (2010) recognized that known biases could exist for the test, content, internal structure, test-taker, and the examiner.

In summary, cultural equivalency occurs when functional, conceptual, linguistic, and psychometric properties have been assessed and met and the assessor practices cultural competence. The term functional refers to when test scores measure psychological characteristics that occur with the 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? Section E of the ACA Code of Ethics outlines key behaviors surrounding testing. Other principles of the ACA code that are relevant to testing are informed consent, confidentiality, and client welfare.

Resources

The ACA 2014 Code of Ethics (2014) section E.2 a. limits of competence, indicates that counselors should use testing and assessment services for which they are trained (p.11). Therefore, counselors are to be knowledgeable about the content of the Standards for Educational and Psychological Testing (AERA), Standards for the Qualification of Test Users (ACA, 2005), and the Code of Fair Testing Practices in Education. The Joint Committee on Testing Practices (2004), developed the code of fair testing practices in education outlining responsibilities of users of standardized tests. Case studies are available for assessing human behavior (Whiston, 2013). The ACA Code of Ethics in section E.2.b. states that

counselors are responsible for the appropriate application, scoring, interpretation, and use of assessment instruments (p.11).

Types of Resources

Oscar K. Buros' Mental Measurement Yearbook (MMYB; Plake, Conoley, Kramer, & Murphy, 1991) is now published by the Buros Institute of Mental Measurements. The MMYB reviews nearly all available psychological, educational, and vocational tests commercially available that meet the criteria for inclusion (Drummond, Sheperis & Jones, 2015). This reference manual provides a critical review of more than 2500 tests.

Tests in Print (Murphy, Conoley, & Impara, 1994) is another source of information about tests published by the Buros Institute. 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 although it does not review tests (Drummond & Jones, 2010).

Standards for Educational and Psychological Testing is a comprehensive guide to 13 standards for the evaluation of psychological tests as a code guide for professionals of AERA, APA, and NCMCE associations (1999). These standards assist in the sound ethical use and in evaluating the technical adequacy of educational and psychological testing. The APA along with the ERA and NCM prepares this source and each revision gives increasing attention to proper test development and use as well as correct interpretations of scores (Whiston, 2017).

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, 2010, 2013). 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 regarding technical merits, purpose, conditions affecting test performance, and other limitations.

Client Rights, Responsibilities and Testing Personnel

The 1998 Rights and Responsibilities of Test Takers guidelines and expectations identified 10 rights that clients can expect during an assessment (APA, 1998). These guidelines are supported by the ACA 2014 Code of Ethics. Also, this guideline lists ten responsibilities for a test taker and ten guidelines for testing professionals. Clients have the right to results that are based on results (E.2.c., E.3.b.), confidentiality (B.1.a-divesity, B.1.b-privacy, B.1.c), and to use the least stigmatizing labels. If a diagnosis is

a component of assessment, counselors are to exercise special care, sensitive awareness of cultural and socio-economic experiences (E.5.a., b., c.) and refrain from a diagnosis if it would cause harm (E.5.d.).

Use of Tests

Tests are used as an efficient means of obtaining information for assessment and evaluation purposes (Gladding, 2012). 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 for a particular test, for a particular client, for a particular purpose (Whiston, 2017). 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 criticism against him/her is unethical (Corey et al., 2010). In summary, Gregory (2013) outlined five uses of tests that are: classification, diagnosis and treatment planning, self-knowledge, program evaluation, and research.

Test Administration

Drummond et al. (2015) recommended specific administrative steps to be taken before, during, and after testing. 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 fair testing practices (Kaplan & Saccuzzo, 2005). Test publishers, as well as professional organizations, state within their code of ethics strict adherence to qualifications to purchase, administer, and interpret instrumentation. The ACA guidelines adhere to degree, training, and supervision to utilize certain tests: E.6.a. (appropriateness of instruments), E.2.a. (competence to use and interpret assessment instruments), E.7. (administration), E.7.a. (administration conditions), E.7.b. (favorable conditions), and E.7.c. (technological administration).

The strictest guidelines would pertain to projective and diagnostic instruments because they often require individual supervision and training. Some examples of this level include, but are not limited to, the Rorschach, Thematic Apperception Test, and the Minnesota Multiphasic Personality Inventory. Other instruments such as interest and most group cognitive (aptitude and achievement) tests would require a test and measurement course and graduate degree. Tests that may require less training are checklists where minimal supervision is required.

The test administrator must also have time to prepare the test materials and the physical setting for the test. Situation variables such as lighting, noise, and ventilation, can affect test results. 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, can alter test performance (Drummond et al., 2015).

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 (Kaplan & Saccuzzo, 2013).

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 & Groth-Marnat, 2005). 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, and those unfamiliar with testing (Whiston, 2017). Finally, rapport is important to assist in anxiety reduction. Tryon (1980) defined 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) 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 a qualified examiner (Drummond et al., 2015) is properly administering the test. 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 (2015) cites what he considers four frequency errors for group testing: incorrect timing, lack of clarity in the directions, variations in physical conditions, and failure to explain whether a subject should guess or not, thus a penalty or no penalty. Violations in this type of test administration contribute to variable errors associated with efforts to derive a true score. Therefore, it is advisable to consult the Standards for Educational and Psychological Testing, which contains five standards for the recommended procedures for administering tests (American Educational Research Association, American Psychological Association & National Council on Measurement in Education, 1985). The overall duties of the test administrator are to schedule the test, utilize informed consent procedures, become familiar with the test, have a test manual present, achieve the best testing conditions, minimize cheating, follow the directions, maintain and establish rapport, be aware that special problems occur, and collect all testing material after the examination (E.2.; Drummond, Sheperis, & Jones, 2015).

Informed Consent (Section E.3.) and Explanation to Client (E.3.a.)

The client should receive a full explanation of the purpose of the test, the kinds of data sought, how it relates to his/her situation, and how the scores will be used (Corey et al., 2010). 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 (Rumley & Herlihy, 2010).

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 & Groth-Marnat, 2005).

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 ensure that there is no misunderstanding of the meaning of scores. The counselor, therefore, has an ethical responsibility to ensure 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 been thoroughly answered (Remley & Herlihy, 2010). Hood and Johnson (2002) suggested where possible score interpretation should be conducted using probabilities.

Another facet of ensuring confidentiality has to do with the storage and retrieval of test scores (assessment security, E.10.). However, such records are maintained (i.e., computer storage, etc.), access should be subject to strict controls to ensure confidentiality (Anastasi, 1976).

The Buckley-Pell Amendment (Family Educational Rights and Privacy Act of 1974-FERPA) was enacted to protect the privacy and confidentiality of a person's test scores. This act refers mainly to educational records but requires (Aiken & Groth-Marnat, 2005; Whiston, 2013):

> Informed consent for data collection includes an awareness of what the material is, and who is going to see it.
>
> Data should be categorized according to sensitivity and treated accordingly. Some information may be privileged.
>
> 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 "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 client's record from inappropriate access. A password identifying the user is one simple, yet effective method for doing this. Also, when transmitting information between computer systems, caution should be used to limit the information transferred. HIPAA requires that entities have encrypted communication.

The use of a computer introduces the need for a judgment weighing the ease of accessibility against the problems of confidentiality. There are no problems with confidentiality that are not apparent with other methods of record keeping. It is no easier to break into a computer system than it is to break into a record room, and with appropriate safeguards, confidentiality is protected.

Client Welfare (E.1.b.)

Client welfare must be a primary concern in effectively transmitting test results. Discussion of test results should be an integral part of the counseling process (Corey et al., 2015; Remley & Herlihy, 2016). Corey et al. (2010) emphasized 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 discrepancy between perceived abilities and interest, as well as those indicated by the test results.

Test Scoring

Scoring answer sheets may be done by hand, machine, or computer scanning. Error rates in computer and machine scoring are small compared to those of hand-scored tests (Gregory, 2015). Scores on individual tests have been dramatically and demonstrably affected by the examiner's biased perception of the client. Gregory (2013) reported 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 (Ary et al., 2014; Corey et al., 2015).

Powell (1994) indicated 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. The 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 adaptive testing procedures to establish difficulty levels. 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 on the last question. The testing procedure is to present a more challenging item after a correct answer and a less difficult question 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.

Reporting Test Scores

In most states, both the examinee and the parents of the examinee have the right to know the results of a test score (C.6.b., third parties, B.5.b., parents and legal guardians). This parent and client right 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, and LSAT (Cohen, Swerdlik, & Sturman, 2013). This disclosure 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. Also, assessment results of personality tests should always be supported by behavioral observations and personal interviews (Whiston, 2017).

Interpretation of Scores

Raw scores from a classroom test or observed behaviors are not interpretable except within the person. The 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 must take place for comparison to others. These comparisons allow 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, and CEEB (Lyman, 1998).

Hanna (1988) indicated the percentile rank (PR) is one of the easiest derived scores to interpret and comprehend. A percentile rank of 88 (ordinal scale) means 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 and interpreted as though there were 100 taking the test when in fact there may have been 32. It does mean percentage in that the student had a score higher than 64% of those that took the test. The score is interpreted as ranking at the 64th percentile.

A confidence band reflects the probable range that a person's score would fall into if taking the test many times. The actual computation of the standard error of measurement is essential to establish a confidence band and is presented within the reliability section of a manual. For interpretation purposes, if a confidence band is identified as 105-115 this is presented as an interval in which the person's true score will likely fall. The confidence attached to this band has to do with the degree of probability. If the standard error of measurement is applied once to the right and left of the mean, then the counselor will make the statement that it is likely that the score will fall in the range of 105-115 two out of three times. This is determined by, ± 1 standard error of measurement from the derived score (110). Plus or minus one standard deviation has an accumulated percentage of the curve 68% (approximation). This is equivalent to approximately the fraction 2/3 or two out of three times. If one desires a greater degree of confidence-then the standard error of measurement must be applied again until attaining the desired degree of confidence. 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.

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 (2012) lists predecessors to good test interpretation. He indicated that counselors must:

> be informed about the instrument (Gladding, 1988).
>
> Tyler indicated that test scores should be seen only as "clues" (as cited in Gladding, 1988).
>
> Tinsley and Bradley (1986), as well as Miller (1988), suggested one begins with the concrete and move to the abstract, avoiding "off the cuff" remarks.
>
> always have a manual present during interpretations (Gladding, 2012).

Also, 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 regarding 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 and Groth-Marnat (2005) stated that computerized interpretations might be inappropriate for some groups of people like young children, the mentally retarded, severe psychotics, and others. He also pointed out that some interpretive programs have not been well validated and that they are based on inadequate norms. Reliability may also be weak. Aiken and Groth-Marnat stated 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) reported that clients 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 and Lehman (1991) listed a few advantages and disadvantages of computer-based test interpretations.

Advantages

a. allow more tests scored in a shorter period
b. accuracy in scoring is usually better than hand-scored reports
c. some bias on the part of the counselor to the client may be ruled out

Disadvantages

a. danger of computer interpretations being read by unqualified people who become subject to misguided, incorrect assessments

b. the software packages score, interpret, and analyze test results and are readily available often to those untrained

c. computers do not make allowances for emotional or physical states of the examinee

d. the software may be updated, but the scoring facility may not be

Records: ACA Code of Ethics, Section B.6. and SP 13

Ethical code B.6.-records and documentation and standard of practice SP 13 pertain to the confidentiality of records. Section B.6.a. acknowledges creating and maintaining records and documents to render professional services. Counselors are to provide a safe containment for the records, and only authorized persons are to have access (B.6.b.). If a recording or observations take place, it is with client permission and is to be documented in the client's chart (B.6.c., B.6.d.). When clients request access to their record, the request is honored but may be limited. The degree of access depends upon available evidence to restrict that access. The request is to be documented and rationale included if access is denied or limited (B.6.e.). Counselors provide assistance when records are requested (B.6.f.). If records are disclosed or transferred the counselor needs to seek written permission (B.6.g.). Storage and disposal of records after closure or case termination is conducted by state or federal regulations (B.6.h.).

The purposes of 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 (Remley & Herlihy, 2014, 2016). The groups that rely on a counselor's documentation to advocate for the most appropriate and effective care are physicians, mental health professionals, referral sources, employers, other payers, managed care companies, and licensing and accreditation agencies. Medical or mental health records are official and practical means of communication to provide a unified treatment approach consistent with the clinicians' work with clients, provide continuity of care from one treatment setting to another, justify need for continued treatment, need for admission, demonstrate appropriateness and cost-effectiveness of care, demonstrate all billable services were provided, and verify the practice's quality of care and approve the clinicians license to operate.

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

Institutional policy and statutes govern institutional records. 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 legal proceedings.

Working notes are considered impressions, half-formed hypotheses, or ideas and are temporary documents.

For the most part, client files (record) do not belong to the client, although the actual data does 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,

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age, education, marital status, employment, date of initial contact, admissions, legal documents, and legal status. Additional information is required if the client is a minor. Examples would be parent or guardian, siblings, childcare, parental occupation, marital status, and reasons for an appointment. Assessment is the appropriate data gathering so that a treatment plan can be written. Piazza and Baruth (1990) listed six areas for the assessment information: client's motivation for treatment, emotional functioning, and the intellectual and verbal capacity to benefit from different types of treatment, whether a history of counseling, the 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. Also, 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 of the presenting problem, goals, activities taken, and assessments. The final category was listed as other and is to include forms such as release, informed consent, and specific paperwork relevant to the client. Some helpful ideas for case notes are as follows:

a.   date and sign every entry

b.   entries are to be timely and should be proofread

c.   watch abbreviations-use those only that exist in the literature

d.   errors should have a line through the incorrect information, initial and date

e.   don't leave blanks-typically infers information left out

f.   place client name and number on each page along with date of entry

g.   use quotes from the client that is clinically significant using descriptive terms

h.   record what was observed during the session

i.   record identified problems from the treatment plan along with goals for treatment

j.   may even want to record diagnostic criteria from the DSM-5™

Record retention is not the same in each state. There is no general record retention rule. For the most part, records are retained as long as there is a therapeutic need for them. An individual should consult with the legal retention law, if it exists, for his/her state (Cullari, 2001; Soisson, VandeCreek & Knapp, 1987). These requirements vary from seven years for IRS retention to states requiring permanent retention.

A well-developed record will enable a counselor to reconstruct the client's course of therapy and to demonstrate that care was provided in line with the standard of care. It is recommended that summary sheets for diagnosis and treatment and notes about canceled appointments should be retained. Consent or release forms should contain the following: name of person whose records are to be released, which records are being released, purpose or intended use, date signed, expiration date, limitation on data, authorizing signature, person's relationship to client, signature of witness, and a copy should be given to the client (Keith-Spiegel & Koocher, 1985).

Summary

Ethical standards regulate the way the counselor maintains, stores, or disposes of records. Law, regulations, agency or institutional policies that ensure that entries are accurate to require storage and disposal of records, and if errors exist in the records appropriate remediation takes place (ACA, 2014; A.1.b. and B.6.h). Records are considered legal principles and contents of the records are viewed as the property of the client.   Records are physical recordings of information related to a counselor's practice that include but are not limited to:

a.   clinical case notes.

b.   administrative records.

c.   audio/video recordings.

d.   computerized information systems (test results, etc.).

It is important to place in the file, as a part of charting, that progress notes and taping releases are included (B.6.b.). Withholding some or parts of the records when requested, considering the recent HIPAA requirements (B.6.d), is a concern (Modifications HIPAA, 2013). Documenting requests for access by other parties is to be included in the chart and file (B.6.e). Some general guidelines as to important note entries may be:

reviewing progress goals.

knowing when and how important decisions were made.

what kind of treatments were undertaken-whether efficacy based or none outcome base.

helping clients measure change and growth (monitoring efforts).

successes and turning points.

continuity of care when referred from one mental clinician to another.

