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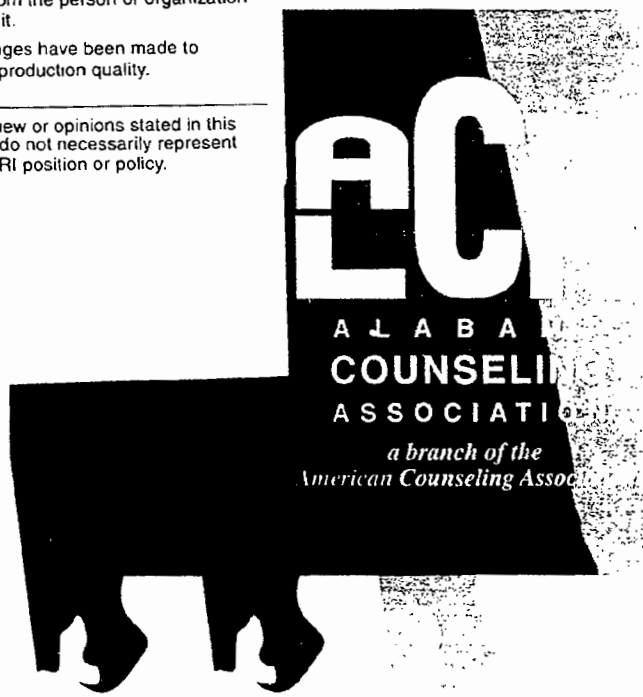
ABSTRACT

This document consists of the two issues of the "Alabama Counseling Association Journal" that make up volume 24. Articles in Issue 1 include: (1) "Learning Comes in Many Forms" (Holly Forester-Miller); (2) "Legislative, Legal, and Sociological Aspects of Alabama's Mental Health System" (David Gamble; Jamie S. Satcher); (3) "Peer Supervision: A Look at the Structures Group Supervision Model to Assist School Counselors" (Laurie L. Williamson); (4) "The Rural School Counselor: Professional Issues, Roles and Training" (Tracy D. Baldo, Kathleen F. Quinn, Theresa M. O'Halloran); (5) "Predicting Resiliency among Children with Asthma" (Robin Blackburn; Jamie S. Satcher); (6) "Boundary Issues in Perspective" (Barbara L. Herlihy, Gerald Corey); (7) "Clinical Supervision of Prelicensed Counselors: A Qualitative Inquiry" (Sandy Magnuson, S. Allen Wilcoxon). The following articles appear in Issue 2: (1) "RESPECTFUL Career Counseling" (Darrell Luzzo); (2) "Vocational Identity and Stress: A Study of Vocational Identity and Occupational Stress among Substance Abuse Counselors" (Joseph G. Law, Jr.; Anna H. Costarides, Vaughn S. Milner); (3) "The Ethical and Social Justice Dilemma of Managed Behavioral Health Care" (Patricia Anne Davis Kennington); (4) "A Twist in the Paradigm of Counselor Helper" (Marijane Fall); (5) "Review of Health and Longevity: Mental Health and Development Issues from 911" (John McCarthy); and (6) "Lest We Abuse Our Personal Power in Counseling and Supervision: An Interview with Dr. Glenda Elliott" (Sandy Magnuson). (MKA)






# The Alabama Counseling Association Journal

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# The Alabama Counseling Association Journal

An official publication of The Alabama Counseling Association, *The Alabama Counseling Association Journal* is published twice a year. A primary purpose is to communicate ideas and information which can help counselors in a variety of work settings implement their counseling roles and develop the profession of counseling. *The Journal* may include thought provoking articles, theoretical summaries, reports of research, descriptive techniques, summaries of presentations, discussions of professional issues, reader reactions, and reviews of books or media.

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*The Alabama Counseling Association Journal*

Volume 24, Number 1 Summer, 1998

# From The Editors

We are pleased to submit Volume 24, Number 1 of the *Alabama Counseling Association Journal* to ALCA members and friends. We believe you will find this issue to contain articles addressing diverse topics. Once again, we have received permission from the American Counseling Association to include chapters from two books. Forester-Miller's reflection of experiences as both a novice counselor and a client provides a salient reminder of "the importance of being with clients, of following their leads, and most important, allowing them to express themselves" (1997, p. 63). Herlihy and Corey's entry heightens sensitivity to various issues related to boundary violations and dual relationships. An interesting and informative history of Alabama's Mental Health System is chronicled by Gamble and Satcher. Williamson proposes a model for supervision of school counselors., and Baldo, Quinn and O'Halloran discuss concerns of school counselors working in rural settings. Blackburn and Satcher provide empirical support for predicting resiliency among children who have asthma. We wish to thank Editorial Board member, Dr. Judith Harrington, who assumed editorial responsibilities for processing and accepting Magnuson and Wilcoxon's article on supervising Certified Counselor Associates.

The *Alabama Counseling Association Journal* provides a forum for counselors to share research activities, professional position statements, descriptions of successful interventions, and reviews of professional resources. Guidelines for authors are included in the back of this issue. Please note the address for submitting manuscripts will change August 1, 1998.

# *Learning Comes in Many Forms*

HOLLY FORESTER-MILLER

Excerpted from:
*Finding Your Way as a Counselor*
an edited book by J. A. Kottler

(Published by The American Counseling Association in 1997, pages 63-64)


As I look back on my counselor education, two significant events stand out in my mind. They probably influenced my development as a counselor more than anything else in all those years of training.

The first experience occurred when I was a master's degree student taking my laboratory practicum class. I was counseling a 12-year-old boy named Brian. In our first session, as I was practicing empathy to the hilt, Brian started to cry. Instantly, my heart and mind started racing, and I thought, "Aha! It works! I hit on something." Then, "Oh no! Now what? The poor kid. He looks like he is in so much pain. He must be so uncomfortable and embarrassed. It hurts me to see him in so much pain. How can I make him comfortable? Oh, look at those huge brown eyes; he looks like Bambi did when he found out his mother had died."

Well, I quickly changed the subject. Brian obliged and changed gears with me, drying his tears. Although he brought up the original subject twice more in the session, I managed to side-step it and keep the session on a superficial, cognitive level. In other words, I ran like hell. I knew immediately what I *should* have done, but tears from a 12-year-old boy caught me off guard and elicited some of my own scary feelings. So, I played it safe. But--what price did Brian pay for *my* discomfort?

My supervisor helped me to understand my own fears and sort out the issues for me regarding Brian's tears. Maxims such as, "boys aren't supposed to cry," and "I am supposed to help him, not hurt him," rang in my ears. But my next session with Brian was different. He brought up the same subject again, and I did some appropriate empathic responding. Once again, he began to cry. Not only did I let him cry this time: I gave him permission to let go. After he cried for awhile, he went on to tell me that I was the first person who ever allowed him to talk about this subject so freely. I am thankful to Brian--he gave me a second chance to "let him talk."

I learned, then, the importance of being *with* clients, of following *their* leads,

and most important, allowing them to express themselves. I made a commitment to learn to be comfortable with my clients' emotions, as well as their thoughts. It took a long time, though, for me to become reasonably comfortable with the intensity of emotional expression. Now when I do a counseling demonstration in one of my classes, and my students say things like,"You probably come by this naturally," I tell them about Brian.

Several years later, I had the opportunity to *feel* the importance of being allowed to deal with emotions in counseling. I learned from a personal experience what Brian probably felt in his first session. I was a doctoral student and had gone to the college counseling center to discuss some major life decisions I was facing and to explore an ongoing internal struggle. On the verge of quitting my studies, I poured my heart out regarding my decision between wanting to have a profession and wanting to be a mom. I wasn't sure I could do either of these tasks well, must less both. I then touched on some of the other issues and struggles I thought I might like to work on in counseling.

Amazingly, the very "cognitive" counselor I was talking to managed to solve my dilemma for me in a record-breaking 45 minutes. Imagine. I had been thinking through this issue for months and hadn't resolved it. At the end of the session, he sent me on my way with a solution in hand and didn't even offer me an opportunity for a return visit. I left the office feeling unheard, unimportant, and angry. Unlike Brian, I knew what counseling was supposed to be, and this wasn't it. I knew that the client was supposed to be more important than the counselor's ego and feelings. I wondered how it was that this counselor, who had a Ph.D. and 20 years of experience, had not learned that yet.

That experience reinforced what Brian had taught me several years earlier. Acknowledging people's feelings and helping them to express them is a crucial component of counseling (although not always easy for the counselor). It may not be the only therapeutic ingredient, but it is the glue that holds everything else together.

There are lots of potential messages in these two stories. The main one is to open yourself up to all the forms of learning that are out there for you. Do the tough stuff. Don't let your fears and insecurities get in the way of dealing with your weak areas. Take risks. Try the techniques that challenge you, especially while you have a supervisor to help you through it. Be open to dealing with your issues and--most important--experience counseling yourself.

If you wait until your fears go away, you will probably never do things. As a good friend of mine says, "Just hold on to your courage stick and dive in, dragging your fears behind you." As Brian and I can tell you from experience, growth isn't always comfortable. Be willing to allow for your own, and your clients', discomfort.

# Legislative, Legal, and Sociological Aspects Of Alabama's Mental Health System

DAVID GAMBLE AND JAMIE SATCHER

*Alabama's mental health system has undergone dramatic changes since the early 1970s. People, ideas, cases, events, and movements have all influenced these changes. Mental health counselors should become familiar with this history in order to better understand how current services have evolved. This article examines the evolution of mental health services in Alabama and the national movements which precipitated, and in many instances, paralleled changes in the way Alabama cares for its citizens with mental disabilities.*

Mental health reform in the United States began in the 1840s with the building of a set of institutions for persons with mental illness (Hogan, 1987). The purpose of these institutions was to establish a structured environment in which people with mental illness could be provided care and eventually return to society (Burti & Mosher, 1989). Unfortunately, this reform soon became a means of segregating society's "less attractive" from the mainstream (Rubin & Roessler, 1987). In addition to people with mental disabilities, prostitutes, criminals, paupers, and non-English speaking foreigners were placed in these new institutions (Burti & Mosher, 1989). As a result of these actions and the theory of Social Darwinism, a societal attitude was shaped which led to widespread neglect of public mental hospitals in the United States for more than 70 years (Grob, 1983).

It was not until the publication of the Shame of the States (Deutsch, 1948), with its expose of the terrible conditions which existed in these institutions, that a true reform movement began (Burti & Mosher, 1989). The result of this reform movement was the formation of the Joint Commission on Mental Health in 1956. At the urging of his sister, Eunice, President John F. Kennedy read a report from the Joint Commission which advocated deinstitutionalization and community services for persons with mental illness (Burti & Mosher, 1989). President Kennedy's enthusiasm for change led him to urge Congress to authorize a federally-funded system of community mental health centers in 1963 (PL 88-164).

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From 1970 to 1990, the community integration focus became stronger at the national level. State mental hospitals were downsized as a result of federal policies requiring deinstitutionalization and promoting a greater emphasis on providing care in community-based mental health organizations (Redick, Witkin, & Manderscheid, 1995). This, in turn, led to a decline of full-time staff in state mental hospitals and Veterans Administration medical centers. At the same time, organizations such as private psychiatric hospitals, general psychiatric services, residential treatment centers, and multi-service mental health organizations had substantial increases in full-time staff (Redick et al., 1995).

In the early 1970s, conditions in Alabama's mental health institutions were deplorable (Hogan, 1987). Overcrowding and client emotional and physical abuse were prevalent (McKee, 1981). In some cases, negligence by institutional staff resulted in the deaths of residents (McKee, 1981). Since that time, the status of mental health institutions in Alabama and the treatment of individuals with mental illness has much improved. This article explores the gradual systemic changes in Alabama's mental health system, the factors and individuals responsible for these changes, and the mental health consumer organizations which both precipitated and advanced the shift in Alabama's mental health system to a more consumer-oriented model.

## Legal Aspects

*Wyatt v. Stickney* (1972) was opened by attorneys George Dean, Ira Demint, and Jack Drake. This case evolved from one at Bryce Hospital in Tuscaloosa, Alabama which was initiated by staff members who were laid off from their jobs as a result of statewide budget reductions (Campbell, 1996; Osmond, 1981). The workers contended that their dismissal violated their civil rights, and they filed a lawsuit against Stonewall Stickney, the commissioner of the Alabama Department of Mental Health and Mental Retardation (DMH/MR) (*Wyatt v. Stickney*, 1972). Although their suit was dismissed, the U.S. district court in Montgomery, Alabama did find violations of patient civil rights. The focus of the lawsuit was then switched to a patient civil rights case. This case was framed as a class action suit involving Bryce Hospital, as well as two other Tuscaloosa institutions serving persons with mental illness and mental retardation: Searcy Hospital and the Partlow State School and Hospital (Campbell, 1996). The lawsuit alleged that a state school designed to habilitate the mentally retarded was being operated in a constitutionally impermissible fashion (Wyatt v. Stickney, 1972). Judge C. J. Johnson, the presiding judge, held that Mr. Wyatt had been denied the right to habilitation and required that Alabama develop and implement minimum standards of care and training for individuals with mental illness and mental retardation.

Stonewall Stickney was a progressive commissioner (Davis, 1981). His concern for allowing individuals with mental illness to be returned to the mainstream of society, combined with Judge Johnson's order, paved the way for change in Alabama's mental health system (J. Drake, personal communication, February

19, 1996). This change was marked by a shift from an institutional focus for persons with mental illness to a community integration focus which was adopted at both the state and national levels (Schnibbe, 1981).

*Wyatt v. Stickney* also had a dramatic impact on funding provided to Alabama's mental health institutions (Leaf & Holt, 1981). For example, after Judge Johnson received a report of findings at the Partlow State School and Hospital, he ordered the institution to hire a large number of additional staff (Cavalier & McCarver, 1981). Following *Wyatt v Stickney*, Alabama's state legislature provided funds to upgrade, and in many instances, rebuild residential mental health facilities (J. Drake, personal communication, February 19, 1996).

Court rulings from Wyatt v. Stickney established minimal constitutional standards for the treatment and habilitation of persons with mental disabilities and paved the way for improved services to Alabama's mental health consumers. Implementing these standards, as well as maintaining a progressive stance toward the treatment of Alabama's citizens with mental impairments, has been difficult (Bleyer et al., 1995). Litigation subsequent to the original Wyatt case is evidence of the ongoing struggle to maintain constitutional treatment for individuals with mental disabilities (e.g., *Lynch v. Baxley*, 1974; *Wyatt v. Hanan*, 1994; *Wyatt v. King*, 1991).

## Systemic and Sociological Aspects

Due to the mental health consumer grass roots organizations which were formed in the late '980s in Alabama, more pressure has been placed on mental health officials to implement and protect constitutional rights guaranteed by court decisions (Cannon, 1995). Mental health consumer groups in Alabama fought for a number of system-wide initiatives in the years subsequent to the initial Wyatt decision. These included an emphasis on community-based programs (deinstitutionalization), more local support groups for individuals with mental illness, improvement of conditions in state mental health facilities, and the guarantee of basic constitutional rights for individuals with mental illness (Schnibbe, 1981). As a result of these consumer groups, the DMH/MR became more responsive to the system-wide change advocated for by mental health consumers (Office of Consumer Relations, 1996). For example, in the early 1970s, Bryce Hospital was grossly understaffed (Hogan, 1987). According to Larry Pate, an internal advocate at Bryce Hospital, there were no social workers or psychologists at this institution in the early 1970s (L. Pate, personal communication, January 30, 1996). Because of court cases and the efforts of mental health advocacy groups, however, this began to change. An internal advocates office was established at Bryce in 1980. This office was initiated to help individuals with mental illness who resided at Bryce if they believed their human or constitutional rights were violated (L. Pate, personal communication, January 30, 1996).

Other events also had a dramatic impact on the changing focus of the Alabama DMH/MR. Consumerism, as advocated by Ralph Nader in the 1970s,

engendered a greater concern for the needs of the mental health consumer (Health Research Group, 1998). This emphasis on consumerism was reflected in increased advocacy among Alabama's mental health consumers and their families. According to Joel Slack, former head of the DMH/MR Office of Consumer Relations, families of individuals with mental disabilities started to act against barriers to consumer-based treatment created by the department (J. Slack, personal communication, August 1, 1996).

The celebrity substance abuse movement of the 1980s coincided with, and in many ways advanced, the mental health consumer movement (J. Slack, personal communication, August 1, 1996) The dramatic rise in clients attending specialized outpatient treatment facilities from 1980 to 1992 is indicative of this advancement (Substance Abuse and Mental Health Services Administration, 1995). During this time, many celebrities were warning of the dangers of substance abuse. Likewise, many people with mental illness also had substance abuse problems (Hatfield, 1998). Celebrities and their stories created greater understanding of mental health issues, allowing the mental health consumer movement to progress (J. Slack, personal communication, August 1, 1996).

## System, Advocacy, and Legislative Aspects

By 1990, Alabama had the nucleus of a statewide consumer advocacy movement ("Many obstacles fall," 1995). This movement occurred as a result of consumers from across the state communicating with one another. David and Ann Marshall, mental health consumers and advocates, were responsible for starting this movement (Stevenson, 1995). They focused their attention on state systemic level mental health change. Through their work, other mental health consumers in Alabama realized that they could advocate for change in Alabama's mental health system at the state level (J. Slack, personal communication, August 1, 1996). Their work empowered other consumers across the state.

Jesse Stinson, nationally known mental health consumer advocate, was also involved in Alabama's mental health consumer movement. While David and Ann Marshall advocated at the state systemic level, Jesse Stinson focused on local self-help groups and support services for individuals with mental illness (J. Slack, personal communication, August 1, 1996). More than 25 mental health consumer support groups now exist in Alabama ("Events and groups calendar," 1996). These support groups play an integral role in the treatment of individuals with mental illness in the state ("Events and groups calendar," 1996). The work of these groups is one of the last legacies of the mental health movement (J. Slack, personal communication, August 1, 1996).

Another lasting legacy of the mental health consumer movement in Alabama is the Office of Consumer Relations. This office is a part of the DMH/MR and was established in February, 1990, by the Alabama Division of Mental Illness Services. This office was the first of its kind in the nation (Office of Consumer Relations, 1996) and is unique in that persons employed in the office must have

experienced mental illness. Its formation was further evidence of a realization by mental health officials in Alabama that the interests and needs of consumers must be a top priority for the DMH/MR to be truly effective.

The Mental Health Consumers of Alabama (MHCA) is another advocacy group operating at the state level. Founded by David Cannon in 1990, this group has become one of the leaders of the Alabama mental health consumer movement. Membership in MHCA approaches 2,000 and was responsible for the passage of the Alabama Mental Health Consumers' Rights Act (Cannon, 1995). This act essentially consolidates and codifies in one piece of legislation the fact that Alabama's citizens with mental illness have the same civil rights as other citizens ("Many obstacles fall," 1995). It ensures that protections granted under the landmark *Wyatt* case apply to individuals with mental illness living in the community, not only to those who are institutionalized ("What does," 1995).

## Future Considerations

The futures of the mental health system and the mental health consumer movement in Alabama are interrelated. According to David Prince, advocacy coordinator with the Alabama Disabilities Advocacy Program, more institutions are likely to close, meaning that institutions will serve fewer patients at increased cost (D. Prince, personal communication, February 3, 1998). In addition, future *Wyatt* cases will likely focus on improving mental health treatment, as well as abuse, neglect, and least restrictive environment (community placements) issues. The DHM/MR is also likely to change. It is anticipated that more money will be spent on community supports and services (D. Prince, personal communication, February 3, 1998). The department may become closer in appearance to a funding agent rather than a direct service provider.

Betty Lowman, an internal advocate for the DMH/MR, reported that consumers are likely to feel a greater sense of empowerment by taking a stronger stand on self-advocacy (B. Lowman, personal communication, February 13, 1998). Leadership training for consumers may be explored to promote empowerment and self-advocacy. Consumers are likely to advocate for changes in community supports and services. Examples include establishing boarding home standards and certification for foster homes

In summary, the service delivery system for Alabama's citizens with mental disabilities has experienced substantial progress since the early 1970s. Much of this progress can be traced to legal action and consumer advocacy. It is anticipated that changes will continue which will strengthen consumer involvement and choice in the provision of mental health services.

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# Peer Supervision: A Look at the Structured Group Supervision Model to Assist School Counselors

LAURIE L. WILLIAMSON

*The author proposes a structured peer supervision model as a viable means of addressing the need for supervision and support for school counselors.*

There is increased attention to the complexity of case loads and the desirability of school counselors to receive regular, professional supervision (Crutchfield et al., 1997). The purpose of this article is to propose peer supervision as a viable means of addressing the need for supervision and support of school counselors. Schools frequently have only one counselor and many smaller districts have only one counselor to serve K-12 (Sutton, 1988). As a result, counselors are often isolated and have little support (Barret & Schmidt, 1986; Borders, 1991; Borders & Schmidt, 1992; Gysbers & Henderson, 1988; Schmidt, 1990; VanZandt & Perry, 1992).

Matthes (1992) found that 87% of counselors surveyed were supervised by building principals who often received little, if any, training in counselor supervision. Counselors are, therefore, frequently left without consistent, formal support. Research has shown that counselors desire some form of clinical supervision (Borders & Usher, 1992; Roberts & Borders, 1994). The peer supervision model presented herein is a feasible and cost effective method of providing school counselors with quality supervision (Wilbur, Wilbur, Morris, Betz, & Hart, 1991). The model can improve coordination and collaboration among district counselors and does not require that new positions be created. Counselors within a district can take the initiative to join together and provide their own supervision through the structure of the peer supervision model.

## Peer Supervision

Meyer (1978) suggested that peer supervision with colleagues is a viable alternative to clinical supervision among practicing counselors as a means of promot-

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*The concepts discussed in this article originally appeared in the January/February 1998 issue of the ASCA Counselor, the official newspaper of the American School Counselor Association.*

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ing continuing education and professional development. Peer supervision is viewed as a powerful teaching tool that can concurrently teach specific counseling skills and techniques as well as promote interpersonal awareness (Yogev, 1982). It encompasses peer review, peer feedback, and personal insight into the interpersonal behaviors pertinent to the development of effective professional counselors (Holloway & Johnston, 1985).

## Goals of Supervision

The fundamental goal of supervision is to facilitate the effectiveness of counselors in meeting the needs of students. Loganbill, Hardy, and Delworth (1982) defined the goals of supervision and identified three components essential to effective and comprehensive supervision. They included (a) factual knowledge and theoretical concepts, (b) helping and crisis intervention skills, and (c) personal self-knowledge. The mastery of these learning tasks can be achieved by participating in continuing education programs or auxiliary methods such as group and peer supervision.

## Types of Group Supervision

There are several major categories of group supervision; each depends upon the activities of the group and the areas addressed by the group. There are (a) didactic presentations, (b) case conceptualizations, (c) the individual development of a supervisee, (d) group development, and (e) the developmental approach (Holloway & Johnston, 1985). Didactic presentations are primarily theoretical and educational in nature. Supervision consisting of case presentations is most typically practiced (Holloway & Johnston, 1985). Supervisee individual development may consist of inter or intrapersonal awareness. Group development assists counselors in acquiring a better understanding of group dynamics. The developmental approach, such as peer supervision, incorporates all of the above and adjusts the content, method, and emphasis according to the participants' level of mastery (Holloway & Johnston, 1985; Sansbury, 1982; Wilbur, Wilbur, Hart, Morris, & Betz, 1994).

Hansen, Robins, and Grimes (1982) completed a six-year review of the research available on practicum supervision. Studies focused on the effectiveness of the different styles of supervision such as didactic, experiential, and peer supervision. The debate surrounding the effectiveness of experiential and didactic methods remains unresolved. Some researchers found no difference between didactic and experimental training programs in preparing students (Austin & Altekruse, 1972; Silverman, 1972, 1973) while Hansen, Robins, and Grimes' (1982) research findings were inconclusive. Peer supervision, however, was determined to be a viable alternative and appeared to improve facilitative communication. Seligman's (1978) study demonstrated that peer supervision "helped to increase the counselor trainee's levels of empathy, respect, and genuiness" (p. 18). Worthington & Roehlke (1979) found that, "What counselors seem to need

most is for their supervisors to blend direct teaching with good relationship enhancement skills" (p. 71). It is the combination of skills training and interpersonal development that fosters quality supervision (Gysbers, 1964; Hansen & Barker, 1964; Lister, 1966; Orton, 1965; Patterson, 1964; Peters & Hansen, 1963; Sansbury, 1982; Truax, 1970; Truax, Carkhuff, & Douds, 1964).