Important points to be mindful of concerning client rights.

review notes with some exceptions

subpoena case notes when involved in litigation

legal representative that deceased clients have the same rights

client refusal rights

Some federal laws that could affect counseling records are HIPAA, Family Educational Rights and Privacy Act (FERPA), and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1972 (Remley & Herlihy, 2014).

Charting/Notes

There are several standard forms to record client treatment and some specific agency preferred methods to meet ethical and legal requirements. A few will be mentioned as examples.

DAP – (D)-description of both the content and process of the session, (A) assessment, intervention, working hypotheses, (P)-response or revision, topic covered, next session

SOAP-(S)-subjective, patient reports (O)-Objective, (A) assessment and functioning level, (P) Plan

BAR-(B) behavior, (A) action, (R) response

DAPT-(D) diagnosis, (A) assessment, (P) plan, (T) treatment

Ethical behaviors for records noted in the ACA Code of Ethics are in Section A (A.1.b. records) and Section B.6. (records and documentation).

Review Questions

Questions 7-34 to 7-40 are a sample of questions for appraisal. The material for the content of these questions can be found in this unit of study. Questions 7-34 to 7-46 are more time consuming than will be found on the NCE.

Question 7-34:
Which one is an example of a measure of variability?

   a. range
   b. median
   c. factor analysis
   d. correlation

Answer: a. range. Range and standard deviation are two variability measures.

Question 7-35:
All are examples of a normalized standard score that has been transformed to fit a normal curve except?

   a. T-score.
   b. z-score.
   c. ratio IQ.
   d. percentile.

Answer: d. ratio IQ

Question 7-36:
It is possible to derive a ratio scale for which type of measure?

   a. personality
   b. attitude
   c. judgment
   d. achievement

Answer: d. achievement

Question 7-37:
Likert scales, which are typically used to measure attitudes, yield which type of measurement?

   a. nominal
   b. ordinal

    c.   Interval

    d.   ratio

Answer: b. ordinal

Question 7-38:

The term that someone's overall attitude toward another person influences ratings on a specific trait is:

    a.   leniency error.

    b.   halo effect.

    c.   Hawthorne effect.

    d.   error of central tendency.

Answer: b. halo effect

Question 7-39:

Bruce has recently transferred to a new school, and the counselor evaluated his reading scores on the Gates-MacGinity Reading Test from his previous school. Bruce's score on reading was 8.9. Upon entrance to the new school, he took the Standard Reading Test and scored 9.2. What can the counselor say about these scores?

    a.   The scores are comparable, and the student is reading above average.

    b.   The scores are not comparable unless the tests are equated.

    c.   The standard error is one year, therefore the student falls within that range, and the scores are comparable.

    d.   The tests measure different traits and are not comparable.

Answer: b. The scores are not comparable unless the tests are equated.

Question 7-40:

The counselor assessed 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. Which confidence band is correct?

    a.   50-64

    b.   54-60

    c.   43-71

    d.   51-63

Answer: d. 51-63

Question 7-41 to 7-44:

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

Mean	82	85	79	89
s.d.	8	6	9	10
Student	English	Social Studies	Mathematics	Science
Linda	98	94	91	93
Tom	94	90	79	90
Bob	92	85	70	92
Sue	96	92	89	96

Question 7-41. Which of these students scored better in English and Social Studies?

Question 7-42. Which of these students scored lowest in math?

Question 7-43. Which students scored below the class mean(s) in each subject area?

Question 7-44. In all four subjects, which student had the highest score in comparison to the rest of the class scores?

Answers:

7-41. a. Linda = English +2.0, +1.5 Social Studies

7-42. Bob (70) = -1.00

7-43. Bob in Math

7-44. Linda exceeded all students with the highest score attained in each subject except Sue in Science

Questions 7-45 to 7-49:

These questions refer to a set of group score results from one administration of the NCE.

Question 7-45. On which section were the scores more homogenous?

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

Question 7-46. Which section of the test had the greatest spread of effect?

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

Question 7-47. When compared to the mean of the group, on which subtest did Mark score better?

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

Question 7-48. On which subtest in comparison to the norm group did he score highest?

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

Question 7-49. Overall, Mark's percentile when compared to the group was?

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

Answers: 7-45. b. #4, 7-46. d. #7, 7-47. b. #5 (2.5 s.d.), 7-48. c. #5 (2.5 s. d.), 7-49. d. 84%

Unit 7 – Terms

COEFFICIENT ALPHA:

Coefficient alpha is a reliability index that is an extension of the KR-20 or 21. All mean split-half coefficients are corrected by the Spearman-Brown formula (Gregory, 2015).

CONSTANT ERROR:

A constant error is a systematic error that causes a measurement to deviate consistently from a true value. A random error deviates in varying amounts, that is, higher or lower than the true value. A constant error goes in one direction, only. If a gasoline pump always provides slightly less than a gallon of gas this constant error exists. If the amount of gasoline were under sometimes and over sometimes it would reflect a random error.

CONVERGENT VALIDITY:

Convergent validity is utilized to show construct validity and 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 regarding 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, 2017).

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).

EFFICACIOUS RESEARCH:

Seligman (1995) reported that efficacious research includes (a) clients are randomly assigned to treatment and control conditions (wait list), (b) controls are rigorous including placebos, and for influence of rapport, (c) treatments are manualized, (d) clients are seen for a fixed number of sessions, (e) target goals are operationalized, (f) raters or counselors are blind to which group the client is a member, (g) clients meet criteria for a single diagnosed disorder, (h) clients are followed for a fixed time and, (i) measurement is by a log-normal, dosage/phase model after each session.

EXPECTANCY TABLE:

Gives probability of different criterion outcomes for a person who obtained a certain score. Expectancy tables can be used in evaluating the criterion-related validity of a test (Cohen & Swerdlik, 2009). Frequently tables show an interval range of scores in which individual scores are placed in categories, like insurance, longevity rates, and PSAT.

FACTOR ANALYSIS:

Attributed to Charles Spearman. A class of mathematical procedures designed to identify factors that are presumed to influence or explain test performance.

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, 2013).

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.

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 characteristic or trait to influence the total rating of that person. It often emerges as a bias on personal-rating scales (Reber, 1985).

IPSATIVE:

An ipsative measurement is one in which an item is scored on one scale, will go up, and, at the same time, will lower another scale. It is a type of item format rather than a normative statement. These types of comparisons are only intra-individual and not appropriate for normative comparisons. The response is reflected or measured against the self.

ITEM ANALYSIS:

The process of evaluating single test items for easiness and difficulty levels and if the item discriminates the learners from the non-learners. The entire test receives an overall value.

ITEM RESPONSE THEORY (IRT):

Item theory or latent trait theory is a concept in an assessment that focuses on item analysis. The objective of item theory is to control error and come up with one true score whereas a classical theory is based on a combined set of items. Two concepts interpret an item theory, that of unidimensionality (one ability or one trait not a combined set) and local independence (Henard, 2000). IRT is useful for rigorous measurements across experimental groups and cross-cultural populations.

LIKERT SCALE:

A scaling method used primarily in the 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). The pre-interview DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adults is a Likert scale instrument to assess for symptoms to determine the frequency, duration, and severity.

MALTREATMENT:

CAPTA and Keeping Children and Families Safe Act of 2003 defined maltreatment as "any act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm (National Clearinghouse on Child Abuse and Neglect Information, 2004; Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved February 2016; Herenkoh, 2005). Four types of maltreatment include neglect, physical abuse, sexual abuse, and psychological abuse.

MEASUREMENT SCALES:

Measurement scales are used to assess the type of data to be interpreted. In assessing for the selection of an instrument for specific interpretations, it is important to know the level of scaling. Each of the four types (nominal, ordinal, interval, and ratio) in an increasing order offers new qualities for interpretation. Statistical tests are used to measure the qualities (Cohen & Swerdlik, 2005).

OMNIBUS:

A test that measures a variety of mental operations. Operations are all combined into a single sequence rather than type by type.

PSYCHACHE:

Psychache is an intense psychological pain, chronic, free-floating, nonsituation-specific anguish, hurt, angst, humiliation, or, more generally, internal perturbation, that leads individuals to seek permanent escape. (Shneidman, 1993). Psychache is considered a necessary condition for suicide (Berlim et al., 2003).

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 (Remley & Herlihy, 2016).

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 upon retesting. Extreme scores tend to be unreliable. A score on one variable is used to predict the score on another variable (Suter, 2012).

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 (Ary et al., 2014).

SOCIOMETRY:

A sociometric is a retrospective measurement by others of traits/attributes of the interpersonal relationships prevailing among the members of a group (Whiston, 2017). Sociometric assessment is a measurement of interpersonal relationships and an individual's social competence within a peer group. This type of measurement is usually with affective instruments and traits. Likes and dislikes can be graphically displayed through sociometry. Methods for sociometric include observations, interviews, and social behavior rating scales.

STANDARD ERROR OF MEASUREMENT:

The standard error of measurement is an estimate in a score of the magnitude of the "error of measurement". This is an amount by which an obtained score differs from a hypothetical true score.

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).

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.

Unit 7 - References

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		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

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UNIT 8 - Research and Program Evaluation

Introduction

Research and evaluation questions tap knowledge in techniques and methodology of measuring, describing, and evaluating data. The number of questions for this study area for the NCE has been reduced from 25 to 21, and 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, correlations, inferences, significant levels, and interpretation statements.

Recent changes in the NCE are reflected in the name change for this chapter, program evaluation. The emphasis in program evaluation will highlight material in analyzing organizational and therapy effectiveness.

Be familiar with Sections G of the 2014 Code of Ethics of the American Counseling Association (ACA, 2014, p. 15). Recent test questions have included research ethics and computer-assisted evaluation. Ethically, it is important to remember that subjects must not be harmed in any way. If a risk is involved, the subjects must be informed of the nature of the risk and informed that participation is voluntary (refusal rights), and a signed release is secured before the study. If subjects are not aware of the nature of their participation in a study for control purposes, then the subjects should be debriefed at the conclusion of the study. It is not ethical to observe a subject without permission. The welfare of the subject is the responsibility of the researcher. Also, all data obtained from an individual should remain

confidential. Scores or observations should be reported in group form (collapsed) rather than as individual scores.

The National Research Act of 1974 and, more specifically, Public Law 93-348 stipulate that research studies involving human subjects be approved by a panel of authorities. These panels are often referred to as an institutional review board (IRB) of an institution (such as a college or governmental agency) or an ethics guidance program. The research proposal and study design are to be submitted to a review board before any aspect of the research is enacted to protect subjects from possible harm and to ensure that they voluntarily participate through informed consent. It is the researcher's responsibility to identify potential sources of risk and to eliminate or reduce them.

CACREP Objectives

The CACREP 2016 Standards for research curriculum are abbreviated, and full statements are to be found on-line at counseling.org (CACREP, 2015, p. 13).

a. importance of research in advancing the profession, critique research

b. identification of evidence-based counseling practices

c. needs assessment

d. development of outcome measures for counseling programs

e. evaluation of counseling intervention and programs

f. qualitative, quantitative, and mixed research

g. research designs used in research and program evaluation

h. statistical methods used in conducting research and program evaluation

i. analysis and use of data in counseling

j. ethical and culturally relevant strategies for conducting, interpreting, and reporting results

Question 8-1 (Objective A.)
Research advances the profession when studies:

a. meet IRB approval.

b. demonstrate social validity.

c.   researchers are trained at the doctorate level

d.   the study meets efficacious levels.

Answer: b.   demonstrate social validity

Question 8-2: (Objective B.)
Evidence-based counseling practices assure the counselor and client that:

a. techniques, procedures, and treatment modalities are grounded in theory.

b. effectiveness and efficacious studies meet the same research standards.

c. findings are based on action research.

d. a comparison group was utilized in the study.

Answer: a. techniques, procedures, and treatment modalities are grounded in theory

Question 8-3: (Objective C.)

Research studies are prepared from a needs-based assessment. All are elements of a research needs-based assessment except:

   a. product.

   b. context.

   c. input.

   d. budget.

Answer: d. budget

Question 8-4: (Objective D.)

Common factors have been researched across different treatment modalities and are considered important for effective treatment. Although there is disagreement as to the most effective common factors there do appear to be several factors observed. The most common or frequent factor observed in many of the studies is:

   a. alliance.

   b. competence.

   c. cognitive complexity.

   d. the level of skillfulness.

Answer: a. alliance (Warwar & Greenberg, 2008)

Question 8- 5: (Objective E)

Which content segment of a research article is the author to include the relevance of an intervention regarding diversity and multicultural competence?

   a. introduction

   b. methods

   c. results

   d. discussion

Answer: d. discussion. The discussion is to include relevance for existing theories and interventions. The discussion section of a published article should discuss the impact of this intervention regarding human diversity factors and multicultural considerations (Falco & McCarthy, 2013).

Question 8-6: (Objective F)

Research using a naturalistic inquiry, case studies, fieldwork, and field studies are all examples of what type of data collecting or research?

   a. qualitative

   b. quantitative

   c. mixed results

   d. meta-analysis

Answer: a. qualitative

Question 8-7: (Objective G.)

An elementary school counselor conducted an effectiveness study regarding one preventive strategy for one 3rd grade student. The more appropriate type of research might be:

   a.   non-parametric.

   b.   action.

   c.   parametric.

   d.   school age.

Answer: b. action. Action research is the choice even though the single subject may be the choice. Action research does not have to be one subject. It could be a single variable.

Question 8-8: (Objective H.)

When using a statistical table from a research textbook and completing the appropriate statistical analysis, the researcher would enter what type of table to read for a significance level?

   a.   F-ratio table

   b.   S-significance table

   c.   Table of Content

   d.   H-hypotheses table

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

Question 8-9: (Objective H.)

When small amounts of data are available in article form and published in journals, it has been common for researchers to combine those small data findings. This is a series of studies referred to as:

   a.   meta-analysis.

   b.   formative analysis.

   c.   qualitative.

   d.   quantitative.

Answer: a. meta-analysis. A meta-analysis combines small data sets and looks for findings.

Question 8-10: (Objective I.)

A researcher conducted a study to determine the effectiveness of mindfulness technique for treating social anxiety. When writing a manuscript for publishing the findings and to make the results available to other therapists the following are to be included in the methods section except:

   a.   population for intervention.

   b.   protocol, techniques, goals for intervention.

   c.   IRB approval document.

   d.   materials needed and relevant terminology.

Answer: c.   IRB approval document. Guidelines for the methods section include all except the IRB approval (Falco and McCarthy, 2013)

Question 8-11: (Objective J.)

The Belmont report emphasized major principles for ethical decisions when conducting research for medical and psychological involvement with people. Which principle was not included in the Belmont Principles?

    a. justice

    b. respect

    c. beneficence

    d. fairness

Answer: d. fairness

Terms

A brief definition is at the end of this chapter.