## Structured Group Supervision Model

Wilbur et al. (1991) developed a model for peer group supervision named Structured Group Supervision (SGS) which can be utilized to meet the needs of school counselors participating in a voluntary group supervision process. The model is based on the idea that professional development occurs in a predictable and developmental sequence. It provides a highly structured group format for the provision and processing of supervision and feedback. A seven year study conducted by the authors lent additional support and justification for utilizing group peer supervision (Wilbur et al., 1994).

There are three primary areas of focus for supervisory sessions in the SGS model. The first is the extrapersonal focus which represents the lowest level of development. This extrapersonal focus is task oriented and aimed at skill development. The goal is to provide the supervisee with an increased understanding of the client and the skills or techniques the counselor might use to address the client's problems. It is a combination of a didactic and case conceptualization type of supervision focus.

The second level is the intrapersonal focus which is defined as psychoprocess. Intrapersonal focus attempts to address the supervisee's efforts at personal growth through increased personal insight and affective sensitivity. This level parallels the intrapsychic growth expected in experiential process groups.

The third focus represents the highest level of sophistication and is referred to as the integrative focus. This integrative area involves the socio-process or interpersonal growth of the group. The goal is to discuss the topic from an interpersonal, attitudinal, and cognitive perspective. "The objective is to assist the supervisee in exploring and integrating his or her beliefs about [the topic] through the collaborative exchange of the differing beliefs and attitudes among group members" (Wilbur et al., 1991, p. 94).

The SGS model is designed to be implemented with 8 to 10 group members during a three hour weekly supervisory session but it can be adapted to meet the needs of the group. The model is a structured group format comprised of five primary phases with each phase lasting approximately 10 to 15 minutes. The sequence of the five phases focuses on an individual supervisee's concern. Throughout the supervision session, the designated chairperson is alert to the possibility that the supervisee or group members may veer off the focus of the original request. The chair can intervene, reiterate the focus of the original request, and redirect the communication and interaction to that topic. Group members' inability of stay focused on the original request topic is interpreted as avoidance

and resistance.

In *Phase One*, a supervisee makes a *Request for Assistance Statement* that specifies an area of concern (e.g., skill development, personal growth, integrative focus). The supervisee provides the group with background information regarding the situation.

During *Phase Two* the supervision group members ask questions to clarify information and gain additional insight into the situation. The round robin technique developed by Delbecq, Van de Ven, and Gustafson (1975) is used and each member takes a turn to ask a question of the supervisee.

*Phase Three* uses the round robin technique again as group members respond to the supervisee by completing a *Feedback Statement*. Through productive suggestions, group members tell the supervisee how they would respond to the issue, problem, or client. During this phase, the supervisee remains silent, but may take notes regarding the comments and suggestions.

The SGS then employs a *Pause Period* or a 10 to 15 minute break during which time the supervisee reflects on and assimilates the group's feedback and prepares responses for the next phase. Group members are not allowed to interact with the supervisee during this time.

*Phase Four* consists of the supervisee responding to the group members' suggestions. The supervisee is encouraged to tell the individual group members which suggestions were useful and which were not. Group members are requested to remain silent while the supervisee responds and comments on their suggestions.

*Phase Five* is an optional phase where the chair may choose to facilitate a discussion regarding the previous four phases. The chair may elect to make comments on the group process, personality dynamics, feedback provided, or any personal reactions to the session. It can also be a time for the chair to summarize the issue being discussed and to provide some closure in terminating the supervisory session (Wilbur et al., 1994; Wilbur et al., 1991).

Wilbur et al. (1994) and Wilbur et al. (1991) contended that by structuring the process the group's productivity improves and the conflict and resistance that are common in group supervision decrease. The authors cited numerous research studies and writings to support their contention that group effectiveness is enhanced through increased structure. The authors submitted that the SGS format enables participants to become more effective in providing productive suggestions as well as receiving input from others. Two particularly salient qualities of the SGS model are that all group members participate and each receives some form of feedback from peers.

Stockton and Morran (1980, 1981) indicated that structure tends to enhance interpersonal behavior during the early stages of group development but may actually impede the group process at more sophisticated levels of functioning. The SGS model is flexible and able to accommodate differences in the levels of group development by implementing varying degrees of structure depending on the focus and goals of the supervisory session (Wilbur et al., 1994; Wilbur et al., 1991).

## Benefits of Peer Group Supervision

There are numerous additional benefits to peer group supervision. Group supervision was previously specified as a requirement for practicum and intern students by the American Personnel and Guidance Association (now American Counseling Association) and the American Psychological Association (Holloway & Johnston, 1985). It is considered to be an efficient and cost-effective use of supervisory time (Wilbur et al., 1994) and an effective use of available group time (Wilbur et al., 1991).

Participants often learn as much, if not more, from each other as peers than from a designated "expert" (Wilbur et al., 1991). Most importantly, peer supervision provides each participant with a wealth of material produced in small group interaction such as exposure to a variety of perspectives and theoretical foundations that would otherwise be impossible for any one formal supervisor to provide (Holloway & Johnston, 1985; Orton, 1965; Sansbury, 1982; Seegars & McDonald, 1963; Wilbur et al., 1994).

Groups can provide a more comprehensive experience and help bridge the gap between the isolation of the counselors in the schools and the activities of their colleagues. In addition, peer groups can provide a supportive and cohesive atmosphere in which participants can experiment and experience trial and error in a safe environment. A group experience helps participants put their failures into perspective by knowing that they are not alone.

Many of these advantages are consistent with the current research on collaborative learning and cognitive skill development (Wilbur et al., 1994). Sansbury (1982) asserted, "A major value of the group is that is provides an excellent setting for the type of learning that includes an affective or behavioral experience followed by cognitive integration" (p. 54). Participants can develop consultation skills in a constructive collegial relationship. Group supervision is a valuable supplement to individual supervision and an economical and unique contribution to trainee learning (Holloway & Johnston, 1985; Orton, 1965; Sansbury, 1982; Truax, Carkhuff, & Douds, 1964; Wilbur et al., 1994).

Bernard and Goodyear (1992) expressed support for group supervision, and also concerns, commenting, "Group supervision is a cost effective form of supervision that offers the participants the benefits of peer relationships, exposure to a greater number of cases, and vicarious as well as direct learning. Therefore, we would be well advised to give this vital form of supervision more empirical attention while we develop and utilize group supervision models" (p. 86).

## Summary and Recommendations

School counselors are encouraged to contact each other and develop a supervision network. The counselors involved need to decide how often, when, and where to meet. Supervision is most effective when it occurs on a regular basis, such as every two weeks or once a month (Roberts & Borders, 1994).

Building principals need to be enlisted for their support so that sessions can occur during the work day or shortly thereafter. Often districts have optional teacher work days which are ideal times to schedule supervision meetings. Counselors can meet at a separate, neutral location or rotate the location of each session at a host school. Individual counselors can be designated as the chairperson on a rotational basis to facilitate each session.

It is apparent that there are many benefits in utilizing peer group supervision. The structure of the SGS model provides for directed and purposeful learning. The variety of theoretical premises, the collaborative interaction, the sharing of perspectives, and the camaraderie evident in groups can enhance counselors' appreciation for the complexities inherent in effective counseling. It is easy to identify the intuitive appeal that group involvement offers. As responsible educators, who are being asked to do more with less, we must continue to develop peer group supervision models and provide the research documentation to support them.

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# The Rural School Counselor: Professional Issues, Roles and Training

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*Rural school counselors were interviewed to clarify their unique roles, struggles, and benefits in rural placements. Implications for school counselor training programs are offered.*

Saba (1991) wrote an article which offered counselor educators insights into the unique issues facing the rural school counselor. He argued that training programs for school counselors need "to be knowledgeable of the sociological dynamics associated with rural America, how these dynamics relate to the role of the school counselor, and what implications these have for counselor education programs." (p. 322). Saba's article was intended to supply the answers to these issues; however, no rural school counselor was asked for input. Saba offered insights without research support. The knowledge that rural school counselors have unique characteristics is supported (Baldo, Quinn, & O'Halloran, 1996; Cody, 1983; Saba, 1991; Sutton, Southworth, & Pearson, 1990); yet rural school counselors have not had the opportunity to share their experiences.

McIntire, Marion and Quagila (1990) noted that rural communities are often racially, ethnically, and socio-economically homogeneous, and that these communities are often our nation's poorest. Additionally, they discussed the fact that rural schools encounter a number of challenges, such as quality of education, networking, using community assistance, promoting individualized instruction, cost of facilities and equipment in communities with limited resources, and the move toward consolidation of small school districts into larger districts. Sutton and Southworth (1990) noted that although environmental differences between non-rural and rural areas are starting to receive more attention, the emphasis is more on recruiting and training qualified professionals, than on the effect, either positive or negative, that the environment has on the professional.

The preponderance of rural school counselor literature was presented in volume 37 of *The School Counselor* in January, 1990. This issue addressed demo-

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graphic issues, their effects upon the rural school guidance counselor, as well as professional issues about career tasks in rural settings. Only two of the articles were formal surveys relating to the role of the school guidance counselor. Wiggins, Evans and Martin (1990) addressed demographic issues but did not include rural counselors. McIntire et al. (1990) addressed rural counselors in terms of their relationships with school administration. The remaining articles were thought pieces based upon individual experience or a review of professional literature. The knowledge and experiences of practicing rural school counselors have been neglected in the professional literature.

Saba (1991) concluded that seven sociological characteristics affected rural school counselors: isolation; time and money; high visibility; lack of specialists; personal interaction; generalists; and local culture. Saba believed these seven factors should be added to counselor training programs to better prepare counselors for rural settings. Before counselor education programs modify their curriculum based on Saba's assumptions, rural school counselors should have the opportunity to voice the issues they are facing. The purpose of this article is to identify issues relevant to rural school counselors.

## Method

### Participants

Sixteen rural school counselors (8 White males and 8 White females) volunteered to participate in this study. The participants were randomly selected from rural school districts in South Dakota, Wyoming, Nebraska, and Colorado. To select the participants, school districts in rural settings, as defined by community populations of less than 6,000, were identified. Sixteen schools were randomly selected. Strategic sampling occurred to insure that counselors from elementary and high schools were invited to participate. All randomly selected participants willingly completed the survey. Five of the participants worked as the school counselor for grades K-12, three worked as elementary school counselors, and eight were employed as high school counselors. The average number of years employed as a school counselor was 11.5.

### Questionnaire

The participants in this study were each asked 11 questions in an attempt to identify the roles, issues, and training needs of rural school counselors. The 11 questions were derived from Saba's (1991) and Sutton and Southworth's (1990) writings. The following 11 questions were asked:

1. Describe your roles as a school guidance counselor in a rural community.
2. Think back over the last year. What issues related to working in a rural setting come to mind?
3. What have been some of the obstacles for you as a professional in terms of the community in which you work?
4. Do you have a strong support network of agencies both personal and technical? Please describe.

5. Is lack of privacy a problem for you? Do you have evening and weekend calls and drop ins? What types of problems?
6. Are there unrealistic community expectations for your personal values and behavior - high visibility?
7. Do you experience problems with confidentiality due to the size or nature of the community in which you work? Please describe.
8. Have you experienced problems with dual relationships for yourself and your clients (students, parents, teachers, etc.)? If yes, please describe.
9. Did you have difficulty gaining acceptance into the community when you were new in the community? Please describe.
10. What are the pluses of rural guidance work?
11. Other comments about your work as a guidance counselor in a rural area?

**Procedure**

School districts that were located in a rural setting (i.e., fewer than 6,000 persons in the community) were first identified for this study. To identify communities with fewer than 6,000 person, a 1996 atlas was consulted which identified population counts. From the selected school districts, 16 schools were randomly selected. A survey was then mailed to the school counselor at the selected school. The surveys took approximately 30 minutes to complete, and involved asking all 11 questions and obtaining minimal demographic information.

As in most small *N* research, the responses were transcribed then coded. The coding scheme used was based on Weber's (1990) guidelines. Weber presented eight steps for coding: (a) Define the recording units, (b) define the categories, (c) test coding on sample of text, (d) assess accuracy or reliability, (e) revise the coding rules, (f) return to step 3, (g) code all the text, and (h) assess achieved reliability or accuracy. One researcher with 18 years of school experience defined the recording units, defined the categories, and tested the coding. Two additional researchers were instructed in the coding methods and coded the same transcribed responses. Revisions were made in coding until all researchers were in agreement on the coding. All three researchers coded the transcribed responses. Discrepancies in coding were discussed until agreement was reached; therefore, the summary was created conjointly by three researchers.

## Results

**Roles**

The overwhelming consensus of the participants was that they considered themselves to be a generalist, or in the words of one participant, "a Jack of all trades." Participants identified the following job tasks: (a) scheduling, (b) offering both individual and group counseling, (c) arranging testing, (d) completing report cards, (e) meeting with parents, teachers, administration, (f) writing a school newsletter, (g) directing scholarship information to appropriate students, parents, and staff, (h) conducting prevention programs/workshops, (i) managing crises, (j) providing career counseling and guidance, (k) consulting, (l) teaching,

(m) coaching, and (n) record keeping. The participants who were providing services for grades K-12 expressed the greatest sense of needing to "know it all."

### Rural Issues

The most commonly expressed rural issues involved limited resources (e.g., time, money, technology, referral network). Because rural school counselors work as generalists, they have limited time for each task. This lack of time is compounded by the limited resources for delegating. Nonrural school counselors often have community resources that offer a referral network. Rural school counselors are often the only "mental health professional" in the area. Other issues identified in Question 2 were: (a) student attendance (e.g., if students are needed to work on the farm/ranch, they often miss school), (b) single parent families, (c) alcoholism and other family issues, and (d) confidentiality.

### Obstacles

Participants identified lack of role clarity for the school counselor and confidentiality as the primary obstacles. Most rural communities reportedly lack mental health professionals, and the school counselor is often perceived as the community counselor. One respondent described his or her role as being perceived as a miracle worker. The school counselor role also is misunderstood in terms of confidentiality. In small rural areas everyone tends to know everyone's business. A caring member of the community might participate in sharing information about community members. The idea of confidentiality is foreign. Teachers and administrators expect to be informed of confidential information about the students. Parents are afraid to have their children see the counselor for fear that confidential family issues may be disseminated into the community. This concern is amplified by the fact that alcoholism and domestic violence were reported by the participants as rather rampant.

Other obstacles reported by the rural school counselors included community resistance to innovation and change, conservative values, lack of student motivation to achieve or to leave the area, lack of resources, distrust and suspicion of newcomers, and feelings of isolation. The topic of isolation also links into confidentiality and role confusion. Community members are afraid to be "friends" with the counselor because they are afraid to be "analyzed," and counselors expressed concerns about making friends because these friends were very likely to be the parents of their students. One final obstacle was that many rural counselors' own children are enrolled within the school in which they are employed. The dual relationship of being school counselor and parent is troublesome and often times unavoidable.

### Support Networks

While all respondents stated that they had a strong support network, their descriptions were unclear. Some of the support networks identified included the local police department, the state counseling association, school administrators, county mental health agencies (often as far as 60 to 90 miles away), and local

attorneys and physicians. Clearly, rural areas are impacted in terms of available support services, yet the rural school counselors did not perceive their support networks as lacking.

**Privacy**

This question included several aspects. First, participants were asked if lack of privacy was a problem for them. Only two participants said lack of privacy was a problem, yet all stated that they received evening and weekend calls and drop ins. One participant stated, "If I am in town, I am expected to be available." The types of "problems" faced during evening, weekend, and drop in times were most often related to student grades or family problems. One participant wrote that the family problems could range from "a spat with friends" to "major abuse." It appears that counselors who choose rural placements are choosing placements that require counseling services "24 hours a day, 365 days a year."

**High Visibility**

One participant thought there were unrealistic community expectations for their personal values and behavior; however, all identified high visibility as an issue. All participants felt they had a responsibility to behave as a professional, yet only one expressed frustration regarding this pressure. One participant argued that, "we do have high visibility and a responsibility to be a model." Another stated, "It seems that my biggest problem is that people come up to you anywhere, coffee shop etc., and say, 'Hi, you're the counselor, tell me what to do with my bed wetter.' It's like we have to have all the answers when we don't."

**Confidentiality**

When asked if the counselors experienced problems with confidentiality due to the size or nature of the community, participants conveyed two distinct messages. Counselors stated that they were able to keep their information confidential, but secondarily, the clients might not. The participants shared that a student might talk with another person (e.g., teacher, peer. administrator, etc.) who did not have the same ethical code in terms of confidentiality, and the counselor was often blamed for breaching the client's confidence. Three quotes summarize this issue concisely. "If something gets out it is assumed that the counselor must have said something, even though the student may have also told four or five friends. That hurts." "It is assumed that because we are a smaller, rural community that everyone does and/or should know what everybody else is doing." "I do not have a problem maintaining confidentiality, but I am sometimes amazed at how quickly word travels around our community."

**Dual Relationships**

Dual relationships in small rural settings are inevitable. Of particular interest were the problems that have been experienced because of the inevitable dual relationships. Participants identified their roles of friend and counselor as the most conflictual. The counselors reported that often the teachers and parents who were

their friends did not understand when the roles changed from friend to school counselor. One participant said that, "Teachers are sometimes too good of friends, some teachers get angry." Another participant said that dual relationships were not really a problem; however, "I did have one little girl that didn't want to see me because my wife and I were friends with her parents and I was one of her Sunday School teachers. I guess I really can't blame her." Another conflictual dual relationship was reported by the counselors who were also teachers or coaches (e.g., "hard to tell me something in confidence when they know they will have me for an instructor.") One participant stated, "You develop a thick skin and move on."

### Community Acceptance

Surprisingly only one individual reported difficulty gaining acceptance. This participant went on to explain that the lack of acceptance was not due to who he or she was as a person, but rather his or her role as the school counselor. For this participant, counseling was non existent prior to his or her arrival. Another participant offered a similar insight, "No, the community was very accepting. . . . The stereotypes associated with what a counselor is is still a barrier to overcome."

### Pluses

The following pluses were identified by the participants: (a) "Lack of violence," (b) "We do not have gangs," (c) "I'm trusted", (d) "Being involved and close to the whole community," (e) "You get to know every student," (f) "Stronger family ties--Most people say 'Hi'--Willing to help," (f) "Flexibility," (g) "Freedom," (h) "I enjoy working and raising my children in a small rural community," (i) "Good values . . . fewer drug/sex problems . . . Nice kids," (j) "It's easy to get to know everyone," and (k) "Do not have near the problems of big cities."

### Comments

The last question allowed participants to freely offer any other comments they wanted to share. Few participants added any further comments; however, the primary comment was a simple, "I love it!" Other comments included: "The students become your family," "I have the best job in the state," and "Have always liked running my own show."

## Discussion and Implications

Saba (1991) suggested that rural school guidance counselors are often generalists. The participants in this study clearly described their roles as generalists. Many were responsible for grades K-12 which requires diverse skills. Saba did not discuss the need for rural school counselors to adopt the role of the community counselor. In particular, training in family counseling seems imperative. The focus of the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) to add a stronger counseling component to school counseling training programs seems merited (Lee et al., 1996).

Saba (1991) identified interpersonal relations skills as necessary for rural school guidance counselors. He suggested that such issues as mistrust of outsiders and conservatism may necessitate that rural counselors learn area-specific ways to communicate to be accepted into the culture. Participants in this study did not indicate that communication or acceptance was a problem. Rather, the problem was more one of misunderstanding the role of the school counselor. According to this study, rural school counselors need to be educated on how to explain their role, how to set boundaries, and how to obtain personal and professional support.

Isolation has been included as a factor in previous articles on rural counseling (Matthews, as cited by Saba, 1991). The participants in this study discussed isolation as an issue only in terms of referral resources and occasional dual relationship issues. When asked if they had a support network, participants in this study reported that they did. Interestingly, the small community seems to meet the personal support needs of the counselors. Clearly the greatest obstacle created by working in an isolated rural setting is the need to be a generalist. The rural school guidance counselor has to "know it all."

Saba (1991) commented that, "Work schedules often do not coordinate with 9-5 office hours," (p. 323); however, he did not convey that rural counselors are on the job "24 hours a day, 365 days a year" as was reported by the participants in this study. Counselors seeking employment in rural settings must be prepared with boundary setting skills to avoid feeling burned out. They need to know that the amount of work they accept "after hours" is within their control. Assertiveness training may be advantageous.

Another theme that needs to be presented in school counselor training programs is the need to have strong counseling skills for children, adolescents, adults, and families. The participants in this study often mentioned the need for skills in working with such issues as alcoholism and domestic violence. As discussed previously, many rural school counselors are the only mental health professional for several miles. When this is true, the community is likely to seek counseling assistance from the school counselor.

Unidentified in previous articles on rural school counseling is the need for legal and ethical discussions for isolated settings. Dual relationships are unavoidable in rural settings. Professional discussions on how to maintain ethical standards under rural constraints would be beneficial.

School counselor educators are encouraged to include course discussions on issues relevant to rural settings. The insights presented by these 16 counselors can offer educators and students the opportunity to prepare for issues unique to rural environments. Finally, training programs which focus on a more general counselor training may be meeting the needs of rural school counselors more effectively than programs targeted towards guidance activities.

Saba (1991) wrote that further research on rural school counselors was needed to validate the characteristics and concerns he had discussed. This study is a

beginning towards providing research into understanding the needs of rural school counselors. However, the small sample and lack of ethnic diversity among participants constitute significant limitations. More research is clearly necessary. In particular, learning what rural school counselors believe they need from their training programs would be a next step toward meeting the needs of this unique population.

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# Predicting Resiliency Among Children With Asthma

ROBIN BLACKBURN AND JAMIE SATCHER

*Children who appear to thrive and succeed despite major life obstacles are often termed resilient. Although resiliency has long been observed among children, empirical evidence of the factors which contribute to resiliency is limited. Using 78 children with asthma, this study investigated size of household, family structure, family income, perceived severity of illness, and number of extracurricular activities in which the children were involved as possible predictors of their resiliency. Only size of household was found to be predictive of resiliency among the children studied. As size of household decreased, resiliency increased. This study also examined differences in resiliency by gender. No significant differences were found based on gender. Implications of this research for school counselors are described and recommendations for further research are provided.*

Counselors who work with children recognize that some seem to thrive despite major life obstacles. This ability to successfully adapt in the face of adversity is often termed resiliency. Resiliency has been defined in a number of ways, including a child's ability to succeed when predicted to fail, survive stress, rise above disadvantage, and withstand the pressures of limited life circumstances (Baldwin, et al., 1993; Baxley, 1993; Linquanti, 1992; Rak & Patterson, 1996; Valentine & Feinauer, 1993; Werner, 1984).

Previous studies of resiliency have been qualitative and have typically used children who have adapted successfully in school performance and social functioning despite disadvantaged family and cultural backgrounds. Characteristics which have been identified among children observed as resilient include: (a) the ability to solicit positive attention from others (Benard, 1991, 1993; Valentine & Feinhauer, 1993; Werner, 1990; Werner & Smith, 1992); (b) strong communication skills (Kimichi & Schaffner, 1990); (c) a liking for school (Tarwater, 1993; Werner, 1990); (d) good problem solving skills (Benard, 1991, 1993; Carson, Swanson, Cooney, Gillum, & Cunningham, 1992; Tarwater, 1993); and (e) the ability to engage in cognitive restructuring (Benard, 1993; Linquanti, 1992; Mrazek & Mrazek, 1987; Valentine & Feinauer, 1993). Furthermore, these chil-

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dren have (a) a sense of spirituality (Kimichi & Schaeffner, 1990), (b) an internal locus of control (Benard, 1993; Valentine & Feinauer, 1993; Werner, 1990; Werner & Smith, 1992), (c) high self-esteem (Carson et al., 1992; Flach, 1988; Valentine & Feinauer, 1993), and (d) a sense of humor (Benard, 1991, 1993; Carson et al., 1992; Flach, 1988).