Action Research	Non-parametric statistic
Analogue	Observer Effect
Attrition	Operational Definition
Attribute Variables	Parameter
Cohort Design	Pilot Study
Conclusion Validity	Placebo effect
Confidence Intervals	Power
Control Group	Quasi-experimental
Covariance	Regression
Degrees of Freedom	Research Blinding
Dependent Variable	Stratified Random
Double Blind Procedure	Type I (Alpha)
Ex-Post-Facto Design	Type II (Beta)
External Validity	Snowball Sampling
F-ratio chart	Social Validity
History	Wait-List
Meta-Analysis	Willowbrook study

OBJECTIVE 8 A: Importance and Purpose of Research

Objective 8a. the importance of research in advancing the counseling profession, including how to critique research to inform counseling practice (CACREP, 2015, p. 13)

CACREP (2015) core curriculum objective 8.a. emphasizes the importance of research in advancing the profession. The 2014 ACA Code of Ethics Section G, Research and Publication (G.1.- G.5.h.), includes ethical understandings and implications concerning precautions, responsibility, multicultural/diversity, rights of participants, informed consent procedures, deception, supervisor and client participation, confidentiality, commitments, disposal of research documents, relationships, beneficial interactions, reporting results, accuracy, unfavorable results, identifying participants, replications, publications, plagiarism, contributors, duplicate submission, and professional review (ACA, 2013). The introduction to the 2014 ACA Code of Ethics (2013) encourages the membership to unite and promote the enhancement of the professional identity of counselors. Whiston (1996) stated that the professional identity of counselors can be enhanced through action research demonstrating the effectiveness of services.

Advancing the profession through research comes about in a multitude of ways. Two validity considerations are important for responsible research that will meet legal and professional regulations in conducting and publishing research. Research that is conducted through a rigorous procedure and in an ethical manner enhances the overall commitment to promoting knowledge, skills, and application of research outcomes.

Wester (2011) emphasized the importance of conclusion and social validity whereby professionals assume personal responsibility when conducting research. Conclusion validity is the degree to which the findings and conclusions are accurate and correct.

Social validity is to consider the impact the study. Does the study question and plan for the research have an impact on the profession and a redeeming value for society? Also, planning for social validity impact emphases reducing bias, acquiring new knowledge, and demonstrating respect for research participants and diversity. Therefore, according to Emanuel, Wendler and Grady (2000) to further the medical, psychological, and sociological professions through research it is crucial that researchers adhere to and practice seven requirements. The researcher has a personal responsibility to promote knowledge, skills and the application of research outcomes

These seven requirements are to:

a. value that the enhancement of health or knowledge is through research
b. that scientific validity methodology is rigorous
c. honor fair subject selection,
d. discuss the favorable risk-benefit ratio
e. utilize an independent review
f. practice informed consent
g. demonstrate respect for subjects (abstract)

Research is the formal, systematic application of the scientific method to the study of the problem (Gay & Mills, 2011; Mills & Gay, 2015). Barkley (1982) stated 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 the research is the same as that of the scientific method, to explain, predict, or control phenomena. In summary, Heppner, Kivlighan, and Wampold (2008) indicated that the purpose of research is to answer questions, solve problems, or develop theories of interest for a specific area, and to add to the existing knowledge.

Sources of Knowledge

Ary, Jacobs, Sorenson, and Razavieh (2010) listed five methods in which answers are derived for different research questions. They categorize these sources of knowledge as experience, authority, deductive reasoning, inductive reasoning, and the scientific approach.

1. Experience: The ability for human beings to learn from their experience is a prime characteristic of human intelligence. However, while researchers can profit from personal experiences as well as the experiences of others, experience has limitations as a source of truth.

2. Authority: Researchers often seek answers to questions from those who have had experience or are considered a reliable source of expertise with a similar problem.

3. Deductive reasoning: If the premise is true, the conclusion is considered to be true. Deductive reasoning enables researchers to organize premises into patterns that provide conclusive evidence for the validity of a conclusion. However, scientific inquiry cannot be conducted through deductive reasoning alone because of the difficulty involved in establishing a universal truth for many statements dealing with scientific phenomena.

4. Inductive reasoning: A conclusion is reached by observing examples and generalizing from those examples to the group being studied. These inductive conclusions are imperfect because all examples would have to be observed to derive a perfectly true induction. In scientific research, one observes a sample of a larger group (population) 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 the 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 & Mills, 2011). Leedy and Ormrod (2016) defined 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, and Ormrod inductive logic is primarily used.

The 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.

The deductive logic begins with a major premise or what seems to be true (Leedy & Ormrod). 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 and Mills (2011) pointed out, both are necessary. Gay stated 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 rejecting the hypotheses.

Classification of Research

Research can be classified by the method or purpose (Gay & Mills, 2011). 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.

Basic Research

Classifying research by purpose entails determining to what degree the findings can be applied or generalized to other situations. Concerned with the development of a theory. Basic research is similar to scientific laboratory research.

Example: Piaget's theory of development.

Applied Research:

Concerned with the application of a theory. It evaluates theory and its usefulness by using existing theories and knowledge.

Example: Testing principles of conditioning to determine if they can be used to improve discipline (behavior modification).

Evaluation

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 & Mills, 2011).

Example: Whether to adopt a new philosophy or not.

Research and Development (R & D):

The purpose of R & D is to develop products, not to develop or test the theory. Field-testing a product. Example: Field-testing of a set of behavioral objectives in a mental hospital.

Critiquing Research:

The American Psychological Association (APA) developed criteria for critiquing research and identifying evidence-based counseling practices. Objectives 8 a. and 8 b., counselor knowledge and obligations to be capable of evaluating treatment guidelines for mental health interventions, have since been applied to other health areas (APA, 2002). The purpose of these guidelines is to determine the strengths and weaknesses as well as the quality and appropriateness of treatment. The overall purposes are two-fold, treatment efficacy and clinical utility.

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Treatment efficacy refers to a valid effect of an intervention when compared to alternative interventions, no treatment, controls, and a wait list. Methods to conduct efficacy are illustrated within objectives 8b., c., and d. Critiquing research requires judgment and distinguishing publication results between the newness of treatment or technique and verification of the clinical efficacy (Chambless & Hollon, 1998, evaluation procedures). The best way to conduct this process is to begin with research methodologies. Acquiring the expertise in research methodologies moves a counselor beyond the sole use of direct experiences for different interventions and the risk of erroneous conclusions. An abbreviation of treatment guidelines for critiquing include:

a. based on relevant empirical literature

b. methodological rigor and research supporting an intervention

c. recognized experts' clinical opinion, observations, and consensus

d. systematized clinical observations valued more than unsystematized

e. methodologies include experimental, quasi experimental, and randomized controlled experiments

f. treatment conditions are compared to the intervention

g. treatment gets better results than no treatment

h. if a client receives benefit beyond being in treatment

i. if intervention gets better results than another intervention

j. patient-treatment matching

k. outcome measures include participant selection, treatment goals, quality of life, life functioning, attrition, long-term consequences, indirect consequences, client satisfaction, side-effects of treatment, clinical significance, methods, treatment goals (p.1055).

Guidelines for clinical utility include specific awareness and knowledge regarding generalizability, feasibility, costs, and development process. Critiquing research requires fundamental knowledge for the type of research conducted recognizing design purposes, strengths and weaknesses of each design, and appropriate applications.

Methods of Research

Historical Method

This method involves studying and explaining past events. The purpose is to arrive at a conclusion concerning the cause, effect, or trends of recent events that help explain current or predict future events (Gay & Mills, 2011). A new treatment cannot be administered using the historical method. Constructs to be considered include:

a. Primary data source: firsthand knowledge, eyewitness reports

b. Secondary source: Secondhand information is when the person is providing information; however, was not present when the behavior or event occurred.

c. External criticism: assesses the authenticity of data

d. Internal criticism: evaluates the worth or accuracy of data.

Example: A study of the effects of the decisions of the U.S. Supreme Court on mental health care

Descriptive Method

Descriptive research involves collecting characteristic data about a population to describe those characteristics and to answer questions about the current status of a population or sample. The data is reported without generalizability or testing a hypothesis (Gay & Mills, 2011; Heppner, Wampold, Owen, Wang, & Thompson, 2016; Suter, 2006).

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 data for extended periods of time in a natural setting.

Example:
A study to determine public attitude towards people with depression.

Correlational Method

Correlational research relates two or more variables to determine whether and to what degree a relationship exists between them, but it does not establish a cause-and-effect relationship, nor does it involve a treatment. This type of research involves one group of people who have two or more variables measured, and it must have a formal hypothesis. The degree of a relationship is expressed as a correlation coefficient (range is -1.00 to +1.00).

a. Directional Hypothesis: X and y are positively or negatively related.
b. Nondirectional Hypothesis: X and y are related or unrelated.
c. Null hypothesis: X and y are unrelated.
d. The Correlational method does not establish cause and effect.

Example: A study to determine if there is a correlation between shoe size and intelligence (IQ).

Causal-Comparative Method

Causal comparative research is sometimes called ex-post-facto research because both the effect and the cause of the effect have already occurred. It involves group comparisons but involves no planned treatment. It can establish a cause-and-effect relationship; however, these are tentative and need to be followed up by an experimental research study. There is no treatment applied during the actual study. The function of a causal-comparative research is to determine the reasons for the present status of things (Wiseman, 1999).

Example: A study of the effect of gender on depression.

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Experimental Method

The experimental research method is the same as causal-comparative except that 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 to determine the effect on the dependent variable (Ary et al., 2010).

   a. Independent variable: An independent variable (experimental variable) is the treatment or the characteristic that is believed to make a difference. The experimenter manipulates the independent variable. It is the "cause."

   b. Dependent variable : (criterion variable) is 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.

   c. Internal validity: Determines if the differences in the dependent variable are the direct result of the independent variable. Internal validity is the confidence one has to infer a causal relationship between the variables while eliminating other hypotheses.

   d. 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 a sufficient number of participants, counseling would be the independent variable, and the amount of satisfaction as measured by observations or instruments would be the dependent variable.

Question 8-12:

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 client attitude scale.

   c. randomly selected 60 flight attendants.

   d.   the change in the attitude scores toward customers.

Answer: a. the type of in-service curriculum. The independent variable is what is being manipulated such as a program of treatment.

Question 8-13:

In the previous question the operational definition of the dependent variable is:

   a.   a new program designed to deal with the history of customer service complaints.

   b. the scores from a scale designed to measure attitudes toward customers.

   c. the gender and size of each group.

   d. an unknown variable that is not described.

Answer: b. the scores from a scale designed to measure attitudes toward customers. An operational definition means specifying the activities or operations that are necessary to measure the construct. In the above example, attitudes toward customers are to be measured.

OBJECTIVE 8 B: Evidence-Based Practice

Objective 8b. identification of evidence-based practices (CACREP, 2015, p. 13)

Evidence-based research (EBR): ACA Code of Ethics Standard C.7.a. The scientific basis for treatment indicates that counselors use techniques, procedures, and modalities that are grounded in theory or evidence of empirical support (ACA, 2013).

Evidenced-based studies are undertaken to improve the quality and accountability of treatment. Evidence-based practices are interventions with scientific evidence that improve client outcome (Drake et al., 2001). This type of research and publication provides feedback in the form of an increasing knowledge base from which a counselor sorts out what treatment is most effective for different dysfunctions, different populations, and age groups. The National Institute on Drug Abuse (NIDA) developed a list of empirically based interventions as a guide to practitioners (NIDA, 2016). When these recommended treatments are applied what followed was monitoring, a further advancement of the profession in clinical work and policy decisions.

Federal policies are requiring the use of evidence-based programs in the schools (Robertson, David, & Rao, 2003). Managed care companies have driven the need for treatment outcomes regarding best client care and cost effectiveness. Third party payers are vigilant that clients receiving treatments are receiving statistically best choices. Managed care companies approve client care based on the number of treatment sessions that are based on literature support for certain treatments and disorders. Leibert (2006) reported on a 30-year survey and cited improvement rates such as 45% to 58% clients improved after 4-7 sessions and 56% to 68% improved after 8-16 sessions. These figures may have included a combined set of efficacy and effectiveness studies and perhaps were global in scope and data measurements were client reports, or rating scales were calculated for a specific number of sessions of therapy.

The main goal of comparative effectiveness is to inform health providers so they can make informed decisions. Decisions critical to the clinician include interviewing, diagnosing, interventions, strategies, techniques, and monitoring for treating clients. Choices involve selecting the different treatments based on benefits and eliminating any possible harm of those options. Effectiveness studies utilized clinical trials, clinical designs, wait lists, and different types of research to carve out suitable designs and meet research methodology to conduct studies.

A standardized procedure is to conduct several randomized clinical trials to compare an alternative practice with a different intervention and using a control group or a wait list. It typically calls for a sophisticated methodology that is efficacy based and is rigorous and sophisticated that would include:

a. clients are randomly assigned to treatment and control conditions

b. controls are rigorous, including placebos, control for influences of rapport, expectations of gain, sympathetic attention

c. treatments are manualized

d. clients are seen for a fixed number of sessions

e. target goals are operationalized

f. raters are blind to which group the client is a member

g. clients meet criteria for a single diagnosed disorder

h. clients are followed for fixed period after termination (Seligman, 1995).

Measurement (incremental change) can be conducted with a phase model that will measure change between a log-normal relationship and a normalized probability of client improvement. Efficacy studies using this model allow for a measurement that delineates a certain therapy revealing improvement in a certain number of sessions for a certain disorder (Howard, Kopta, Krause, & Orlinsky, 1986).

Leibert (2006) cited the work of Jacobson and Truax (1991) and Hill and Lambert (2004) who utilized conceptualization to determine what determines effectiveness. Two criteria were important to these authors. The first is that a norm exists for a measure of functional and dysfunctional populations so that when a client is nearer the functional than dysfunctional the criteria is met for significance. Secondly, the amount of client change exceeds the expected random markers inherent in the measuring system, and that is statistically reliable and reflects the change index. When both measures are met the change is considered clinically significant (Ogles, Lambert, & Fields, 2002).

In summary, the most scientific approach to research involves efficacy studies. This type of study is a tightly controlled experiment involving random assignment, control groups, standardized measures, and use of practice manuals for an intervention (James & Mennen, 2001). Evidence-based research and outcome-based studies generate a research-to-practice protocol and foster a learning environment in which clinicians, researchers, agency personnel and informed policy benefit through this collaboration (Grella, Hser, Teruya, & Evans, 2005). When relying on outcome research, efficacy, or effectiveness studies caution is the rule throughout the process and during follow-up. Researchers and clinical practitioners should be aware of values, nature of the data and evidence, and limitations of the reported results or evidence (Drake, Goldman, Lehman, Dixon, Mueser & Torrey, 2001).

Identification of evidence-based counseling practices

Institutional Review Boards (IRB)

Section G.1.c. stipulates that independent researchers are to consult with researchers who are familiar with IRB procedures for appropriate safeguards (ACA, 2014). In 1979 the federal government developed regulations and ethical principles in conducting research for the protection of human subjects. The institutional review board reviews research proposals in state and federal agencies that receive federal funding. The purpose of this board and the research committee is to protect the rights and welfare of the individual research subject or group of subjects. Requirements for regulatory research are evaluated during the review by an IRB committee include:

a. the risk to subjects is minimized (G.1.e., G.2.a.3)

b. the risk to subjects is reasonable about anticipated benefits

c. selection of subjects is equitable, and fair

d. informed consent is sought from each subject or his/her legally authorized representatives (G.2.a.)

e. informed consent is appropriately documented

f. when appropriate, the research plan makes provisions for monitoring data collection

g. privacy and confidentiality of research subjects are appropriately protected, and

h. when some or all of the subjects are likely to be vulnerable to coercion or undue influence, additional safeguards have been included

In summary, the IRB criteria reviews are conducted for the prospective subject population, methods of recruitment, research methods and procedures, potential risks, potential benefits, risk/benefit analysis, subject compensation, confidentiality, informed consent, investigator qualifications, and monitoring requirements.