The literature describes a number of family variables which are believed to contribute to the resiliency of children. For example, Benard (1992) and Werner (1990) observed that resilient children live in families in which their parents allow them to participate actively in their environment. Other family variables which have been observed to contribute to resiliency include the existence of a family environment in which (a) there is a sense of "warmth," (b) the mothers are perceived as competent and caring, (c) feelings are openly expressed, (d) the children are encouraged and supported by their parents, and (e) family members agree on values and moral issues (Benard, 1992; Carson et al., 1992; Cowen & Work, 1988; Garmezy, 1991; Werner, 1990). There also exists within the family consistent, clear parental expectations for behavior (Bernard, 1991, 1992). Finally, resilient children tend to come from middle-class families in which the parents are well educated, there is no history of psychopathology in the family, and there is access to good health care (Carson et al., 1992; Mrazek & Mrazek, 1987).

**Children with Asthma**

Children with chronic illnesses often face unique and stressful life circumstances. According to Lubkin (1993), the prevalence of chronic illness among children has replaced acute illness as the primary health concern for children. In fact, over one million children and adolescents in the United States experience a severe, chronic illness (Haggerty, 1984). This number will increase as survival rates for children with chronic illnesses improve due to medical and technological advances (Goldberg, 1990; Newacheck & Taylor, 1992; Thompson & Gustafson, 1996).

Of particular importance is the impact of chronic illness on the child's social and educational functioning. For example, children with chronic illnesses often live in families in which the illness creates family distress related to caretaking responsibilities, medical expenses, possible home modifications, and altered sibling relationships (Frieman & Settel, 1994; Koch-Hattem, 1986; Kramer, 1984; Madan-Swain, Sexson, Brown, & Ragab, 1993; Patterson & Garwick, 1994). Furthermore, children with chronic illnesses are at increased risk for school dysfunction and absenteesim (Fowler, Johnson, & Atkinson, 1985). These problems may be manifested through behavioral acting out; academic failure, or both (Sexson & Madan-Swain, 1993).

Asthma is the most common chronic illness among children in the United States (Bender, 1995; Carson & Schauer, 1992). The implications of asthma cross familial, social, intrapersonal, and educational lines. For example, Carson and Schauer (1992) described asthma as a family disease and reported that families of children with asthma are at risk for experiencing parental dysfunction and eco-

nomic stress. They further reported that parents of children with asthma experience more severe marital problems and have a higher divorce rate than do parents of healthy children. From a social perspective, children with asthma report feeling left out of their nondisabled peer group which may result in decreases in self-esteem and self-confidence (Walsh & Ryan-Wenger, 1992). Many report feeling inadequate, helpless, and depressed (Bender, 1995; Celano & Geller, 1993). Children with asthma often experience high rates of school absenteeism (Olson, Mullins, Gillman, & Chaney, 1994). School personnel are often frightened by their asthmatic episodes and, as a result, limit their participation in school activities (Walsh & Ryan-Wenger, 1992). These children also experience higher levels of school failure than children who do not have asthma (Bender, 1995).

Whereas many studies have been conducted examining social and educational outcomes for children observed to be resilient, as well as variables which are observed to contribute to resiliency, no empirical evidence of which the authors are aware is available which quantifies resiliency and identifies predictors of resiliency among chronically ill children. A method of quantifying and measuring resiliency would contribute to the validity of the construct resiliency. Furthermore, determining predictors of resiliency among children with asthma would provide a basis for identifying those children who might benefit from counseling interventions to increase their adaptability. The purpose of this study was to identify predictors of resiliency among children with asthma and to determine if resiliency differed by gender.

## Method

### Participants

The population used was children with asthma attending American Lung Association camps in three southern states, one in each state. Usable data was obtained from 78 children and their parents or guardians. Forty seven of the children were male, 31 were female. They ranged in age from 9 to 15 years ($M$ = 10.86, $SD$ = 1.19). Annual family income was from less than $10,000 to over $100,000. Household structure was as follows: (a) Nuclear family with bioligical parents (54%), (b) single mother-headed family (21%), (c) single father-headed family (1%), (d) stepfamily with one or more children (20%), and (e) other (5%). Household size ranged from 2 to 15 ($M$ = 4.44, $SD$ = 2.11). The number of extracurricular activities in which the children were involved ranged from 1 to 12 ($M$ = 4.91, $SD$ = 2.41). The children were asked to describe the severity of their asthma using a scale ranging from 0 *(Has affected me a little)* to 10 *(Has affected me a lot)*. Responses ranged from 0 to 10 ($M$ = 4.98, $SD$ = 2.89).

### Procedures

Contacts were made through telephone calls to the directors of the camps and permission was granted for the primary researcher to visit the camps and collect data. At two camps, the data were collected from parents and children at the time

of check in. At one camp, parent or guardian permission forms and surveys were distributed by the director who returned these to the primary researcher on the first day of camp. At this camp, children whose parents or guardians had given prior consent were administered the survey on the day of their arrival to camp. Approximately 150 instruments were distributed the parents or guardians and their children at all three camps. The children were asked to complete the Blackburn Resiliency Scale and to provide information regarding their age, extracurricular activities, and perceived severity of disability. The parents or guardians were asked to provide information relative to income, family structure, and household size.

**Instrumentation**

The instrument, the *Blackburn Resiliency Scale*, was developed for this study by the primary author after an intensive review of the literature. The content of the instrument reflects items which were described in the literature as characteristic of resilient children (Bernard, 1991, 1993; Carson, et al., 1992; Kimichi & Schaffner, 1990; Linquanti, 1992; Mrazek & Mrazek, 1987; Tarwater, 1993; Werner, 1990; Werner & Smith, 1992). Children are asked to respond to the extent which they feel these items describe themselves using a Likert scale ranging from 1 *(Definitely unlike me)* to 5 *(Definitely like me)*.

The original instrument consisted of 21 items. A pilot study was conducted using 134 elementary school children to examine the instrument's reliability and construct validity. Construct validity was investigated using principal components factor analysis. Factor analysis is a statistical technique which examines the dimensions (factors) which are latent in a large set of variables (Hair, Anderson, & Tatham, 1987). As such, it is typically used as a measure of the validity of an instrument measuring a construct (such as resiliency). Factor analysis categorizes each item according to the extent to which it correlates with a certain dimension of an instrument. Factor loadings of .30 or higher are considered to be significant (Hair, Anderson, & Tatham, 1987). The factor analysis for the pilot study indicated that 16 items loaded on one factor with each item having a factor loading of .40 or higher. The remaining five items were removed from the instrument, resulting in a 16 item scale which can be found in Table 1.

The internal consistency of the instrument was assessed using item-to-total correlations. These correlations were all significant ($p < .01$) and ranged from -.22 - .67. Using Cronbach's Alpha, the reliability of the instrument was found to be .79.

## Results

The children had a mean resiliency score of 63.52 ($SD = 8.01$). Reliability analysis of their responses using Cronbach's alpha yielded a reliability coefficient of .83. Full entry multiple regression analysis was used to test predictors of their resiliency.

Prior to conducting this analysis, the data were examined for multicollinearity using bivariate correlations. A correlation matrix showing these relationships can be found in Table 2. Two predictor variables were significantly correlated: family structure and family income. Because of the significant relationship between income and family structure, family income was not included in the subsequent regression analysis. The researchers were more interested in the type of family in which the children lived as a predictor variable than with the income of the family.

The results of the regression analysis can be found in Table 3. Only household size was found to be predictive of resiliency among children with asthma. As the size of the household decreased, resiliency increased. This variable accounted for 11% of the variance associated with the resiliency scores of the children with asthma.

Gender differences were examined using one way ANOVA. Males had a mean resiliency score of 62.78 ($SD$ = 8.83). The mean score for females was 65.07 $SD$ = 6.14). No significant differences were found based on gender, $F(1.69) = 1.39$, $p > .05$.

## Discussion

Understanding variables which contribute to the resiliency of children with asthma is important to help school counselors, as well as counselors in other settings, to understand why some children are more adaptable than others. This research, which represents seminal work in quantitative resiliency studies, attempted to identify variables which predict the resiliency of children with asthma and to determine if their resiliency differed by gender. Previous research on resiliency has taken individuals observed to be resilient and has identified characteristics which differentiate them from nonresilient persons. No research known to the authors had attempted to examine research from the perspective of characteristics which may predict resiliency.

In this study of children with asthma, only one variable was found to be predictive: size of household. For these children, the smaller the size of the household the higher were their scores on the resiliency instrument. Although more research is needed to validate this finding, it may be that the demands of coping with a chronic illness means that children with asthma need greater attention within the family than can be provided in larger families. School counselors may need to be aware of this need so that additional attention may be provided to children with asthma when they are known to come from larger families. It is important to note that household size, while a significant predictor, explained only 11% of the variance associated with the resiliency of these children, leaving 89% unexplained.

This study was limited in a number of ways. First, the population used was children attending American Lung Association camps. Without a comparison group of children with asthma who do not attend such camps, it cannot be deter-

mined if these children represent the general population of children with asthma. It is possible that their participation in these camps represents a level of resiliency which may differ from other children with asthma. It is also possible that those variables which were predictive of their resiliency may differ from those which would predict the resiliency of children who do not attend these camps

Much of what accounted for the children's resiliency was not explained by this study. Future researchers should consider both the representativeness of the population being studied as well as the inclusion of additional variables to be studied (e.g., number of siblings, frequency of asthmatic episodes, days missed from school because of asthma). Identifying subjects through school health records or personal contacts with physicians might increase the likelihood of having a representative sample.

The study was also limited in that the procedures for collecting data differed for one of the camps. Because the camp director at one camp wanted to mail permission forms to the parents or guardians prior to the children arriving at the camp, a precise response rate could not be determined. The researchers cannot be certain that all forms sent to the director were actually mailed to the parents.

Finally, the research was limited in that the *Blackburn Resiliency Scale* is a new instrument developed for use with this study. With the exception of the pilot study of healthy children, little is available to support the psychometric properties of the instrument. It is recommended that the instrument be given to children with varying backgrounds to further assess its psychometric soundness.

**TABLE 1.**
**Resiliency Scale Items**

1. I look on the bright side of things
2. I get positive attention from other people who are important in my life
3. I do really well in at least one thing at school. A few examples include my school work, sports, drama, art, or music
4. I have a hobby that I enjoy
5. When I have a problem, one of the first things that I do is look over the whole situation and consider ALL of the pieces of information
6. When I have a problem, I put a lot of energy into solving it
7. When something goes wrong, I look for something good in the situation
8. I believe that everything will work out for the best
9. I believe that I can achieve whatever I want to
10. I do not blame other people for my mistakes
11. I feel that my life has purpose and meaning
12. When I have a problem, I usually do the first thing that I can think of to solve it*
13. I do not cause bad things to happen around me
14. I control my temper well
15. I can find something funny in most situations
16. I usually have plans that will help me reach my goals

*Reverse scored

**TABLE 2.**
**Correlation Matrix: Independent Variables**

| | Activity | Housesize | Income | Severity | Structure | Resiliency |
|---|---|---|---|---|---|---|
| Activity | | .07 | -.19 | -.18 | .03 | 12 |
| Housesize | | | -.05 | -.02 | -.08 | -.30* |
| Income | | | | -.09 | -.29* | -.01 |
| Severity | | | | | -.01 | -.12 |
| Structure | | | | | | -.06 |

*$p < .05$

Note. Housesize refers to the number of members in the household. Structure refers to the type of family in which the children lived (nuclear family with both biological parents, single-mother headed family, single father headed family, stepfamily, other). Family structure was dummy coded from 1 (nuclear family with both biological parents) to 5 (other) with higher order numbers representing increased distance from the nuclear family.

**TABLE 3.**
**Predictors of Resiliency: Children with Asthma**

| Variable | B | SE B | Beta | T |
|---|---|---|---|---|
| Activities | .40 | .36 | .12 | 1.12 |
| Household Size | -1.33 | .40 | -.36 | -3.27* |
| Severity | -.29 | .30 | -.10 | -.96 |
| Family Structure | -.53 | .62 | -.09 | -.85 |

*$p < .01$, $R^2 = .11$, $F(4,70) = 3.23$, $p < .05$

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# Boundary Issues in Perspective

BARBARA HERLIHY AND GERALD COREY

Excerpted from:
*Boundary Issues in Counseling: Multiple Roles and Responsibilities*
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Dual or multiple relationships occur when professionals assume two or more roles simultaneously or sequentially with a person seeking their help. This may involve taking on more than one professional role (such as counselor and teacher), or combining professional and nonprofessional roles (such as counselor and friend or counselor and lover). Another way of stating this is that helping professionals enter into a dual or multiple relationship whenever they have another, significantly different relationship with one of their clients, students, or supervisees.

Multiple relationship issues exist throughout our profession and affect virtually all counselors, regardless of their work setting or the client population they serve. Relationship boundary issues affect the work of helping professionals in diverse roles, including counselor educator and supervisor, agency counselor, private practitioner, school counselor, college or university student personnel specialist, rehabilitation counselor, and practitioners in other specialty areas. These issues can impact the dyadic relationship between counselor and client, and they can also emerge in complex ways when relationships are tripartite (as in client/supervisee/supervisor or client/consultee/consultant) or involve families or group work. No professional remains untouched by the potential difficulties inherent in dual or multiple relationships.

*Boundary Issues in Counseling: Multiple Roles and Responsibilities* is a revision of the 1992 Dual Relationships in Counseling book, but with an expanded focus. Since 1992 there have been many changes in how helping professionals think about multiple relationships, power issues, managing multiple roles and responsibilities, and boundary issues in counseling. In many respects *Boundary Issues in Counseling: Multiple Roles and Responsibilities* is a new book rather

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than a simple revision.

The term *dual relationships* is now a bit simplistic, and it really no longer adequately describes the complexity of issues that mental health practitioners, counselor educators, and supervisors face in trying to determining the appropriate boundaries of their relationships with those they counsel, teach, and train. Professionals sometimes need to manage multiple roles, and there is an inherent duality even in some roles that are supposedly singular. Although we use the terms *dual relationships* and *multiple relationships* somewhat interchangeably, *Boundary Issues in Counseling: Multiple Roles and Responsibilities* is based on the assumption that counseling professionals must learn how to manage multiple roles and responsibilities effectively. This entails dealing effectively with the power differential that is inherent in counseling relationships and training relationships, balancing boundary issues, and striving to avoid using power in ways that might cause harm to clients, students, or supervisees. *Boundary Issues in Counseling: Multiple Roles and Responsibilities* rests on the premise that we need to develop ethical decision making skills that allow us to weigh the pros and cons of multiple roles.

Over the past two decades, the counseling profession has become increasingly concerned about multiple relationships and appropriate boundaries as ethical issues. Much has been written about the harm that results when counseling professionals enter into sexual relationships with their clients. Throughout the 1980s, sexual misconduct received a great deal of attention in the professional literature, and the dangers of sexual relationships between counselor and client, professor and student, and supervisor and supervisee have been well documented. Today, there is clear agreement that sexual relationships with clients, students, and supervisees are unethical, and prohibitions against them have been translated into ethics codes and law.

In the 1990s, nonsexual dual and multiple relationships have been getting more attention, and the topic has been appearing more frequently in our professional journals. Recent revisions of the codes of ethics of the American Counseling Association (ACA, 1995), the American Psychological Association (APA, 1992), the National Association of Social Workers (NASW, 1996), and the American Association for Marriage and Family Therapy (AAMFT, 1991) have dealt more specifically and extensively with topics such as appropriate boundaries, recognizing potential conflicts of interest, and ethical means of dealing with dual or multiple relationships.

Nonsexual dual or multiple relationships are often complex, which means that there are few simple and absolute answers that can neatly resolve dilemmas that arise. It is not always possible for counselors to play a singular role in their work, nor is it always desirable. It is likely that they will have to wrestle with balancing multiple roles in their professional relationships. Examples of problematic concerns include whether to barter with a client for goods or services, whether it is ever acceptable to counsel a friend or social acquaintance, how a counselor edu-

cator should manage dual roles as educator and therapeutic agent with students, how ethically to conduct experiential groups as part of a group counseling course, whether it is acceptable to date a former client, and how to manage the budget for a caseload of clients in rehabilitation counseling.

In Chapter I of *Boundary Issues in Counseling: Multiple Roles and Responsibilities*, we focus on nonsexual dual relationships that can arise in all settings. These questions guide our discussion:

- What guidance do our codes of ethics offer about dual relationships?
- What makes dual relationships so problematic?
- What factors create the potential for harm?
- What are the risks inherent in dual relationships, for all parties involved?
- What important but subtle distinctions should be considered?
- What safeguards can be built in to minimize risks?

## Ethical Standards

The codes of ethics of all the major professional associations of mental health professionals address the issue of multiple relationships. Following are excerpts from the codes of ethics for counselors, psychologists, social workers, and marriage and family therapists:

- Counselors are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of clients Counselors make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of harm to clients. (Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.) (ACA, 1995, A.6..a.)
- Psychologist must always be sensitive to the potential harmful effects of other contacts on their work and on those persons with whom they deal. A psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons if it appears likely that such a relationship might impair the psychologist's objectivity or otherwise interfere with the psychologist's effectively performing his or her functions as a psychologist, or might harm or exploit the other party. (APA, 1992, 1.17)
- Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interest to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client. (NASW, 1996, 1.06)
- Marriage and family therapists are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of

such persons. Therapists, therefore, make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of exploitation. (AAMFT, 1991, 1.2)

As can be seen, these regulations address dual relationships quite extensively. The careful attention given to the issue in the newer codes is one reflection of the fact that dual relationships have been a problematic ethical issue for mental health professionals. Other evidence is offered by studies such as that conducted by Gibson and Pope (1993), who surveyed a large national sample of counselors regarding their beliefs about a range of behaviors. Respondents were asked to indicate whether they believed each of the behaviors was ethical or unethical. Fully 42% of the items that were found to be controversial (with at least 40% of the participants judging the behavior ethical and at least 40% judging it unethical) described some form of nonsexual dual relationship. This study clearly indicated that there is little consensus among counselor around nonsexual dual relationship issues.

## What Makes Dual Relationships So Problematic?

Dual or multiple relationships are rarely a clear-cut matter. Often, counselors need to make judgment calls and to apply the code of ethics carefully to specific situations. Dual relationships are fraught with complexities and ambiguities. They are problematic for a number of reasons, including that

- they can be difficult to recognize;
- they can be very harmful, but they are not always harmful;
- they are the subject of conflicting views; and
- they are not always avoidable.

### Dual Relationships Can Be Difficult to Recognize

Dual relationships are relatively easy to define but much more difficult for us to recognize in our daily practice (Pope & Vasquez, 1991). They can evolve in subtle ways. Some counselors, counselor educators, or supervisors may somewhat innocently establish a form of extraprofessional relationships. They may go on a group outing with clients, students, or supervisees. They may agree to play tennis with a client, go on a hike or a bike ride, or go jogging together when they meet by accident at the jogging trail. Initially, this social encounter may seem to enhance the trust needed to establish a good working relationship in therapy. If such events continue to occur; however, eventually a client may want more. The client may want to become close friends with the counselor and feel let down when the counselor declines a request. Or if a friendship does begin to develop, the client may become cautious about what he or she reveals in counseling for fear of negatively affecting the friendship. At the same time, the counselor may avoid challenging the client out of reluctance to offend someone who has become a friend.

It can be particularly difficult to recognize potential problems when dual relationships are sequential rather than simultaneous. Yet "the mere fact that the two

roles are apparently sequential rather than clearly concurrent does not, in and of itself, mean that the two relationships do not constitute a dual relationship" (Pope & Vasquez, 1991, p. 112). A host of questions present themselves: Can a former client eventually become a friend? How does the relationship between a supervisor and supervisee evolve into a collegial relationship once the formal supervision is completed? What kinds of posttherapy relationships are ever acceptable?

**Dual Relationships Are Not Always Harmful.**

A wide range of outcomes to dual relationships is possible, from harmful to benign. Some dual relationships are clearly exploitive and do serious harm to the helpee and to the professional involved. Others are benign; that is, no harm is done. To take two examples:

- A high school counselor enters into a sexual relationship with a 15-year-old student client. All professionals agree that this relationship is exploitive in the extreme. The roles of counselor and lover are never compatible, and the seriousness of the violation is greatly compounded by the fact that the client is a minor child.
- A couple invite their marriage counselor to attend a social occasion. The couple plan to renew their wedding vows and host a reception after the ceremony. The counselor attends the ceremony, briefly appears at the reception to offer her best wishes to the couple, and leaves. The couple are pleased that the counselor came, especially because they credit the counseling process with helping to strengthen the marriage. Apparently no harm has been done. In this case the counselor's blending of a social role with her professional role could be argued to be benign or even beneficial to the counseling relationship.

**Dual Relationships Are The Subject of Conflicting Views.**

The topic of dual relationships has been hotly debated in the professional literature. Some writers have taken a conservative stance, maintaining that codes of ethics will be of little value if professionals take great latitude in interpreting them. These writers have tended to focus on the problems inherent in dual or multiple relationships and to favor a strict interpretation of ethical standards that are aimed at regulating professional boundaries. Pope and Vasquez (1991) asserted that counselors who engage in dual relationships are often skillful at rationalizing their behavior as a means of evading their professional responsibility to find acceptable alternatives to dual relationships. Pope (1985) and Pope and Vasquez (1991) identified the following problems in dual relationships:

- Entering into dual relationships with clients, or even considering entering into them after termination, can drastically change the nature of therapy. Counselors could begin using their practices unconsciously to screen clients for their likelihood of meeting the counselor's social, financial, or professional needs.
- Dual relationships create conflicts of interest, and thus compromise the

objectivity needed for sound professional judgment.

- There is a danger of exploiting the client because the counselor holds a more powerful position.
- Dual relationships distort the professional nature of the therapeutic relationship, which needs to rest on a reliable set of boundaries on which both client and counselor can depend.
- Dual relationships affect the cognitive processes that benefit clients during therapy and help them maintain these benefits after termination.
- If a counselor were required to give testimony in court regarding a client, the integrity of the testimony would be suspect if a dual relationship existed.

Bograd (1993) noted that the power differential between the helper and the helpee undermines truly equal consent to a relationship outside the professional boundary. Even when practitioners have good intentions, they may unconsciously exploit or harm clients who are vulnerable in the relationship. If the professional boundaries become blurred, there is a strong possibility that confusion, disappointment, and disillusionment will result for both parties involved.

St. Germaine (1993) made the point that, although dual relationships are not damaging to clients in all cases, counselors must be aware that the potential for harm is always present. She mentioned that errors in judgment often occur when the counselor's own interests become part of the equation. This loss of objectivity is one factor that increases the risk of harm.

Other writers have believed that codes of ethics should be viewed as guidelines to practice rather than as rigid prescriptions, and that professional judgment must play a crucial role. Corey, Corey, and Callanan (1993) reminded as that ethics codes are creations of humans, not divine decrees that contain universal truth. They did not believe that all dual relationships are always unethical, and they have challenged counselors to reflect honestly and think critically about the issues involved.

Bograd (1993) noted that some professionals celebrate multiple connections that cross boundaries among teaching, supervision, therapy, collegiality, and friendships. These helping professionals tend to view multiple relationships as an inevitable and potentially beneficial complexity of interpersonal relationships rather than as evidence of professional indiscretion. For example, Tomm (1993) believed that codes of ethics, in expecting practitioners to maintain their professional distance, imply that all dual relationships are wrong. According to Tomm actively maintaining interpersonal distance focuses on the power differential and promotes an objectification of the therapeutic relationship. He suggested that dual relating invites greater authenticity and congruence from counselors and that, in fact, counselors' judgment may be improved rather than impaired by dual relationships, which can make it more difficult to use manipulation and deception or hide behind the protection of professional role.

Hedges (1993), who presented a psychoanalytic point of view, believed that there is an essential dual relatedness in psychotherapy. He argued that transfer-

ence, countertransference, resistance, and interpretation de facto rest upon the existence of a dual relationship. He urged practitioners to remember that, when viewed in this light, all beneficial aspects of therapy arise as a consequence of a dual relationship.

Whatever stance one takes, Tomm made an excellent point that it is not duality itself that constitutes the ethical problem. Rather, the core of the problem lies in the counselor's personal tendency to exploit clients or misuse power. Thus simply avoiding multiple relationships does not prevent exploitation. Counselors might deceive themselves into thinking that they cannot possibly exploit their clients if they avoid occupying more than one professional role. In reality, there are many ways that counselors can misuse their therapeutic power and influence and many ways they can exploit clients even though they are not engaging in dual or multiple relationships.