There have been some unethical practices with human subjects, many resulting in physical and psychological harm. The types of risks may be physical, psychological, social, legal, and economic. Some unethical studies emanate from the medical research environments such as the Nuremberg codes, Tuskegee syphilis study, Willowbrook hepatitis study, plutonium study, Jewish chronic disease study, Cincinnati project, and the Washington state prison and lead paint study at John Hopkins. Some unethical practices have been reported in psychological research such as the Milgram study. Whether medical or psychological the over-riding protocol or lack of one, where clients were not informed of the risks or were not provided releases to participate in the study.

Dubois (2006) outlined several vulnerabilities for research participants. Vulnerabilities are characteristics that might interfere with the participant's ability to protect themselves. These vulnerabilities include:

a. cognitive or communicative

b. institutional

c. deferential

d. medical

e. economic

f. social

OBJECTIVE 8C: NEEDS ASSESSMENT

Objective 8c. needs assessment (CACREP, 2005, p.13)

Strong research support is grounded in a needs assessment that reflects a problem-based issue and will advance research in the profession. When discrepancies between an existing state and the desired state regarding a ratio of cost to benefit are evident, a needs-based assessment should be conducted (Suter, 2006). A client, group, or institution can benefit from a needs assessment.

CIPP (C-context, I-input, P-process, and P-product) is a four-element model to conduct a needs assessment (Stufflebeam, 1983; Stufflebeam et al., 1971; Stufflebeam & Skinkfield, 2007). Elements of this evaluation include context (environment), product, input, and process and answers for each will shape decisions. For each element, problems are identified whether met or unmet and decisions about which

objectives to pursue. Strategies or plans are developed for resources and if available to meet the objectives, necessary personnel, required finances, and the means to meet program goals. For continuous improvement, the CIPP is a framework to systematically guide the conception, design, implementation, and assessment of the learning and provide feedback and judgment of the program effectiveness (Stufflebeam, 1972). Stufflebeam (2007) developed a series of questions for a checklist to consider for contractual agreements, context evaluation, input evaluation, product evaluation, process evaluation, effectiveness evaluation, sustaining evaluation, transportability, meta-evaluation, and a final synthesis report.

Theory-based methodological tasks would include a plan to meet proper sampling, implanting controls, using reliable and valid measuring tools, proper statistical effect size, and rigorous research analysis (Suter, 2006, 2012).

Need-based assessment is available for specific counselor work tasks in different domains for counseling. Unit four, Career Development, contains an example of a need-based assessment model for profiling, assisting, and empowering job seekers (Englert, Doczi, & Jackson, 2014).

OBJECTIVE 8 D: OUTCOME MEASUREMENT DEVELOPMENT

Objective 8d. development of outcome measures for counseling programs (CACREP, 2005, p. 13)

Outcome-based Research (OBR)

Section C.7.a. of the 2014 ACA Code of Ethics (scientific bases for treatment modalities) refers to the inherent value of research to provide the foundational information in developing and promoting a scientific basis for clinical knowledge and application (ACA, 2014).

Several terms for outcome-based research exist such as effectiveness, efficacy, and comparative effectiveness and appear to be interchangeable in the literature although this is not always the case. Advancing the profession through outcome-based research is important as the findings can be used to improve practice (Grela, Hser, Teruya, & Evans, 2005).

The ethical obligation of nonmaleficence is critical when using clinical interventions (Eaves & Erford, 2010). The spirit of this research is in the best interest of the client, counselor, and profession.

Information evidence, or lack of evidence, gleaned from outcome research and efficacy studies guide the counselor's choices for client treatment. Outcome research is the study of end results (outcomes) that are captured in services to the client's experiences, preferences, and values (Clancy & Eisenberg, 1998).

Accountability rests with the counselor to become aware of the information in the published literature, seek training accordingly and apply those treatments that are grounded in theory, and have empirical or scientific foundations. When counselors use techniques or treatments that do not meet that criteria, they are to inform the client that the procedures are "unfounded" or "undeveloped" and advise them of the potential risk or harm (C.7a., C.7b.). The counselor will take steps to see the client is not harmed A.4.a. (avoid harm, E.5.c., ; ACA, 2014).

In conducting outcome-based research, it is imperative that the researcher takes into account conceptualization, methodological issues, effect size, and issues inherent in agency settings (Hill & Beamish, 2007). The pivotal outcome in this research is change. It is critical to define the outcome for client change and to be mindful to compare treatment with diversity, disorder, age, research methodology (the type of design), and the length of treatment, stages of change and other variables.

Counseling effectiveness is not a single theory rather the common factors that cut across different theoretical models. Lambert (1992) researched common factors that contributed and found they were a combination of common factors that produced an outcome. His findings suggested that positive counseling outcome resulted from a combination of client outcome and extra- therapeutic factors (40%), common factors (30%), placebo, hope, and expectancy factors (15%), and model/technique factors (15%).

Positive common therapeutic factors across therapies are associated with improved outcomes. Lambert and Cattani-Thompson (1996) reported that positive client outcomes are a result of common factors and specific interventions. Lambert and Anderson (1996) found that the most important factors for outcome appear to be the severity of the disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and ability to identify a focal problem. Sexton (1999) reported common factors to be the counseling relationship, learning (corrective emotional experiences and skill acquisition), and action (behavioral regulation, mastery, and behavior change). Leibert and Dunne-Bryant (2015) reported from client reports that client factors, client-counselor factors, and client expectancy were the three most common elements for counseling outcome.

Outcome-based research provides scientific evidence regarding the decisions as to the procedures, treatments, and techniques implemented during a therapy study (Krumbolz, 2009).

The American Psychological Association Division of Psychotherapy Task Force, Division 29 identified elements of effective therapy relationships and effective methods of therapy regarding individual client issues (APA, 2002). These client characteristics are considered reliable markers for matching the therapy relationship to effective outcomes. Markers were resistance, functional impairment, and coping style. The same task force in 2006 defined evidence-based practice as the "integration of the best available research with clinical expertise in the context of client characteristics, culture and preferences" (p. 273). Warwar and Greenberg (2008) singled out the therapeutic alliance as the most important common factor in effectiveness. Sexton (1999) suggested that effective outcome in therapy has more to do with the level of skillfulness (competence), cognitive complexity (think diversely and complexly) and the ability to relate to the client.

Krumholtz elaborated on this difference emphasizing the purpose of outcome research that is to observe how the client treatment impacted, that is, the consequence of the alternative treatment. Also, impact to society is achieved through the client's observation, others who pay attention to the outcome such as the providers, health care payers (insurance, managed care), and the public. Outcome research focuses on the client and public perspectives. Treatment has been implemented, and outcome data and record keeping are essential that guide future use and at the same time gathers knowledge as to what improves the lives of clients. In a simplistic description the clinician, perhaps in collaboration with the client, determines what treatment will work best and then work backward from there. The dependent variable is the outcome variable.

Best practice counseling has come to mean an evidence-based, evidence-informed approach or outcome-based research that is derived from clinical research. The Journal of Counseling and Development added to the table of contents a section titled Best Practices.

Isolating out the differences between efficacy and effectiveness is best understood by reviewing the definitions, procedures, and requirements for the study. Efficacy studies are highly controlled and are methodological. Effectiveness studies look at how much benefit the client gains from the therapy or intervention. Clients have already begun the therapy in effectiveness studies. In this type of research, the researcher has no say in how therapy is conducted and does not select the clients who undergo which type of therapy. A control group is not necessarily created to form a baseline, and no placebos are administered. There are pros and cons to efficacy and effectiveness studies (Seligman, 1995).

Effectiveness Research:

Effectiveness research is concerned with how much benefit is gained from the therapy or intervention. Typically, these studies are conducted with ready-made groups and clients are experiencing the issue (disorder). A pre-post measure such as the Beck Depression Inventory is administered with a functional or preferable-based identification for symptoms measures (Clancy & Eisenberg, 1998). A preferable-measure is to ask the client to make a judgment about the value of a mental health status or ask questions representing symptoms. The Quality of Life of Well-Being asks questions about social role function. A functional measure assesses the ability of the client to carry out daily activities and during intake can be assessed for physical, mental, psychological distress, social and role functions.

The researched group meets for a specified number of sessions, and a statistical analysis is conducted to determine if the mean change score for the group is significant. If the members are available, a post-administration assesses for lasting change or the improved treatment gain.

Limitations for effectiveness research include a sampling bias because participants are self-selected, random sampling is not conducted therefore generalization is void, the possible small number of participants not meeting effect size, and improvement observations are retrospective. Time may have lapsed after therapy termination during which gains or losses are a reflection of memory.

Efficacy Research:

Seligman (1995) reported that efficacious research includes:

a. clients are randomly assigned to treatment and control conditions (wait-list)

b. controls are rigorous including placebos, control for influence of rapport, expectations of gain, sympathetic attention

c. treatments are manualized

d. clients are seen for a fixed number of sessions

e. target goals are operationalized

f. raters are blind to which group the client is a member

g. clients meet criteria for a single diagnosed disorder

h.   clients are followed for a fixed period and

i.   measurement is by a log-normal, dosage/phase model after each session.

Leibert (2006) in a survey of 2400 clients over a 30-year period reported effective rates (session percentage of clients improving):

a.   29-38% clients improved after 1-3 therapy sessions

b.   48-58% clients improved after 4-7 sessions

c.   56-68% improved after 8-16 months

d.   75% improved after 6 months

e.   85% improved after 1 year

Criticism exists regarding a full commitment to supporting evidenced-based treatments (EBT). Field (2014) provided a specific criticism that present research is a left hemisphere intervention. The left hemisphere is responsible for rational, logical, and abstract cognition and conscious knowledge and research has mostly ignored the function or impact of the right hemisphere. The right hemisphere is composed of the unconscious social and emotional learning, and includes intuition, empathy, creativity, and flexibility and has been ignored in the research regarding effectiveness. There is ample support for the importance of the relationship for outcome-based interventions for client improvement. Combining the left and right brain functions are supported by neuroscience integration.

In summary, a goal of the outcome-based research is to determine what works in a practical sense regarding an intervention or technique across a population of clinical issues (James & Mennen, 2001). To move the profession forward using this mode of research requires a research design, use of an institutional research board (IRB), data collection, review of the research procedures and information, being open to different populations, client reactions to the intervention and adding findings to the literature.

OBJECTIVE 8 E: EVALUATION OF INTERVENTION

Objective 8e. Evaluation of counseling interventions and programs (CACREP, 2015, p. 13).

Efficacy Evaluation Procedures

The sophistication of efficacy for treatment studies research designed and subjected to outcome research evaluation criteria has been established by Nathan and Gorman (2002), Chambless and Hollon (1998), Chambless et al., (1996), and Chambless and Hollon (1998).

Well-established, probably efficacious, possibly efficacious, and experimental refers to the degree that each study meets specific criteria. Nathan and Gorman's criteria are to meet one of six types (Type I, III, III, IV, V, and VI).   Terms or statements for each classification include:

Nathan and Gorman criteria (2002):

Type 1: Randomized, random assignment, blind assessment, clear inclusion/exclusion criteria, state-of-the-art diagnosis, adequate sample size to power analyses and statistical procedures, treatment measures.

Type 2: Clinical trials with comparison groups testing intervention, some significant flaws but not a critical design, can include single-subject designs.

Type 3: Significant methodological flaws, uncontrolled studies using pre-post designs and retrospective designs

Type 4 and 5: Secondary analysis articles

Type 6: Case reports

Chambless et al. (1998) criteria:

Well-established (WE):

1. treatment manuals, specified participant groups meeting two independent well-designed group studies showing the treatment is better than placebo or alternative treatment or equivalent to established effective treatment
2. none or more single-subject design studies using strong designs and comparison to an alternative treatment

Probably efficacious:

Specified participant groups, treatment manual preferable but not required, and either of three no-treatment characteristics:

1. two strong group studies by the same investigator showing the treatment to have better outcomes than the no-treatment control group
2. two studies showing better outcomes than a no-treatment control group
3. three or more single-subject design studies that have a strong design and compare the intervention to another intervention.

Possibly efficacious: one "good" study demonstrating the intervention to be efficacious in the absence of evidence to the contrary.

Experimental treatment: treatments yet to be analyzed

It should be noted that commonalities exist within the two sets of criteria. For preparation purposes for the NCMHCE, where professional literature exists regarding the rigorous level of the design regarding treatment and is subjected to efficacious criteria, these treatments may be best choices on the examination.

Family Treatment Evidence-Based Guidelines

Sexton, Gordon, Gurman, Lebow, Holtzworth, Monroe, and Johnson (2011) reported a more recent "best" method or design for the evaluation of evidence-based approaches for family therapy. This approach is a three-level design that reflects the complexities of family and couple-based practice.

Level I effectiveness is based on psychological research although the design is not rigorous enough to warrant a higher level of sophistication yet draws attention to clinical treatment and well-validated models. Techniques have some supporting research.

Level II shows promise in the research results because the strength is based on identification of specified techniques and interventions and have the possibility of replication. Examples of such promising treatments for adolescents and families have been insight-oriented marital therapy and attachment-based family therapy (Sexton et al., 2011)

Level III: Evidence-Based Treatments are specific and comprehensive treatment intervention programs demonstrating high-quality evidence.

The three levels are further classified by categories to include:

Category 1 defines the strength of the evidence as compared with reasonable alternatives. The evidence is minimal and stated as two types of research with outcomes that are absolute and have relative efficacy/effectiveness.

Category 2 defines the existence of validated change mechanisms for positive outcomes. The evidence is linked to relevant identifiable outcomes, as theoretically expected. According to Sexton and Turner (2010) and Beach and O'Leary (1992), Behavioral Couple Therapy for Depression is such treatment.

Category 3 defines with an ecological validity in which the approach has demonstrated the validity and having contextual efficacy to be efficacious. The treatment produces change and is effective for specific populations.

In summary, efficacy studies are time-consuming, expensive, and require randomization. Monitoring for improvement in efficacy studies is conducted after each session. Effectiveness studies use surveys, have a sampling bias, participants are self-selected, low cost, and rely on retrospective observations.

Examples: Feeding and Eating Disorders

Efficacious Treatment: (child & adolescents)

Keel and Haedt (2008) conducted eating problems and eating disorder efficacious study for the years 1985-2006. The efficacious research included 2 Type I studies, 10 Type II studies for young adolescents (ages 11-20) and 49 empirical studies for adults aged 17-65. Many of the studies related to Bulimic Nervosa (BN). In the adult studies, CBT is the treatment of choice for older adolescents. CBT is the treatment of choice for adolescents (ages 18 to 21). The Maudsley model of family therapy is the most widely used treatment for children and adolescents emphasizing family organization and interaction,

facilitating eating and weight gain (parables, paradoxes, personal authority, rationalizations, and psychodynamic interpretation), and homework

Well established (WE):

Family therapy

Probably efficacious:

None

Possibly efficacious:

Psychoanalytic therapy, Cash's Body Image Therapy, Family Therapy for BN, CBT Guided Self-Care for Binge Eating in bulimia nervosa.

Conduct and Oppositional Disorders

Efficacious Treatment:

Eyberg, Nelson, and Boggs (2008) conducted an evidenced-based study for the years 1996 to 2007 regarding psychosocial treatment for children and adolescents with disruptive behavior (conduct and oppositional defiant disorders). The review included 20 Type I studies and 14 Type II studies in addition to specific information regarding sample type, child race, sex, and age.