The diversity of perspectives summarized here indicates that the debate over dual relationships has been extensive. At this point, we ask you to consider for a moment: What is your stance toward dual or multiple relationships? With which of the perspectives do you most agree? How did you arrive at this stance? What do you see as its risks and benefits?

**Some Dual Relationships are Unavoidable.**

One consensus that seems to be emerging from the controversy over dual relationships is that not all dual relationships can be avoided. The recent revisions of the code of ethics of the American Counseling Association and the American Psychological Association acknowledge this reality:

- When a dual relationship cannot be avoided, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no exploitation occurs. (ACA, 1995, A.6.a)
- In many communities and situations, it may not be feasible or reasonable for psychologists to avoid social or other nonprofessional contacts with persons such as patients, clients, students, supervisees, or research participants. (APA, 1992, 1.17)

Perhaps the clearest example of a situation in which dual relationships may be unavoidable is that of the rural practitioner. In an isolated, rural community the local minister, merchant, banker, beautician, pharmacist, or mechanic might be clients of a particular counselor. In such a setting, counselors may have to play several roles and are likely to find it more difficult to maintain clear boundaries than do their colleagues who practice in urban or suburban areas.

## Some Subtle but Important Distinctions

Dual relationships have not always been clearly defined in the literature, which has compounded the confusion surrounding this complex issue. As we mentioned earlier in the chapter, dual relationships have been a frequent topic in our professional journals. The debate has been extensive, and much of it has been enlightening and thought provoking. However, it seems to us that we have sometimes "painted with too wide a brush" in cautioning against dual relationships.

Some roles that professionals play can be combined without creating a problematic dual relationship. Individuals who choose to enter the helping professions are not expected to sacrifice the multiple roles in which people naturally engage, nor are they expected to restrain themselves from acting as friends, neighbors, relatives, or employers (Glosoff, Corey, & Herlihy, 1996). Ethical questions that arise around the issue of whether it is ever appropriate to assume any of these roles with a client need to be framed somewhat differently when a counseling relationship is not involved. For instance, mentoring a student is often mentioned by counselor educators as one type of "beneficial dual relationship." Although serving as a mentor to a student involves playing a multiplicity of roles (perhaps including thesis or dissertation adviser, course instructor, encourager, collaborator in research projects, and coauthor of a professional publication), the mentor does not serve as the student's counselor. Problematic dual relationships arise from the simultaneous taking on of the role of counselor and another distinctly different role (such as friend, lover, relative, employer, or business partner) with a client, student, or supervisee, but other types of role blending, in which professionals play more than one noncounselor role (such as the roles involved in mentoring), need not be routinely discouraged. Nonetheless, any relationship (including mentoring) that involves a power differential carries with it a potential for exploitation, and the person in the more powerful position must remain alert to possible problems. The mentor and student need to discuss in advance any issues that might arise, such as who gets what type of credit for any research or publication, or whether conflicts of interest could occur when the mentor is in a position to evaluate the student. Some leaders in the profession are now making mentoring arrangements with graduate students at other institutions rather than with their own students. Although this type of arrangement may require more effort because of the distance involved, it seems to us to be an excellent way to provide the benefits of mentoring while avoiding many of the pitfalls.

Some behaviors in which professionals may engage from time to time have a potential for creating a dual relationship but are not, by themselves, dual relationships. Some examples might be accepting a small gift from a client, accepting a client's invitation to a special event such as a wedding, going out for coffee with a client, accepting goods rather than money as payment, or hugging a client at the end of a particularly painful session. Some writers (Gabbard, 1995; Gutheil & Gabbard, 1993; Simon, 1992; Smith & Fitzpatrick, 1995) have suggested that these incidents might be considered *boundary crossings* rather than boundary

violations. A *crossing* is a departure from commonly accepted practice that might benefit the client, but a *violation* is a serious breach that causes harm. Crossings occur when the boundary is shifted to respond to the needs of a particular client at a particular moment. Interpersonal boundaries are not static and may be redefined over time as counselors and clients work closely together. Nonetheless, even seemingly innocent behaviors such as those just described can, if they become part of a pattern of blurring the professional boundaries, lead to dual relationship entanglements with a real potential for harm.

Some roles that professionals play involve an *inherent duality*. One such role is that of supervisor. Supervisors often find that supervisees experience an emergence of earlier psychological wounds and discover some of their own unfinished business as they become involved in working with clients. Ethical supervisors do not abandon their supervisory responsibilities by becoming a counselor to a supervisee, but they can encourage their supervisees to view personal therapy with another professional as a way to become more effective as counselors and as persons. At the same time, it needs to be recognized that although the supervisor and therapist roles differ, personal issues arise in both relationships, and supervisors need to give careful thought as to when and how these issues should be addressed. As another example, counselor educators serve a teachers, as therapeutic agents for student growth and self-awareness, as supervisors, and as evaluators, either sequentially or simultaneously. There is always the possibility that this role blending can present ethical dilemmas involving conflicts of interest or impaired judgements.

None of these roles or behaviors actually constitutes an ongoing dual relationship of the type that is likely to lead to sanctions by an ethics committee. Nevertheless, each does involve two individuals whose power positions are not equal. Role blending is not necessarily unethical, but it does require vigilance on the part of the professional to ensure that no exploitation occurs. One of the major difficulties in dealing with dual relationship issues is the lack of clear-cut boundaries between roles. Where exactly is the boundary between a counseling relationship and a friendship? How does a counselor educator remain sensitive to the need to promote student self-understanding without inappropriately acquiring personal knowledge about the student? How can a supervisor work effectively without addressing the supervisee's personal concerns that may be impeding the supervisee's performance? These are difficult questions, and any answers must include a consideration of the potential harm to clients, students, or supervisees when a dual relationship is initiated.

## The Potential for Harm

Whatever the outcome of a dual or multiple relationship, a potential for harm almost always exists at the time the relationship is entered. To illustrate, let us revisit the example given earlier of a behavior that was identified as benign. As it turned out, no apparent harm was done when the marriage counselor attended the

renewal-of-wedding-vows ceremony and reception. But what might have happened if the counselor had simply accepted the invitation without discussing with the couple any potential problems that might arise? What if the counselor had been approached at the reception and asked how she knew the couple? Had the counselor answered honestly, she would have violated the privacy of the professional relationship. Had she lied or given an evasive answer, harm to the clients would have been avoided, but the counselor could hardly have felt good about herself as an honest and ethical person.

One of the major problems with dual relationships is the possibility of exploiting the client (or student or supervisee). Borys studied a variety of possible nonsexual dual relationship behaviors and concluded that they were all related to the same principle: Do not exploit (Borys, 1988; Borys & Pope, 1989). Kitchener and Harding (1990) contended that dual relationship lie along a continuum from those that are potentially very harmful to those with little potential for harm. They concluded that dual relationships should be entered into only when the risks of harm are small and where there are strong, offsetting ethical benefits for the consumer.

How does one assess the potential for harm? Kitchener and Harding (1990) have identified three factors that counselors should consider: incompatibility of expectations on the part of the client, divergence of responsibilities for the counselor, and the power differential between the parties involved.

First, the greater the incompatibility of expectations in a dual role, the greater the risk of harm. For example, John, a supervisor, is also providing personal counseling to Suzanne, his supervisee. Although Suzanne understands that evaluation is part of the supervisory relationship, she places high value on the confidentiality of the counseling relationship. John is aware that her personal problems are impeding her performance as a counselor. In his supervisory role, he is expected to serve not only Suzanne's interests but also those of the agency in which she is employed and of the public that she will eventually serve. When he shares his evaluations with her employer has his supervisory contract requires, and notes his reservations about her performance (without revealing the specific nature of her personal concerns), Suzanne feels hurt and betrayed. The supervisory behaviors to which she had agreed when she entered into supervision with John were in conflict with the expectations of confidentiality and acceptance that she had come to hold for John as her counselor.

Second, as the responsibilities associated with dual roles diverge, the potential for divided loyalties and loss of objectivity increases. When counselors also have personal, political, social, or business relationships with their clients, their self-interest may be involved and may compromise the client's best interest. For example, Lynn is a counselor in private practice who has entered into a counseling relationships with Paula, even though she and Paula are partners in a small, part-time mail-order business. In the counseling relationship, Paula reveals that she is considering returning to college, which means that she will have to give up her role in the business. Lynn is faced with divided loyalties because she does not

want the business to fold but she does not have the time to take it over. As this example illustrates, it is difficult to put the client's needs first when counselors are also invested in meeting their own needs.

The third factor has to do with influence, power, and prestige. Clients, by virtue of their need for help, are in a dependent, less powerful, and more vulnerable position. For example, Darla is a counselor educator who is also counseling Joseph, a graduate student in the program. When a faculty committee meets to assess Joseph's progress, Joseph is given probationary status because his work is marginal. Although Darla assures Joseph that she revealed nothing about his personal problems during the committee meeting, Joseph's trust is destroyed. He is fearful of revealing his personal concerns in counseling with Darla because he knows that Darla will be involve in determining whether he will be allowed to continue his graduate studies at the end of his probationary period. He wants to switch to another counselor but is afraid of offending Darla. Counselor educators and counselors must be sensitive to the power and authority associated with their roles. They must resist using their power to manipulate students or clients. Because of the power differential, it is the professional's responsibility to ensure that the more vulnerable individual in the relationship is not harmed.

## Risks in Dual or Multiple Relationships

The potential for harm can translate into risks to all parties involved in a dual relationship. These risks can even extend to others not directly involved in the relationship.

### Risks to Consumers

Of primary concern is the risk of harm to the consumer of counseling services. A client who believes that he or she has been exploited in a dual relationship is bound to feel confused, hurt, and betrayed. This erosion of trust may have lasting consequences. The client may be reluctant to seek help from other professionals in the future. Clients may be angry about being exploited but feel trapped in a dependence on the continuing relationship. Some clients, not clearly understanding the complex dynamics of a dual relationship, may feel guilty and wonder What did I do wrong? Suppressed anger is a potential outcome when there is a power differential. Students or supervisees, in particular, may be aware of the inappropriateness of their dual relationships yet feel that the risks are unacceptably high in confronting a professional who is also their professor or supervisor. Any of these feelings--hurt, confusion, betrayal, guilt, anger--if left unresolved could lead to depression and helplessness, the antitheses of desired counseling outcomes.

### Risks to the Professional

Risks to the professional who becomes involved in a dual relationship include damage to the clinical relationship and, if the relationship comes to light, loss of professional credibility, charges of violations of ethical standards, suspension or

revocation of license or certification, and risk of malpractice litigation.

From a legal perspective, nonsexual dual relationships are less likely to produce sanctions than are sexual dual relationships. For instance, Neukrug, Healy and Herlihy (1992) found that sexual dual relationships comprised 20% and other dual relationships comprised 7% of complaints made to state counselor licensure boards. However, in recent years state licensing boards seem to be addressing the issue of nonsexual dual relationships more vigorously (Pope & Vasquez, 1991). Malpractice actions against therapists are a risk when dual relationships have caused harm to the client, and the chances of such a suit being successful are increased if the therapist cannot provide a sound clinical justification and demonstrate that such practices are within an accepted standard of care.

Many dual relationships go undetected or unreported and never become the subject of an inquiry by an ethics committee, licensure board, or court. Nonetheless, these relationships do have an effect on the professionals involved, causing them to question their competence and diminishing their sense of moral selfhood. Repeated violations of any ethical standard lead professionals down a slippery slope (Bok, 1979) along which it becomes easier and easier to succumb to the temptation to commit further violations.

**Effects on Other Consumers**

Dual relationships can create a ripple effect, impacting even those who are not directly involved in the relationship. Other clients or potential clients can be affected. This is particularly true in college counseling centers, schools, hospitals, counselor education programs, or any other relatively closed system in which other clients or students have opportunities to be aware of a dual relationship. Other clients might well resent that one client has been singled out for a special relationship. Because a power differential is also built into the system, this resentment may be coupled with a reluctance to question the dual relationship openly for fear of reprisal. Even independent private practitioners can be subject to the ripple effect. Former clients are typically a major source of referrals. A client who has been involved in a dual relationship and who leaves that relationship feeling confused, hurt, or betrayed is not likely to recommend the counselor to friends, relatives, or colleagues.