Well-established efficacious (WE):

Parent management training Oregon mode (PMTO)

Probably efficacious

Anger control training, assertive group training, helping the noncompliant child (HNC), Incredible years parent training (IY-PT), Incredible years child training (IY-CT), incredible years (IY), multidimensional treatment foster care (MTFC), multisystemic therapy (MST), parent-child interaction therapy (PCIT), positive parenting program, Triple P enhance treatment, problem-solving skills training (PSST), PSST + practice, PSST + parent, rational-emotive mental health program (REMH)

Question 8-14:
Common factors in effectiveness studies have to do with all except:

  a. competence.
  b. thinking diversely and complexly.
  c. relating to the client.
  d. theoretical orientation.

Answer: d. theoretical orientation. Sexton (1999) and Sexton, Schofeld, and Whiston (1997) are in agreement regarding that the common factors are a. (competence-skillfulness), b. (cognitive complexity), and c. relating to the client (relational qualities of client-counselor).

Question 8-15:

A clinician developed a long-term research project to assess the efficacy of EMDR for clients experiencing anorexia nervosa. An effect size was met, and clients were pre-assessed to be within an acceptable severity range using a functional measure. Which methodological method controls for internal validity?

    a. randomization

    b. use of a parametric statistical analysis

    c. use of the functional measure

    d. pre-assessment level of the distress

Answer: a. randomization

OBJECTIVE 8 F: RESEARCH METHODS

Objective 8f. qualitative, quantitative, and mixed research designs (CACREP, 2015, p. 13)

Method of Research

Qualitative Method

Ary et al. (2014) stated that qualitative inquiry is a generic term for a variety of approaches to research and evaluation. Qualitative research is referred to as ethnographic research (Wiseman, 1999). The naturalistic inquiry, case studies, fieldwork, field studies, and participant observation are all examples of qualitative inquiry. The qualitative method involves the researcher observing people or events in their natural setting. The major purpose of qualitative research is to understand the effect of the context on the events. Qualitative researchers frequently use narrative to describe findings. Qualitative inquiry differs from quantitative inquiry in the study of social and behavioral phenomena in their basic aim and methods (Ary et al., 2014). Qualitative methods are inductive rather than deductive.

Descriptors for qualitative research includes artifacts, context sensitivity, emersion (unobtrusive involvement), extended presence, field notes, naturalistic settings, nonrandom sampling participant-observers, photographs, process examination, tentative hypotheses, and triangulation (Wiseman, 1999).

Quantitative Method

Suter (2006, 2012) defined quantitative methods as research that will test hypotheses with numerical values rather than explaining the conclusion or complex question through a written or verbal description (numbers versus words). The data is analyzed statistically and has tables or charts to reflect the findings.

What is being researched using a quantitative method requires identifying and describing the target population. Quantitative methods are utilized when the question or need is more objective, little is known about the topic or population, to support or disconfirm theoretical formulations (Trusty, 2011), is more deductive and the research design is set before the data are collected (Creswell, 2007).

Wiseman (1999) listed descriptors as control groups, correlation, data sets, dependent variables, experimentation, independent variables, and intervening variables, level of confidence, moderator variables, questionnaires, statistical analysis, and testing.

Single-case designs or single-subject designs are utilized when treatment is administered to a single subject. There is to be at least one posttest. The purpose of a single-case is to monitor behavior rather than to generalize results. Baseline data is acquired, and later data observed to note the change. This procedure can be done several times, baseline followed by treatment followed by baseline followed by treatment and a posttest.

Action Research

Lewin coined action research for the use of the scientific method to solve research questions that have social value (as cited in Johnson & Johnson, 1997). The purpose is to solve practical problems through using scientific methods (Guiffrida, Douthit, Lynch & Mackie, 2011). The goal is a solution to a specific problem. There is no concern if the solution is generalizable. Herr and Anderson (2005) indicated that action research is concerned with 'rather' than with subjects or participants in the study. The problems are generated by the subjects rather than by someone else, and the results are to empower or improve the condition. The power of this research is its ability to be pragmatic that is use qualitative, quantitative or a mixed approach. The outcome of action research is not to seek knowledge for generalizability rather seek knowledge for a specific situation (Guiffrida et al., 2011).

Example: Research to find a solution for nonattentiveness among clients at the day treatment program in City X.

After a problem has been identified and stated, the researcher conducts a review of the literature that is related to the problem. After the review is completed, a hypothesis, which is necessary for all types of research except descriptive, is formulated.

Meta-Analysis

Meta-analysis is a method to synthesize data. According to Erford, Savin-Murphy, and Butler (2010), the purpose of meta-analysis is to quantitatively analyze the results of some empirically researched topics. Conducting meta-analysis is another way to advance the profession. It is useful to gather conducted research from a variety of fields (i.e., social work, psychology, counseling, education) where the same topic or intervention has been studied for statistical analysis and outcome results from individual studies for future use and modifications. Often these individual studies are not published in the journals but found in dissertations but do offer contributions to the profession. Like quantitative studies meta-analysis research does have dependent and independent variables. Also, the effect size is to be conducted. Effect size is to translate the data from each study to standard score form much like the simple t-test. Another definition for effect size is an index expressed as a standardized difference between two means, a percentile shift from a baseline (Suter, 2006). The effect size index is useful when considering sample size. For publication, sample size is to be reported for a meta-analysis.

Whiston and Li (2011) provided a 6 step-outline for planning a meta-analysis study. The procedural steps are to; (1) formulate a research question, (2) determine meta-analytic approach that best fits, (3)

search the literature and identify possible studies, (4) determine inclusion criteria and develop the coding manual, (5) extract and code study information, and (6) perform data analysis. A process and needed observations in the results has to do with adjustment for biases. Types of biases may be sample sizes, quality of studies, and studies included because they vary in qualities (designs, reliability, and validity of measurements).

Question 8-16:
A specific difficulty in conducting a true experimental design is:

    a. defining measurable variables.

    b. locating appropriate dependent variables.

    c. securing permission.

    d. managing the controls.

Answer: d. managing the controls. Controls are not to be managed; therefore, whatever happens to them can influence results.

Question 8-17:
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. Descriptive-review section on methods.

OBJECTIVE 8 G: DESIGNS

Objective 8g. designs used in research and program evaluation (CACREP, 2015, p. 13)

Research Designs

Ethical practice in conducting research encourages counselors to plan, design, conduct, and report research that is consistent with ethical principles, federal, state laws, host institutional regulations and scientific standards that govern research (G.1.a, ACA, 2014).

TRUE EXPERIMENTAL DESIGNS are the most highly recommended designs for experimental research because of the control that they provide (Ary et al, 2014; Campbell & Stanley, 1963; Gay & Mills, 2011; Suter, 2006). 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:

    a. manipulate or vary the conditions systematically and note the variation

b.   make the event occur at a time when they are ready to make accurate observations and note accurate measurements

c.   repeat observations under the same conditions to verify, describe or replicate results

d.   manipulation of the independent variable and random assignment are the two distinguishing features that separate a true experimental design from a quasi-experimental design

Some designs that reflect an experimental design are pre-post-test control, post-test only, and Solomon Four group.

The type of statistic selected (parametric or non-parametric) is dependent upon the type of measurement scale (nominal, ordinal, interval, ratio) and independent-dependent variable. If the independent variable is considered nominal and the dependent variable is ratio data a parametric statistic may be the statistic of choice. If neither the dependent nor independent variable is ratio nor interval scales a non-parametric statistic may be the more likely choice. This does not suggest that if one of the variables is nominal that a parametric statistic would not be appropriate.

Pretest-Posttest Control Group Design:
Controls for all sources of internal validity. External validity problems occur because of the pretest that may make the results generalizable only to others who have had the pretest.

Posttest-Only Control Group Design:
Controls for all sources of internal validity except mortality. Controls for all external validity.

Solomon Four-Group Design:
Controls for all sources of internal and external validity, but it requires twice as many subjects so is not used as often as others.

Quasi-Experimental Designs

A quasi-experimental design is used when subjects are not randomly assigned and are usually ready-made or available groups (Campbell & Stanley, 1963; Coolican, 2014). Quasi-experimental designs are useful in studying the effect of treatment on a single subject and are often useful in behavioral research (Ary et al., 2010). Some examples are:

Nonequivalent Control Group Design:
Sources of invalidity are possible regression and selection interaction that involves maturation, history, and testing. The problem of external validity exists due to the pretest.

Time Series Design:
History and instrumentation are sources of internal invalidity (threat) for this design. The problem of external validity exists due to the pretest.

Counterbalanced Designs:
Selection interactions are a problem for internal validity. External validity could be poor because of the pretest administration and because of the multiple treatments received by subjects.

In summary, using a quasi-experimental design without randomization but with manipulation weakens the ability to search out cause-and-effect relationships.

Question 8-18:

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

    a. a sample of all preschool-age children in the U.S. who are read a story by their fathers will not retain the material when compared to those who read the same story by their mothers.

    b. a sample of teenagers with learning disabilities is more likely to have behavior problems documented in school records than are teenagers without learning disabilities.

    c. all children in a county whose parents are divorced have lower self-esteem than do children from intact families.

    d. all the above research hypotheses call for experimental research designs.

Answer: a. preschool-age children who are read a story by their fathers will not retain the material as long as those who are read the same story by their mothers. This research hypothesis calls for an experimental design because an independent variable is being manipulated. There are other conditions and variables that are to be met to qualify for a true experimental design.

Causal-Comparative (ex-post-facto)

Causal-comparative research or design is used to discover relationships for causes or effects. This is accomplished by comparing groups of people who differ on an attribute, not an independent variable. The search may be for preexisting conditions or behaviors. Thus, the cause and effect have already occurred. An example might be to research, after ten weeks, the effects of an already administered antidepressant with two different racial groups diagnosed with depression. The attribute variable, not independent variable, already exists and the difference discovered in recovery, could be time, side effects, or on some scale of rating for improvement. In causal-comparative research, there is no manipulation, randomization, and intervention. Caution is exercised in making conclusive statements.

Factorial Design

A factorial design "is one in which two or more independent variables are manipulated simultaneously 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, Sorensen, & Razavieh, 2010, p. 311). The 2 x 2 factorial design is the most common. Considered strength, a factorial design allows the testing of more than one hypothesis and how the factors interact (Glass & Stanley, 1970). It is the simplest factorial design, with each factor having two levels. In a factorial design, independent variables are called factors. A factor may have two or more levels. In a 2 x 3 factorial design, the first factor has two levels (male and female for example—2 in the first position) and the second factor has three levels (high IQ, medium IQ, and low IQ—3 in the second position). Factorial designs can have more than two factors. For example, a 3 x 3 x 2 design has three factors, two of which have three levels and one of which has two levels.

Question 8-19:

A group of researchers is interested in evaluating the effectiveness of three different therapy approaches and a control group for clients who exhibit symptoms of depression due to unresolved grief issues. The researchers are also interested in whether males or females resolve grief issues differently. After six therapy sessions, the mean scores on the Beck Depression Inventory are compared among and between

the four groups. From the available data which type of research design would these researchers utilize in analyzing the data?

   a.   quasi-experimental

   b.   historical

   c.   experimental

   d.   factorial

Answer: d. factorial. Without more specifics, a 3 x 2 factorial design would be recommended. The first independent variable (therapy) has three approaches while the second independent variable (gender) has two, male and female. Letter a. quasi-experimental design could be a choice as there is no information about the manipulation of the treatment and randomization. On the NCE one of the options would not be available (a. or d.).

Threats to Experimental Validity

Misinterpretation takes place during research, and as a result, there may be different interpretations to the results. Two common interpretations found in the literature occur due to subtle cues that provide a false reading, Pygmalion, and Hawthorne. The Pygmalion misinterpretation is due to expectations while the Hawthorne to attention or novelty effect (Suter, 2006). Effects such as expectations and attention are variables to be controlled through design and research blinding (keeping data collectors unaware of conditions) to reduce threats to internal and external validity.

Valid experimental results are due only to manipulation by the independent variable, and the results are generalizable to other situations. If extraneous variables affected the results, then the experiment is not as internally valid. If the results are not generalizable to situations outside the experimental setting, then the experiment is not externally valid.

Threats to Internal Validity

Internal validity refers to the ability of an investigation to produce findings that are valid to the group under study (Wiseman, 1999, p. 50). Bledsoe (1963) outlined eight major threats to internal validity.

   History
Affects performance on the independent variable during the time of the treatment but is not the independent variable. Events in one's environment surface during the research. Example: Between the pre-test and the post-test, a loud thunderstorm began. Control: Best method is to use two groups so the event affects both groups equally.

   Maturation
The physical or mental changes that occur within subjects over time. Example: Results of a pre-test given at the beginning of the school year and a post-test given at the end of the school year may be due in part to age increase of subjects (more knowledgeable, better coordinated, etc.). Control: random assigning preferred.

   Testing
Improved results on the post-test as a result of the subjects having taken a pre-test. Example: Subjects

learn 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 before 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 clients in an already-formed morning group from the population for group A and in group B the clients in the already formed evening group are selected that do not represent the population (Wiseman, 1999).

Mortality (attrition):
Mortality 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 the extent to which the findings of that study can be generalized to other populations" (Wiseman, 1999, p. 50). Gay and Mills (2011) incorporated Bracht and Glass's (1968) threats to external validity into Campbell and Stanley's conceptualizations. External validity refers to the generalizability of the results of a study.

Pretest Treatment Interaction:
When subjects respond differently to treatment because they have been pre-tested, so the results are only generalizable to other pre-tested subjects. Example: If a subject was pre-tested on attitudes about homosexuals, then read a story with a subplot about a homosexual relationship, the subject might focus on the subplot because he or she realizes that is the point of the study whereas subjects who had not been pre-tested would not.

Multiple Treatment Interference:
When more than one treatment is administered in an experiment, the earlier treatments may affect the later treatments. This could include subjects who had previous treatment in another study. Example: If a study were conducted on individuals with multiple phobias who had responded well to systematic desensitization with one phobia and were later treated with a new therapy for their other phobias, then

some of the apparent success of the new therapy may be due to the previous learning of systematic desensitization techniques.

Selection-Treatment Interaction:

Occurs when subjects are not randomly selected from the population. If the sample is not representative of the population, the results cannot be generalized to the population.

Specificity of Variables:

While the population and the sampling method must be described in detail, care should be taken that the experimental situation is still generalizable. Example: Attempting to generalize to all high school students the effects of a specific career counseling procedure when the subjects were all rural eleventh graders.

Experimenter Effects:

When the researcher causes the results to be different from what they would have been because of the experimenter bias effect when the researcher's expectations affect the researcher's behavior, and it then will affect the outcomes (Gay & Mills, 2011). 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 (Mills & Gay, 2015).

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). The highly experimental situation the researcher creates to increase internal validity may decrease external validity.

Question 8-20:

In planning a research design with the focus on influencing variables that might affect the outcome the researcher would attempt to control for:

    a.   internal and external validity

    b. internal and external reliability

    c. internal validity

    d. external validity

Answer: a. internal and external validity

Question 8-21:

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 to internal validity regarding the results.

    a. history

    b. maturation

c. instrumentation

d. regression

Answer: b. maturation

Question 8-22:
Identify which of the following is a threat to internal validity, that is, an event that is not the independent variable that affects performance on the independent variable.

a. instrumentation

b. testing

c. history

d. maturation

Answer: c. history

Program Evaluation

Program evaluation is a systematic process of collecting and analyzing information about the efficacy and effectiveness of services including the counselor, agency, and community impact of the program and services (Boulmetis & Dutwin, 2011). The types of evaluations can consist of micro evaluations for local service and action-research based to improve that service after monitoring has taken place. A program evaluation is a type of accountability intended to plan, implement, and refine services and outcome. Lusky and Hayes' (2001) mode of consultation is a form or model for a program evaluation. Specific program evaluations are available for cost efficacy, assessing goal achievement, decision-making, determining consumer impact, and improving the quality of services (Astramovich & Coker, 2007). They described a program evaluation consisting of four stages: (1) program planning, (2) program implementation, (3) program monitoring, and (4) outcome assessment. Critical stage elements include feedback from consumers and stakeholders, strategic planning, needs assessment, service process and outcome objectives, and communication. The Lusky and Hayes (2001) described a model of five phases: (1) planning, (2) analyzing, (3), designing, (4) implementing, and (5) evaluating. Lapan and Kosciulek (2001) developed an evaluation framework for a theory-based collaborative community career system program to identify post-high school outcomes and diverse needs of local and global communities. The program assessed a complex set of elements that includes individual differences, pre-K-12 school settings, business practices, perceived opportunities, regulatory legislation, community resources, local and global conditions and needs, work readiness-behaviors, peer group influences, family socialization, and summative outcomes. An interior set of individual components includes academic achievement, self-efficacy, choice goals, work readiness, job-self compatibility and vocational interests to measure self-understanding characteristics.

Developmental Research

Naturalistic: Natural setting, such as a home, school, or work situation provide the data source. 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 the behavior in question. "Nature" performs the experiment and the researcher is an observer (Dacey & Travers, 2002).

Case Study: Data are collected from a single individual. A disadvantage of the case study is the inability to generalize the findings. Systematically comparing individuals is difficult. Piaget used the case study for much of his accumulated data.

Cross-Sectional:
Data are collected from people of different age groups. Frequently, a stratified random sample is attained. Age cohorts may be the differences rather than maturation (Dacey & Travers, 2002).

Longitudinal:
A performance of a group of individuals over a repeated period, such as Terman's genius study for longer than 60 years. An advantage is to derive lasting behaviors such as habits. A disadvantage is any change in the environment.

Survey:
This method is composed of the interview and various types of questionnaires in order to sample subjects for their feelings, thoughts, or actions under prescribed conditions.

Correlational:
Observations under identical conditions and variables not manipulated measure existing phenomena. A correlation coefficient is derived that expresses the degree of relationship between two variables.

Hypothesis

Suter (2006) identified four types of variables and three types of hypotheses. Variables are independent, dependent, attribute and extraneous. Hypotheses are research, alternative, and null. A research hypothesis provides for a best-predicted outcome or reasonable outcome. An alternative hypothesis may be a competing hypothesis based on some influence and usually eliminated. A null hypothesis states there is no difference or connection among the variables.

In summary, a hypothesis is a:

"logical supposition, a reasonable guess, an educated conjecture which may give direction to your thinking on the problem and thus aid in solving it" (Leedy & Ormrod, 2016, p. 77).

"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 & Mills, 2011, p. 113).

Question 8-23:
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 is to (Gay & Mills, 2011):

a. provide a reasonable explanation.

b. state the expected relationship between two variables as clearly as possible

c. define the variables in a measurable term.

d. be testable.

Answer: d. be testable

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

Directional hypothesis (rarely used terminology): Couples with marital problems who go through one year of therapy will demonstrate a significant improvement in the ability to communicate with each other. The direction is an 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 reduced.

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. The difference does not indicate better or worse (up or down).

Null hypothesis:
There is no difference (mean scores) in the ability to communicate with each other between couples with marital problems who have gone through one year of marital therapy and couples who have had no therapy.

Subjects

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 are selected. Inferences about the population are drawn based on the behavior of the sample.

Population

A population is a group to which the researcher wants the results of the research to be generalized (Gay & Mills, 2011; Mills & Gay, 2015). 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 and possible replicating the study (Gay & Mills, 2011, p. 89). Example: college students in a state.

Sample

A sample is the smaller group or subset that is selected from the assessable population that is used in the research to represent the larger population (Cohen, 2001). The degree to which the sample accurately represents the population determines how comparable the results are. The techniques used to select the sample are therefore very important.

Sampling Techniques

No sampling technique guarantees a sample that is representative of the population, but there are techniques that increase the chances of a representative sample is selected. Random sampling is the best technique and is required for inferential statistics. Snowball sampling is the easiest to develop as it starts with a small number of participants and builds up.

Random Sampling

Random sampling is a process of selecting individuals from the population so that each has an equal and independent chance of being selected for the sample (Gay & Mills, 2011; Suter, 2006). Cohen (2001) pointed 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 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, Heppner, & Owen, 2016), 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 and Mills (2011) defined systematic sampling as "sampling in which individuals are selected from a list by taking every Kth name" (p. 122). A number is assigned for K. For example, every Kth name could be every second name or every eleventh name. All individuals do not have an independent chance of being selected in this type of sampling because after the first person is selected from the list, the rest of the subjects have already been determined.

Example: Taking every fourth name from the telephone directory.

Question 8-24:
A group of professors in the counseling department at a local university planned to investigate within their state the effectiveness of middle-school counselors. These researchers randomly selected 20 private middle schools in that state. In the selected schools, the team administered a packet of Likert-type instruments to all teachers and students in the seventh grade. The process of sampling used by the investigators in this study is known as:

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

Answer: d. cluster. Because the schools were selected this example randomly would be a randomized cluster. Cluster sampling is the process in which groups rather than individuals are randomly selected. The professors from the local university randomly selected 20 private schools rather than public schools to represent all private schools statewide.

Sample Size

Leedy and Ormrod (2016) identified three factors to be considered when determining what size a sample needs to be.

a. the degree of precision required between the sample and the population
b. the variability (standard deviation) of the population and the
c. 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 & Mills, 2011). Keep in mind numbers alone do not determine a proper sample size. The 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) suggested 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.

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

    b. Correlational: minimum of 30 subjects

    c. Causal-comparative: minimum of 30 subjects

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

Sample Error and Sample Bias

The sampling 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, & Mills, 2011; Mills & Gay, 2015). These sampling techniques include:

Convenience Sampling:
Samples of convenience are the most common in research such as the use of volunteers or already-existing groups such as Psychology 101.

Judgment Sampling:
When the researcher uses his or her judgment to create a sample that is believed to be representative of the population.

Quota sampling (most often used in research involving interviews):
Where a certain number of people are provided by request for an interview. This group does not represent the people more difficult to access.

Selection of an Instrument

More than one instrument can be used in a research study. The important factors in selecting an instrument include the consideration of the reliability and the validity. The operational definition of whatever is being measured (independent variable) is determined by the instrument measuring it. For example, extroversion could be defined as scores on the Myers-Briggs Type Inventory. A rationale, as well as a description of an instrument, should be a part of the write-up for the study (Mills & Gay, 2015).

OBJECTIVE 8 H: Statistical Methods

Objective 8h. statistical methods used in conducting research and program evaluation (CACREP, 2015, p. 13)

Descriptive statistics involve 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, Sorensen, & Walker, 2014; Cohen, 2001; Gay & Mills, 2011). The inferences can be parametric or nonparametric.

Research questions can be grouped as descriptive, differences, and as a relationship (Drew & Hardman, 1985). Descriptive questions ask what an event is like and are answered through surveys, inventories, and interviews. Difference questions make a comparison between groups of people and are analyzed through between-group and within-group designs. Relationship questions analyze the degree to which two events (constructs) are related. Correlations and regression equations are appropriate statistical tools for this measurement.

Descriptive Statistics

Important types of descriptive statistics include the following (Gay & Mills, 2011; Heppner et al., 2016):

Measures of central tendency—used to describe the average score of a group of scores. Examples: mode, mean, median.

Measures of variability—describe how spread out a group of scores is or how they spread themselves away from the central tendency (mean). Examples: The range and standard deviation are more commonly utilized.

Correlation

For correlational research, the degree of relationship between two variables is sought. This relationship is expressed as a number between -1.00 and +1.00. If the two variables are highly related, the correlation coefficient will be close to -1.00 or close to +1.00. If the two variables are unrelated, the correlation coefficient will be near 0.00. Though a decimal point is used, a correlation coefficient is not a percentage. A correlation of .70 does not indicate that the variables are 70% related. Also, a correlation of .20 is not twice as strong as a correlation of .10. It is important to remember that no cause and effect relationship is claimed to exist with these calculations or expressions. The strength of the correlation is referred to as strong, moderate, and low.

The common variance is the "variation in one variable that is attributable to its tendency to vary with the other" (Mills, & Gay, 2015). 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 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 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. Also, 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.

Correlation Types

Spearman Rho: If the data in the correlational study are expressed as ranks, the Spearman rho is used to calculate a correlation coefficient. 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 & Mills, 2011).

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 between the variables is a linear one. Both are <u>interval or both ratio</u> (Mills & Gay, 2015). Variable examples may include height, weight, achievement and personality measures. The Pearson r is frequently utilized to determine the reliability and validity of certain traits such as personality.

Phi: When both variables are genuine or true dichotomies, this test is used (Drew & Hardman, 1985). An example is when a person is present or absent.

Point Biserial: When the data on one variable are <u>continuous, and on a ratio or interval</u> 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.

Biserial: When the data on one variable are <u>continuous</u> (interval or ratio) and the data on the other variable are <u>artificially dichotomous (nominal)</u>, 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.

Tetrachoric: When both variables have been artificially dichotomized variables this test is used (Drew & Hardman, 1985). For example, if a researcher wants to study the relationship between students who are dichotomized as being superior athletes or poor athletes and their ability to speak in public, which is also dichotomized as superior or poor, then the researcher's only scores are 0 (superior) or 1 (poor).

Question 8-25:

A correlation coefficient of .93 can be described as:

   a.   strong positive.

   b.   strong negative.

   c.   mild positive.

   d.   mild negative.

Answer: a. strong positive. 93 is sufficiently high and near 1.00 to indicate a strong positive correlation.

Question 8-26:

Two evaluators ranked five dogs for running form for each of two days of trials. The evaluators assigned ranks for each dog for each day. Which correlation would be the most appropriate to analyze the data?

   a.   Spearman r

   b.   Tetrachoric

   c.   Point Biserial

   d.   Phi

Answer: a. Spearman r. The intention is to correlate rankings on day 1 with rankings on day 2. The correlation is one set of ranks with another set of ranks of the same dog.

Inferential Statistics

Inferential statistics, parametric and non-parametric, help determine how likely scores obtained for a sample (statistics) are the same as the scores that would be obtained for the population (parameters). This determination is obtained by using a test of significance. These tests allow us to decide if we are going to accept or reject the null hypothesis.

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 in a population. If not, then the difference between the two means is accountable to chance. Parametric and non-parametric are two classifications of inferential statistics.

Power

Power is a probability. The purpose of power analysis is to be able to reject the null hypothesis when the hypothesis is false. When consideration is given to designing a study the desired effect size, significance level, and sample size are important in a quantitative research (Balkin & Sheperis, 2011). If a low power index exists a type II error is more likely to occur.

The power of a test is an index between 0 and 1 and referred to as a probability of finding a difference (Suter, 2006, 2012). The purpose of determining power is to uncover relationships to reject the null hypothesis (difference does exist). Researchers prefer to establish power to be .90 or higher. To establish power the researcher is concerned about the size of the sample and the strength of the effect. In

planning the research, the question is posed as to what might be the minimum number in the sample because as the sample size increases so does the power. Power is calculated as 1-beta or type II error. Finally, beta decreases as sample size increases. APA requires power to be reported in a manuscript for publication.

Null Hypothesis

The null hypothesis states that there is no true difference between the mean score of two groups, and if a difference is found, then it is the result of sampling error. With this hypothesis, there are four possible outcomes. The researcher can accept the null hypothesis when it is correct, accept the null hypothesis when it is false, reject the null hypothesis when it is correct, or reject the null hypothesis when it is false.

For example, if the null hypothesis states that there is no difference in the means of group A and group B and 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 false, it is a type II error (beta error).

Question 8-27:
A type I error in a null hypothesis is a:

    a. false rejection.

    b. valid rejection.

    c. beta error.

    d. valid acceptance.

Answer: a. false rejection or false negative, rejecting the null hypothesis. Type II error is a failure to reject a false while a Type I error is rejecting when one should be accepting.

Significance Levels

The test of significance that the researcher applies to the data determines whether the researcher will accept the null hypothesis. This test is made at a predetermined probability level. This probability level is usually at the 95% (.05) or the 99% (.01) level of significance. When a researcher states that a difference between groups is significant at the .05 level, this means that this difference would occur 5 times out of 100 by chance rather than by manipulation of the independent variable. It also means that there is a 95% chance that the difference occurred because of the manipulation of the independent variable. When a difference is significant at the .01 level, it means there is a 99% chance that the difference can be attributed to the independent variable.

Question 8-28:
The following information was reported in a recent journal article. The mean score for group A was significantly higher than the mean score for group B (p < 01). This statement by the researcher means there is a:

a. 95% probability that the difference occurred because of the manipulation of the dependent variable.

b. 1% probability that the difference occurred because of the manipulation of the dependent variable.

c. 1% probability that the difference occurred due to the manipulation of the independent variable.

d. 99% probability that the difference occurred due to the manipulation of the independent variable.

Answer: d. 99% probability that the difference occurred due to the manipulation of the independent variable. There is one chance in 100 that the change occurred because of an error component or chance.

Standard Error

Because sample means are used to make inferences about the population, an estimate of the amount of error involved is needed. The standard error of the mean is this estimate.

The standard error of the mean is the standard deviation of the sample means (Gay & Mills, 2011). 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 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 & Mills, 2011; Mills & Gay, 2015):

a. The variable measured must normally be distributed in the population.

b. The data must represent an interval or ratio scale.

c. The subjects must be randomly selected.

d. The variances of the population comparison groups are equal.

Gay and Mills (2011) pointed out that with the exception 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). Also, the question of the group is usually tested with parametric statistics (e.g., t-tests, ANOVA) whereas relations between and among variables are usually correlations or regressions (Tabachnick & Fidell, 1989). A few of the more commonly utilized parametric tests will be highlighted.

t-test for Independent samples:

A t-test is utilized for a 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 & Mills, 2011).

The t-test is utilized with several different distributions (normal or otherwise) and with various sample sizes, and

a. t-test will test population means and develops a T-ratio

b. scores are interval or ratio

c. population from which sample is drawn is normally distributed

d. variability is equal for population and sample

A pretest is given to 30 students who were randomly selected from all the applicants for the October NCE testing. At the end of training, a posttest was administered, and a t-test for no significant mean change was computed.

If a pretest is administered to two different groups taking the October NCE testing a t-test can be conducted for non-independent samples. This could be one group when administered a pre and posttest, one group with two mean scores. A significant difference between two groups can be compared, and subjects matched on variables related to the dependent variable in order to equate groups.

Simple ANOVA (One-way Analysis of Variance)

A test for significant differences among three or more groups (yields an F ratio, One-Way or Two-way). This is the most common design in which there is a quantitative dependent variable and one or more qualitative independent variables (Cohen, 2001).

Statistical procedure conducted for several comparisons for three or more sample means and one independent variable and the F ratio is computed resulting in a 'p' value. A certain number of participants are assigned to three or more groups, and 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 and:

a. variability is observed between and among groups
b. quantitative dependent variable
c. less power than ANCOVA

A training group for the NCE took a pretest, posttest, and a post-posttest six months after the examination. The statistical ANOVA was utilized to test for mean differences between and among the administrations. It is possible to conduct three t-tests. However, ANOVA allows for this calculation to be conducted at the same time (efficiency).

Factorial ANOVA

Follows the same design and statistical procedure as explained for the simple ANOVA, but there are multiple independent variables. There is a significant difference among four groups that are subgrouped.

Example: Researchers are interested in investigating the effectiveness of three different types of behavior change intervention strategies in six middle-school grade students. Several variables were considered. These variables included the type of behavior change intervention program, grade level (6 grades), and gender representing a 3 X 6 X 2 design (3 interventions, 6 grade levels, and 2 gender) with three independent variables. The dependent variable is not listed.

Analysis of Covariance (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, Sorensen, & Razavieh, 2010, p. 317). It is used to equate unequal already-formed groups to make a fair comparison. It is also used to increase power. 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 (Mills & Gay, 2015).

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

A non-parametric statistic measures qualitative attributes, characteristics, and categories. This type of data is considered <u>nominal or ordinal</u> (Cohen, 2001). Three common non-parametric statistics are the median, sign, and chi-square tests.

Median Test

The 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 and:

a. two groups have same median

b. scores are ordinal

c. two independent samples are used

Sign Test

A non-parametric alternative to the t-test for matched pairs is the sign test. An assigned + for direction above and assigned - for direction below an identified point is the initial process. A summary of the + and - signs are subjected to the sign test statistical analysis and:

a. correlated samples where subjects are matched

b. use plus and minus signs

c. the dependent variable is continuous

d. members are ranked

Chi Square

A non-parametric test used to find the significance of differences among proportions. The chi-square test examines two sets of frequencies, observed and expected (Ary, Jacobs, Sorenson, & Walker, 2014; Cohen, 2001; Heppner et al., 2016). This type of nonparametric test of significance is used when the data is in the form of frequency counts and represent a nominal scale. One of the two data sets exists or is found in the literature such as the exact number of voters (Republicans or Democrats who are registered voters) in a precinct and includes:

a. independence of the frequency count

b. observed and expected frequency

Scheffé

The non-parametric test used for multiple comparisons, for example, if an F-ratio is significant; Scheffé is used to determine where the significance lies.

Mann-Whitney U

Mann-Whitney test is a nonparametric used when two dependent samples were drawn from the same population.

Kruskal-Wallis

Non-parametric test used for more than two groups.

Question 8-29:

A teacher administered two different forms of a test measuring math achievement to all students. She wanted to know if there is a relationship between the scores on the first form and the second form. What statistical technique should she use?

    a. simple ANOVA

    b. factorial design

    c. t-test for independent samples

    d. Pearson r

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

Question 8-30:

If the teacher in the previous question wanted to know if there is a difference between the raw scores on each of the two forms, what parametric test should she use?

    a. simple ANOVA

    b. factorial design

    c. t-test for independent samples

    d. Pearson r

Answer: c. t-test for independent samples

Question 8-31:

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 descriptive

Answer: a. experienced pre-marital counseling. Premarital counseling is the independent variable. The control group is not receiving premarital counseling.

Question 8-32:

Suppose that you want to test the hypothesis that in seal families with only two seals, the first-born is more gregarious than the second-born. You randomly select matched pairs of puppies with each pair consisting of the first-born puppy and the second-born puppy from a given family. You administer the puppy chow test of gregariousness/ shyness and derive a mean score of 30 first-born puppies and 30 second-born puppies. What would be the appropriate statistical technique?

    a. t-test

    b. analysis of variance

    c. Pearson product correlation

    d. chi-square

Answer: a. t-test

Question 8-33:

What is the appropriate research design for the following hypothesis? A researcher hypothesized that randomly selected students who received computer-assisted instruction would have greater gains in algebra achievement than students who do not receive computer- assisted instruction.

    a. pretest-posttest control group design

    b. posttest only control group design

    c. nonequivalent control group design

    d. Solomon four group design

Answer: a. pretest-posttest control group design

Question 8-34:

If we decrease the probability of a Type I error by choosing alpha small, we:

    a. increase probability of Type II.

    b. increase probability of Type III.

    c. increase probability of Type IV.

    d. increase probability of Type V.

Answer: a. increase probability of Type II. If everything else is constant when alpha error (Type I) is increased, beta (Type II) error will decrease. As sample size and alpha selection changes, so will this answer.

Question 8-35:

A researcher sets out to determine if fifth-grade students in Georgia have a higher or lower self-esteem rating than first-grade students. The researcher randomly selects several fifth-grade and first-grade classes from several different schools across Georgia. This is an example of what type of sampling?

    a. stratified

    b. systematic

    c. cluster

    d. k sampling

OBJECTIVE 8I: ANALYSIS AND USE OF DATA

Objective 8I analysis and use of data in counseling (CACREP, 2015, p. 13)

Organizational Modifications

Organizational program evaluation refers to "a systematic process of collecting and analyzing information about the efficiency, the effectiveness, and the impact of programs and services" (Astramovic & Coker, 2007, p. 162).

The ethical guidelines as adopted by the American Counseling Association (ACA, 2014) state that counselors monitor their effectiveness as professionals (C.2.d.) and that they regularly submit for professional review and evaluation by their supervisor or employer (F.4., F.6., F.6.a.). Similar responsibility is entrusted to appropriate individuals (clinical director, administrator, and 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) cited APA standards for psychological interventions. The treatment must be supported by at least two good between-group design experiments to establish effectiveness. The treatment must be superior to a pill or placebo and equivalent to an existing treatment in experiments with adequate statistical power. A second method is to use a large series of single case designs (Chambless et al., 1996).

Organizations and counselors have felt the pressure for accountability to research and document effectiveness of program services and counseling interventions and treatment outcomes. Reasons for lack of outcome information in the literature has to do with counselors and administrators expressing and demonstrating a sufficient level of research expertise in methods and in formulating appropriate researchable questions, collecting relevant data and identifying appropriate analyses (Isaac, 2003; Whiston, 1996). Program effectiveness and counselor effectiveness are linked in ways to promote healthy outcomes for clients. Schmidt (1995) detailed time constraints, elusive measures of school outcomes, lack of training in research and evaluation methods, and fear that evaluation results will have a negative impact on the counseling program. Mental health counselors utilizing managed care contracts are required to document detailed records about interventions, monitoring interventions and outcomes for individual sessions (Granello & Hill, 2003). A positive outcome for organizational and counselor outcome studies is a better-informed practice, improved quality, assessed goal achievements, provided feedback on decision-making, examined cost-effectiveness, and improved counseling services (Madaus & Kellaghan, 2000).

Also, as previously noted, regarding objectives for effectiveness studies a critical review is to include:

a.   improve quality

b.   client satisfaction

c. feedback on effective and ineffective interventions

d. effective and ineffective interventions for different populations (diversity)

e. impact on larger social problems (Royse et al., 2001).

f. highlight local needs

Powell, Steel, and Douglas (1996) provided a list of questions to be asked and researched to improve services and counseling outcomes. The questions are:

a. Are clients being helped?

b. What methods, interventions, and programs are most helpful for clients?

c. How satisfied are clients with services received?

d. What are the long-term effects of counseling programs and services?

e. What impact do the services and programs have on the larger social system?

f. What are the most effective uses of program staff?

g. How well are program objectives being met?

Astramovich and Coker (2007) developed a four-stage model entitled the accountability bridge counseling program evaluation model. The four stages of program evaluation cycle are program planning (needs assessment), program implementation, program monitoring and refinement, and outcomes assessment.

Question 8-36:

What research design is recommended for evaluating program and counselor effectiveness due to the complexity of measurement in monitoring and improving a program or intervention?

a. action

b. experimental

c. quasi-experimental

d. two-fold factorial

Answer: a. action research (Astramovich & Coker, 2007)

Counseling Effectiveness

Program evaluations help to know when theories work and when they do not. Program evaluations make comparisons. It is 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, 2013). A review of this research reveals that 75% of clients who enter treatment show some benefit (Lambert & Ogles, 2002). Whiston and Coker (2000) identified three important counselor contributions to effective counseling. These include:

a. the level of skillfulness, competence

b. ability to think diversely and complexly about client cases (cognition)

c. ability to relate to the client (relational)

d. third party payers, large group practices, hospitals, and nonprofit agencies use the ACRON collaboration for treatment effectiveness for their organization. A Core Outcome Resource Network's (ACORN) database contains psychotherapy treatment outcomes, a clinical information system that analyzes on a continuous basis for easy access and is user- friendly (Brown, Simon, Cameron, & Minami, 2015).

More so than ever, counselors are challenged to demonstrate treatment effectiveness. Sexton (1999) pointed 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 to evaluate the effectiveness of counseling has many positive implications for counselor accountability as well as counselor education/training and supervision.

In 1995 Consumer Reports published findings that revealed that clients "benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy" (Seligman, 1995, p. 965). Unfortunately, the Consumer Reports study also revealed that when the number of the therapy sessions or choice of the 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).

A key role for the counselor and supervisor in working together is to locate a routine outcome monitoring (ROM) program that measures and evaluates the counselor's treatment intervention. The purposes of the different ROMs include feedback for client change, therapy effectiveness, and immediate interactions with the client. These routine outcome monitoring measures offer session-by-session feedback to track the client's progress and in some clients less change or even deterioration. Lambert and Shimokawa (2011) reported strong evidence for the use of the OQ-system and PCOMS for preventing or being alerted to client deterioration or ruptures in the relationship, cases at risk and for failure. These routine outcome measures provide warning signals for the counselor to become aware of the pauses in therapy and when the therapy is not working for the client.

Hatfield and Ogles (2004) reviewed Phelps, Eisman, and Kohout's (1998) survey administered to psychologists for their responses to the use of ROMs. Twenty-nine percent reported using some form of

outcome measurement and 60% reported they used a standardized measure such as the Beck Depression Inventory.

Supervision research provides an empirical base for supervisee growth, treatment effectiveness, and a method to monitor treatment outcome. A key component of monitoring is the relationship between the supervisor and supervisee and the supervisee and the client. The effectiveness of this relationship has a direct bearing on the treatment objectives and the relationship between the supervisee and the client. Monitoring and providing accurate feedback requires a methodology implemented at the beginning of therapy and session-by-session assessment of client change.

Routine outcome monitoring (ROM) tools are used to acquire treatment feedback for client change (positive and less so). Specific objective measures to determine client change and to assist clinician decision-making can be based on the pattern of progress or lack of achievement. Supervisors introduce and integrate outcome programs in order to develop an effective method to obtain and use objective client feedback, to inform through discussions of specific clients in agenda setting, use patterns of outcomes across clients to facilitate supervisee/counselor growth and development (problem- solving), and to track and predict client treatment change, improvement, deterioration, or failure.

Alliance-Focused Training (AFT) focuses on therapist's skills for negotiating problems or ruptures in the alliance (brief relational therapy; BRT). The goal of AFT training is to increase the therapist's ability to recognize, tolerate, and negotiate alliance ruptures by enhancing supervisee self-awareness, affect-regulation, and interpersonal sensitivity (Eubanks-Carter, Muran, & Safran, 2015; Friedlander, 2015; Safran & Muran, 2002a, b).

Self-awareness, affect regulation, and interpersonal sensitivity are three skills used interdependently. Self-awareness is the supervisee's ability to attune to one's immediate experience and be better able to detect strains in the alliance (p. 169). Affect regulation is responding empathically and resisting the urge to answer client hostility with a counter hostile response or to avoid behaviors to reduce one's anxiety. Interpersonal sensitivity is the ability to communicate with the client about what is taking place without worsening the rupture.

AFT training begins with reading, definitions, and an approach for rupture resolution. When there is an alliance rupture that is severe clients often drop out of therapy and a less severe rupture may be caused by inadequate negotiation of the goals and tasks of treatment (Friedlander, 2015). Friedlander reports that therapist responsiveness is required when the counselor describes the client behavior as a troubled alliance. A supervisor task is to become responsive to the treatment and to also respond to the supervisee's reactions to the therapeutic rupture. Three training tasks included in the AFT model are a videotape analysis of challenging moments, use of awareness-oriented role-plays, and mindfulness.

Holt et al. (2015) reported that clinical supervisors use an evidence-based supervision model to track outcome and to teach principles of clinical supervision. The measures include the STS Clinician Rating Form (Fisher, 1999) and the Therapist Process Rating Scale (TPRS; Malik, Beutler, Alimohamed, Gallagher-Thompson & Thompson, 2003) to assess therapist competence and the exactness in details of the quality of treatment. Eight principles for supervision include impairment (clients with low social support systems), three relationships (strong working alliance, therapist relates to a client in an empathic way, resolve alliance ruptures), resistance (use directive therapeutic interventions), two coping principles (externalizing clients, internalizing), and readiness.

Each of the ROMs measure different aspects of psychotherapy, so it is important to select one that will meet the needs of the counselor, client disorder, and the agency. Some of these routine outcome measures include:

(1) Outcome Questionnaire-45 (OQ-45): psychological disturbance/functioning and prediction of treatment failure (Lambert, 2015); Clinical Outcome in Routine Evaluation (CORE; Barkham & Mellor-Clark, 2015): psychological distress and change, problems, life functioning, and risk.

(2) A Collaborative Outcome Resource Network (ACORN; Brown, Simon, Cameron, & Minami, 2015): common symptoms reported, social isolation/conflict, functioning in daily living, substance, and a Global Distress Scale (GDS)

(3) Counseling Center of Psychological Symptoms (CCAPS; Youn et al., 2015): depression, GAD, social anxiety, eating concern, substance use, family distress, academic distress, and hostility

(4) Partners for Change Outcome Management System (PCOMS) and PCOMS contains an outcome rating scale (ORS; Duncan & Reese, 2015):

(5) Treatment Outcome Package (TOP) consisting of 12 symptoms and functional domains (Boswell, Kraus, Castonguay, & Youn, 2015)

Evaluation Process

A five-step procedure or process for conducting an effectiveness evaluation for institutional treatment centers recommended by Lewis, Packard, and Lewis (2012) is to:

1. conduct a needs assessment.
2. define the goals and objectives of the counselor or agency.
3. identify alternative methods for meeting goals.
4. make appropriate decisions.
5. develop plans for implementation and evaluation.

An evaluation of a counseling service should include an internal and external approach. This comprehensive approach is intended for professional improvement and to provide clients a reasonable expectation of the effectiveness of treatment provided by the counselor or agency.

The counselor or agency organizes a plan to gather objective, performance-oriented data in a systematic and nonbiased manner. As referred to in the assessment unit, both formative and summative evaluations are important.

Purpose of the Evaluation

Gibson and Mitchell (2003) highlighted eight functions of evaluation. In summary, these eight functions reflect what works and doesn't work and to what degree, rate, and level progress is noted, feedback for improvement in the practice, enhancement and building credibility, increased insight, placing responsibility for successes and failures at appropriate positions or individuals, increased participation in decision-making, and providing a rationale for improving the overall accountability. These eight functions are appropriate both for the overall agency functioning in providing quality care and for the individual counselor in assessing his/her effectiveness.

In conducting this formative or summative review, appropriate research techniques should be employed. Thus, what is important is that each agency or counselor has established goals by which such an assessment can be conducted. For the individual counselor, this evaluation can be targeted at his/her counseling theory, program, technique, or approach to counseling. Step one is to identify those specific goals followed by how to identify valid criteria best to measure those goals. If the counselor is attempting to treat depression, the goal may be a reduction or elimination in the symptoms known to be associated with depression. These criteria might be the symptomology listed in the DSM-5™ or even the Beck Inventory symptoms and as measured by the evaluation scaling. Another step in the process is to seek feedback and follow-through that is, sharing the results.

Covering all aspects of an internal evaluation is far more extensive than will be presented in this unit. However, for the individual agency or counselor typical means to derive effectiveness data have been through controlled studies as well as surveys. Also, counselors have utilized audio and video taping to gather data that are submitted to an independent evaluator or supervisor for feedback. Other means to gather counselor feedback data can be through two-way mirrors, ROMs, in session observations by a trained observer, pre-post instrument measures on effectiveness, the bug in the ear (BITE), walk-ins, and phone-ins. In all situations, appropriate approval for such research is conducted through and with the full consent of the clients as well as an internal or external review board for human subjects.

According to Gibson and Mitchell (2003) evaluation can be a before-and-after method, a comparison method, and a how-do-we stand method. Each method has advantages and disadvantages and appropriate selection procedures based and evaluated upon the goals of the counselor, therapy, and the agency. The before-and-after method evaluation assesses client progress during therapy or counseling. The counselor's evaluation measure might be the Beck Depression 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 some designated 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 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 required evaluations.

OBJECTIVE 8 J: Research Ethics

Objective 8j. ethical and culturally relevant strategies for conducting, interpreting, and reporting the results of research and program evaluation (CACREP, 2015, p. 13)

Ethical Strategies for Interpreting & Reporting

ACA Code of Ethics G.4.

Reporting research in each stage of the research process (G.1.a.) includes planning, conducting, and reporting with accuracy including all aspects of the report. This report provides for a cost-benefits statement and refrains from any deviations with the data, design, bias or altering the outcome (G.4.a.). The same holds true for unfavorable results that are to be reported (G.4.b.). Should an error be reported in a publication, the researcher takes appropriate action to correct (G.4.c.). The participant's identity is to remain confidential, and in most cases, data is collapsed (G.4.d.). If an outside researcher request data from another researcher for the purpose of a replication study the primary researcher is obligated to make available original research to qualified professionals (G.4.e.). In the event research is published with multiple authors credit can be in the form of acknowledgements, footnote statements, and minor authorship (G.5.d.). Whatever form of credit for the research contribution is to be agreed upon before the research (G.5.e.). Submissions are to one journal at a time (G.5.g.) and are not published in another journal without acknowledgment and permission (ACA, 2014).

Wester's (2011) overview of publishing ethical research covers the scope of ethics and research. Each person preparing to take the NCE is encouraged to read the article to understand the scope of the entire research process from generating research ideas to publication. Safeguards such as ACA Code of Ethics, IRB's, federal government regulations (1974 research act), and HIPAA are in place for guaranteeing respect, informed consent, disclosure, selection of subjects, minimizing risks, methodology procedures, statistical techniques, power, effect, recognizing authorship and recognition for those contributing members. Five ethical principles are emphasized in this article in conducting research with human subjects.

The initial point in conducting ethical research is early attention to conclusion validity. According to Wester (2011) respect for participants includes five principles:

a. autonomy (respect and dignity for choice)
b. protection of vulnerable populations (informed consent when participants are unable to understand or feel pressured to participate)
c. beneficence (protection from harm from beginning to after the study
d. justice (benefits and risks are distributed fairly)
e. fidelity (keeping promises, be truthful, loyal, and follow through with commitments)

Wester cited Rosenthal (2008) and Bruce's (2002) research for what will satisfy social validity, that is, what impact the study will have on the population and society. The salient points in the process of conducting ethical, social validity research include:

a. research idea-social validity reflecting impact

b. design-consideration for risk and benefits

c. data analysis includes power, effect size, significance level, type I error

d. conclusion validity stating accuracy of data

e. article for publication-credit is applied to contributors

f. do not seek out a different statistical technique until significance is found

g. to not falsify data or meaning

A meta-analysis study conducted by Lau, Cisco, and Delgado-Romero (2008) regarding research productivity patterns was reported in five nominated research journals regarding multicultural psychology. Using a snowball sampling method, the five journals with highest ratings were the Journal of Cross-Cultural Psychology (JCCP), the Cultural Diversity and Ethnic Minority Psychology Journal (CDEMP), the Journal of Multicultural Counseling and Development (JMCD), the Journal of Black Psychology (JBP), and the Hispanic Journal of Behavioral Science (HJBS). Although there were several important implications and limitations of this report the findings for the five nominated journals for the years 1994-2007 suggested that for multicultural psychology there may be a reduced effect or impact on the field from the research journals from such a limited number of journals devoted to this research.

Publications

The Journal of Counseling and Development devoted a special research section in the Table of Contents for best practice. The articles reflected a broad range of domains researched across culturally relevant topics. Research was devoted to information regarding a variety of topics to include diverse populations, race, gender, age, culture, identity, biases, client issues, counselor training, supervision, ethical awareness, and practice.

Informing professionals is an important function of ACA, subdivisions, and affiliates. The major publications are the Journal of Counseling and Development and Counseling Today. These professional publications are distributed to all members of ACA. Counseling Today covers information regarding activities of the profession as well as members. The specific objectives for Counseling Today can be found in each monthly publication. The monthly publication advertises materials, workshops, and legislative actions, and provides current information regarding voting for membership positions within ACA and subdivisions of ACA.

The Journal of Counseling and Development (JCD) is considered a flagship journal for the profession. This journal is published four times a year. Manuscripts considered for publication fall into the areas of theory, practice, research, assessment and diagnosis, profiles, trends, books and media, and best practices.

In summary, counselors are to plan, design, conduct and report research that follow ethical principles, federal and state laws, and scientific standards for human subjects (G.1.a.). When deviating from standard practice the researcher is to seek consultation (G.1.d.). When an IRB is not accessible the researcher is to locate and receive guidance from knowledgeable researchers who are trained (G.1.c.), and to take precautions to avoid harm to participants (G.1.e.). The researcher is to always inform the participants of accuracy, procedures, benefits, alternative procedures, answer questions, describe limitations, format, and

that subjects are free to leave the study at any time (G.2.a., 1-9). Confidentiality is maintained before, during and after the study (G.2.d.). Data is to be collapsed, and procedures for disposal of documents and records are retained for a period (B.6. h.). In reporting research results of primary importance is accuracy (G.4.a.), obligation to report unfavorable results and errors (G.4.b., G.4.c.), disguise identity of participants (G.2.d., G.4.d.), recognize contributors (G.5.d., G.5.e), and to submit to only one journal at a time and articles published in whole or part submitted to another journal only with permission from previous publisher (G.5.g.).

The resources guide for those designing, implementing research and publishing articles is the Publication Manual of the American Psychological Association (APA, 2010).

Question 8-37:
The results segment of a published article is to contain all except:

    a.   outcomes of the intervention

    b.   pilot data

    c.   target outcomes population n description

    d.   population description.

Answer: d. population description. Population description is to be included in the methods section.

Question 8-38:
The discussion segment of a published article is to contain all except:

    a.   case examples.

    b.   connections to the purpose, goals, and the outcome of intervention.

    c.   collected data on intervention into context.

    d.   evaluate the data regarding diversity and multicultural competence.

Answer: a. case examples. Case examples, if included, are to be in the methods portion of the publication.

Question 8-39:
Publication is intended to further the findings in the specified problem; however, what aspect included in the discussion advances the importance of research in the field (objective 1)?

    a.   limitations of the study

    b.   correct statistical procedures

    c.   previous topical research

    d.   researcher's background in identified topic

Answer: a. limitations for the study. If research is to be replicated, it is important to be aware of variables the researcher was and was not capable of controlling.

Question: 8-40:
A concern that research participants may raise in signing an informed consent to participate in a study is that in signing that document they may be:

    a.   giving up their right to fair treatment or legal means regarding maltreatment.

b. required to submit some amount or undetermined amount of payment to participate.

c. held accountable for the outcome of the study.

d. harmed in some way unbeknownst to them.

Answer: a. giving up their right to fair treatment or legal means regarding maltreatment (Mann, 2008; Wester (2011).

Question 8-41:

An article appearing in a professional counseling journal reported a power effect size very low. It is likely the reader would expect the researcher to report the decision to:

a. accept the null hypothesis.

b. reject the null hypothesis.

c. accept the null hypothesis and describe the limitations.

d. reject the null hypothesis and describe the limitations of internal validity.

Answer: b. reject the null hypothesis

Ethical Obligation

Ethical research responsibilities are covered in the ACA 2014 Code of Ethics (ACA, 2014) involving conducting research (G.1.a.), confidentiality (G.1.b.), independent researchers (G.1.c.), deviation from standard practice (G.1.d.), avoiding injury (G.1.e.), principal researcher (G.1.f.), participant rights (G.2a.), student/supervise participation (G.2.b.), client participation (G.2.c.), confidentiality (G.2.d.), not capable of informed consent (G.2.e.), commitment to participants (G.2.f.), after data collection explanation (G.2.g.), informing sponsors (G.2.h.), record custodian (G.2.i.), maintaining boundaries (G.3.a.), extending researcher-participant boundaries (G.3.a.), relationship with participant (G.3.b.), harassment of participant (G.3.c.), reporting accurate results (G.3.a.), report unfavorable results (G.4.b.), reporting errors (G.4.c.), identity of participants (G.4.d.), replication (G.4.e.), case example (G.5a.), plagiarism (G.5.b.), previous work (G.5.c.), contributors (G.5.d.), agreements (G.5.e.), student research (G.5.f.) duplicate submission (G.5.g.), and professional review (G.5 h.).

Question 8-42:

An ethical advantage in using a wait list as opposed to a control group is:

a. to allow for the provision of care.

b. confidentiality is maintained.

c. clients do not have to pay for services.

d. participants are not a part of the statistical analysis or the publication.

Answer: a. to allow for the provision of care (Cunningham, Kypri, & McCambridge, 2013).

Question 8-43:

There is growing concern in the use of waiting list control designs in psychological and behavior intervention research because:

a. participants perceive that they must wait for the intervention to change.

b. wait list controls improve more than those who are the experimental group.

c. there is a higher dropout rate that affects the statistical power.

d. the treatment for a disorder has research supporting clients get better without the treatment.

Answer: a. participants perceive that they must wait for the intervention to change. This result is different from a normal control that tends to get better or improve with the passage of time (Miller & Rollnick, 2002).

Unit 8 – Terms

ACTION RESEARCH:
This type of research is designed to solve a problem through the scientific method.

ANALOGUE:
This type of research is conducted under situations or conditions that approximate real counseling contexts. This situation is an experimental simulation of some aspect of the counseling process. The client, the counselor, or the counseling process is manipulated. When discussing analog research, the topic of naturalistic vs. experimental research usually ensues.

Generalizability is the major disadvantage while the advantages are control, achieving a high level of specificity in the operational definition, isolating specific events, and reducing the ethical and practical obstacles in research (Heppner, Kivlighan, & Wampold, 2008).

ATTRITION:
The effect of subjects dropping from the study. The term mortality is often used synonymously with attrition.

ATTRIBUTE VARIABLES:
Attribute variables are characteristics of subjects such as gender, anxiety, intelligence, learning styles and are rarely manipulated in a research study (Suter, 2006, 2012).

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.

CONCLUSION VALIDITY:
Conclusion validity is the degree to which the findings and conclusions are accurate and correct.

CONFIDENCE INTERVALS (BAND):
The confidence placed around the fixed value of a population mean. The sample means deviate around this value. Specific values are:

90% = 1.65 SEM   95% = 1.96 SEM   99% = 2.56 SEM

The NCE is more than likely to use whole-number standard errors of measurement; that is, ± 1 or ± 2 rather than 1.65 and 1.96. Instead of using 90% at ± 1.65 times the SEM, it is easier to use ± 1.0 times the SEM for the 68% or two out of three times. Confidence limits are utilized when one desires to know how they would have scored were there not any errors in the process of testing.

CONTROL GROUP:

A group of subjects who do not receive the active treatment. There are different types of control groups such as the no treatment, waiting list, placebo, and matched. The placebo group believes that it is receiving the treatment.

COVARIANCE:

Covariance permits the researcher control by identifying and taking into account sources of variances not wanted because of concomitant variables. Covariance will take into account or adjust for initial differences in two or more dependent variables. Example: A teaching method for the NCE (independent variable) is lecture, PowerPoint, and manual study and the researcher wants to adjust for counselor degree levels (masters and specialist) at the beginning of the program. Covariance allows for this initial adjustment if 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.

META-ANALYSIS:

A meta-analysis is a process of combining different studies involving similar variables by estimating the effect size in each study. This way sample sizes can be combined thus increasing the power. To understand knowledge of power and effect size is important (Cohen, 2001).

NON-PARAMETRIC STATISTICS:

A distribution-free type of test where the population values are free of certain assumptions. Non-parametric tests are used when data are in frequency or rank form.

OBSERVER EFFECT:

Gay (2011) 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 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 & Mills, 2011).

PILOT STUDY:

A pilot study is a mini-study 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.

POWER:

Power is referred to as the probability that a true relationship does exist. Power is dependent upon the statistical test used, alpha level, and the directionality of the statistical test, the effect size, and the number of subjects (Heppner et al., 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.

REGRESSION:
Regression is a statistical technique used to predict a variable (success) when a second variable (skill) is known, that is, the relationship between success and skill. Regression is usually presented as a linear equation. Regression designs are multiple, stepwise, hierarchical, and simultaneous. Finally, it is defined as a tendency of scores to move toward the mean.

RESEARCH BLINDING:
Research subjects do not have data or information that might influence or distort perceptions. This procedure is used to reduce the effects of bias. A placebo is introduced so that participants do not know who is receiving the placebo or another independent variable, say a drug or non-drug pill.

SOCIAL VALIDITY:
Social validity is considered in research to ensure that the outcome has benefit to the profession or society. Examples of social validity might be to expand a theory (teaching/practice), isolate symptoms (diagnosis), and medication side-effects for the greater good of the client and the profession.

SNOWBALL SAMPLING:
This procedure allows for the researcher to recruit subjects from among their acquaintances. The method is to start with a small number of participants and build over time. As in all sampling procedures, strengths and weaknesses exist. Strength is to fairly select participants known to be helpful, and a disadvantage is community bias, not random, and if the sample is an accurate example of a target population.

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 on census data.

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 true a false claim is made. 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).

TYPE II (Beta):
Type II (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 a test of significance. A Type II error is a false positive result meaning the inclusion of 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.

Wait list is the group that is randomly assigned to receive the intervention later becomes the comparison research controls. After the study is completed, the wait list does receive the treatment or intervention (Brown, Heimbert, & Juster, 1995). Brown, Wyman, Guo, and Pena (2006) reported a class of wait lists includes subjects randomly assigned to different groups, and all groups receive the intervention, but the intervention is timed for the different groups.

WILLOWBROOK STUDY:

The purpose of this study was to determine if gamma globulin was an effective intervention for untreated hepatitis. Children diagnosed with hepatitis virus were fed extracts of stools from infected individuals, and later subjects received injections of more purified virus preparations. This study was conducted between the years 1963-1966 at the Willowbrook State Hospital in Staten Island, New York. Additional other documented violations of ethical research practices include the 1932 Tuskegee Study, Nuremberg Codes (injections with typhus fever, petroleum), Milgram's experiment, and Laud Humphrey's "Tearoom Sex" study (Babbie, 2004), Cincinnati Project (military-radiation personnel could sustain), and Johns Hopkins Lead Paint Study (low income housing families given housing but not told).

Unit 8 - References

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