**Effects on Other Professionals**

Fellow professionals who are aware of a dual relationship are placed in a difficult position. Confronting a colleague is always uncomfortable, but it is equally uncomfortable to condone the behavior through silence. This creates a distressing dilemma that can undermine the morale of any agency, center, hospital, or other system in which it occurs.

Paraprofessionals or others who work in the system and who are less familiar with professional codes of ethics may be misled and develop an unfortunate impression regarding the standards of the profession.

**Effects on the Profession and Society**

The counseling profession itself is damaged by the unethical conduct of its members. As professionals, we have an obligation both to avoid causing harm in dual relationships and to act to prevent others from doing harm. If we fail to assume these responsibilities, our professional credibility is eroded, regulatory agencies will intervene, potential clients will be reluctant to seek counseling assistance, and fewer competent and ethical individuals will enter counselor training programs. Conscientious professionals need to remain aware not only of the potential harm to consumers but also of the ripple effect that extends the potential for harm.

## Safeguards to Minimize Risks

Whenever we as professionals are operating in more than one role, and when there is potential for negative consequences, it is our responsibility to develop safeguards and measures to reduce (if not eliminate) the potential for harm. These include the following:

- *Set healthy boundaries from the outset.* It is a good idea for counselors to have in their professional disclosure statements or informed consent documents a description of their policy pertaining to professional versus personal, social, or business relationships. This written statement can serve as a springboard for discussion and clarification.
- *Involve the client* in setting the boundaries of the professional relationship. Although the ultimate responsibility for avoiding problematic dual relationships rests with the professional, clients can be active partners in discussing and clarifying the nature of the relationship. It is helpful to discuss with clients what you expect of them and what they might expect of you.
- *Informed consent* needs to occur at the beginning and throughout the relationship. If potential dual relationship problems arise during the counseling relationship, these should be discussed in a frank and open manner. Clients have a right to be informed about any possible risks.
- Practitioners who are involved in unavoidable dual relationships need to keep in mind that, despite informed consent and discussion of potential risks at the outset, unforeseen problems and conflicts can arise. *Discussion and clarification* may need to be an ongoing process.
- *Consultation* with fellow professionals can be useful in getting an objective perspective and identifying unanticipated difficulties. We encourage periodic consultation as a routine practice for professionals who are engaged in dual relationships. We also want to emphasize the importance of consulting with colleagues who hold divergent views, not just those who tend to support our own perspectives.
- When dual relationships are particularly problematic, or when the risk for harm is high, practitioners will be wise to work under *supervision.*
- *Counselor educators and supervisors* can talk with students and supervisees

about balance of power issues, boundary concerns, appropriate limits, purposes of the relationship, potential for abusing power, and subtle ways that harm can result from engaging in different and sometimes conflicting roles.

- As more a legal than an ethical precaution, professionals will be wise to *document* any dual relationships in their clinical case notes. In particular, it is a good idea to keep a record of any actions taken to minimize the risk of harm.
- If necessary, *refer* the client to another professional.

## Conclusions

We have examined what the codes of ethics of the major professional associations advise with respect to dual or multiple relationships. We have explored a number of factors that make such relationships problematic. Factors that create a potential for harm and the risks to parties directly or not directly involved in multiple relationships have been identified. Some strategies for reducing risks were described.

What is critical is that counselors give careful thought to the potential complications before they get entangled in ethically questionable relationships. The importance of consultation in working through these issues cannot be overemphasized. As with any complex ethical issue, complete agreement may never be reached nor is it necessarily desirable. However, as conscientious professionals we need to strive to clarify our own stance and develop our own guidelines for practice, within the limits of codes of ethics and current knowledge.

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# Clinical Supervision of Prelicensed Counselors: A Qualitative Inquiry

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*A comprehensive qualitative inquiry was conducted to obtain descriptive data related to perceived needs and existing practices for supervision of prelicensed, entry-level counselors in Alabama. Twelve thematic categories emerged in the data analysis: (a) benefits of supervision for prelicensed counselors, (b) perceived purposes of supervision of prelicensed counselors, (c) responsibilities attributed to supervisors of prelicensed counselors, (d) perceived professional needs of prelicensed counselors, (e) practices and approaches for supervising prelicensed counselors, (f) the process of supervision, (g) prelicensed counselor performance indicating successful supervision, (h) characteristics attributed to effective supervisors, (i) perceptions of ineffective supervision of prelicensed counselors, (j) concerns related to professional ethics, (k) training for supervisors of prelicensed counselors, and (l) recommendations for improving the supervision of prelicensed counselors. This manuscript features a summary of the findings in each of these categories.*

Significant changes in professional literature (Riordan & Kern, 1994; Swanson & O'Saben, 1993) and licensing laws (Borders & Usher, 1992) addressing supervision of counselors in the past decade have been documented. Fifteen years ago Goodyear and Bradley (1983) purported that "Our knowledge of supervision, the very cornerstone of [rigorous counselor] training, has not developed at the same pace as has our knowledge of psychotherapy or counseling . . . . Supervision is . . . a logical area of development for a profession . . . ." (p. 66). Carifio and Hess (1987) supported that assertion and suggested that little was known about the supervision process. The counseling profession's overt response is reflected in the growing body of literature available to supervisors of practicing counselors and counselors-in-training (Borders, Cashwell, & Rotter, 1995; Riordan & Kern,

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1994; Ronnestad & Skovholt, 1993).

Both empirical findings and practice suggest that professional needs of counselors change as they acquire experience (Fisher, 1989; Ronnestad & Skovholt, 1993; Stoltenberg & Delworth, 1987; Usher & Borders, 1993). However, minimal attention has been devoted to identifying the characteristics and traits for competent supervision of novice counselors who are provisionally licensed (Borders & Cashwell, 1992). Borders et al. (1995) called attention to this segment of professional development when counselors graduate from academic settings and engage in supervision to meet requirements for licensure, noting, "Little is known about supervisors of counselor licensure applicants or their supervisory practices" (p. 55). Borders and Usher (1992) had previously asserted that, "It is unclear what supervision is being provided and what types of supervision programs should be created. To make more informed decisions about post-degree supervision, existing practices first need to be described" (p. 594).

In response to this void in the professional literature, a comprehensive qualitative investigation was conducted to identify perceived needs and existing practices for clinical supervision of prelicensed counselors in Alabama. This manuscript features a summary of findings from this inquiry.

## Method

### Setting

This investigation, relying on in-depth interviews for data collection, was conducted in Alabama in 1995 (Magnuson, 1995). The Alabama Board of Examiners in Counseling (ABEC) regulations include a provision for entry-level counselors to practice as Certified Counselor Associates (CCA) under the supervision of a Licensed Professional Counselor (LPC) for a period ranging from one to three years prior to being licensed to practice independently (ABEC, 1995). In 1995 ABEC revised the regulation to require additional clinical experience and educational preparation for the supervisors of these prelicensed counselors (ABEC, 1995). This inquiry was conducted with authorization and endorsement of ABEC, and was completed prior to the implementation of the increased supervisor requirements.

### Participants

Participants for this study represented three groups: (a) supervisors of prelicensed counselors, (b) prelicensed counselors, and (c) counselor educators. The supervisor informants were recommended by the Executive Officer of ABEC as potentially "information rich" (Patton, 1990, p. 169) contributors. Prelicensed counselor informants were randomly selected from those who had completed at least one year of the required supervision in order to become an LPC. Counselor educators represented masters level programs from which graduates met ABEC educational requirements.

Three (3) counselor educators, four (4) prelicensed counselors, and five (5)

supervisors participated in the inquiry. The counselor educators reported teaching experience within a range from 7 to 25 years (median=23 years). Supervisors reported counseling and supervising experience ranging from 2.5 to 25 years (median=18 years). Supervisors reported experience in supervising from 1 to 25 (median=3) prelicensed counselors during a span of time ranging from 4 months to 16 years (median=10 years). The prelicensed counselors had graduated from masters level counselor education programs between the years of 1991 and 1993, and had been practicing under supervision for at least one year.

**Interviewer and Interview Procedures**

Information related to the supervision of prelicensed counselors was solicited during semi-structured interviews conducted by the primary investigator. The investigator had supervised masters level counseling students during practica and internships. She was licensed; however, she had not provided supervision for prelicensed counselors.

While the interviewer endorsed the importance of supervision across the professional lifespan and advocated clarity in standards for the practice of supervision, she had minimal knowledge of the existing practices for supervising CCAs. She had no a priori assumptions about the participants, their specific practices, or their perceptions related to supervision of CCAs. Adopting the posture of a student (Spradley, 1980) the investigator conducted the interviews to learn about the participants' perceptions and experiences (Merriam, 1988).

Nine (9) of the interviews took place in the participants' offices, and three (3) were conducted via telephone. The time required for interviews ranged from 40 to 90 minutes; typical interviews lasted approximately 65 minutes. The interview process was continued within each informant group until the investigator perceived "saturation" (Strauss & Corbin, 1990, p. 188) was attained.

The researcher endeavored to demonstrate credibility with strategies for establishing triangulation and member checks as recommended by Lincoln and Guba (1985). Multiple participants from three sample groups and combined sampling techniques contributed to opportunities for triangulation (i.e., purposeful random selection of prelicensed counselors, typical case selection of counselor educators, and intensity selection of supervisors). Throughout the interviews, the investigator summarized, clarified, and requested verification of information provided. She endeavored to maintain neutrality and acquire accurate and complete data with reflective listening strategies (Merriam, 1988). Subsequent to each interview she encouraged the informant to submit additional or different information. All interviews were audiotaped and transcribed. After the investigator reviewed the transcripts she submitted them to the participants for verification. Following Lincoln and Guba's (1985) guidelines, a research auditor reviewed tapes, transcripts, and the interviewer's journal to verify accuracy and dependability of interview data and analytic procedures.

### Data Analysis

The data were analyzed throughout the investigation according to established guidelines (Lincoln & Guba, 1985; Stainback & Stainback, 1984; Strauss & Corbin, 1990). Formal analysis included transcript notations of emergent themes. Separating and filing transcript elements according to preliminary codes enabled organization of the data, and recognition of patterns (Bogdan & Biklen, 1992; Patton, 1987). A synthesis of the data ultimately reflected 12 categories. "Cross-interview" (Patton, 1987, p. 376) analyses were conducted within each thematic category to identify areas of convergence and divergence (Bogdan & Biklen, 1992; Patton, 1987).

## Summary of the Findings

### Benefits of Supervision for Prelicensed Counselors

Participants in all groups corroborated the importance of supervision for prelicensed counselors. Benefits were cited not only for prelicensed counselors receiving the supervision but also for their supervisors and their clients. Additionally, participants identified advantages for the counseling profession, the general public, and universities. Specific advantages identified for prelicensed counselors included enhanced awareness of the therapeutic process, increased knowledge, and personal growth.

A prelicensed counselor's comments were consistent with other participants. She characterized her experience as "pleasurably necessary" and added, "I can't imagine turning people loose to do this on their own with no accountability . . . . We need supervision because this is a tremendously complex field . . . ."

### Purposes of Supervision of Prelicensed Counselors

The participants' contributions revealed purposes of the required supervision which fell into the broad categories of prelicensed counselors' professional growth and maintenance of professional standards. The theme of accountability seemed to permeate both categories. One participant characterized the process as that of a mentor introducing the entry-level counselor to the profession with guidance and facilitation, while concurrently overseeing his or her work to protect the public.

Other references were made to prelicensed counselors learning to function autonomously and demonstrating their mastery of requirements to become licensed professional counselors according to the Alabama Code (Act 79-423). A supervisor suggested that supervision provided a mechanism for affirming "to the Board and to the public that this person meets the requirements that the Board of Examiners set up for people who are going to be LPCs." Another supervisor added, "It's a real quality control kind of dynamic where the . . . masters level counselor has a . . . mentor looking over that shoulder . . . ."

### Responsibilities Attributed to Supervisors of Prelicensed Counselors

Participants also identified dual supervisor responsibilities in the contexts of

monitoring the work and simultaneously facilitating the professional growth of prelicensed counselors. They indicated that supervisors were responsible to the prelicensed counselor, the clients, the counseling profession, professional colleagues, and the general public. A supervisor amplified her perception of her responsibilities by saying, "I see it as a very, very big responsibility." She went on to say the magnitude of the task was much greater than she had anticipated.

Another supervisor's contribution seemed to capture the essence of others. She stated:

> *I think the responsibility is dual in that I'm certainly responsible for the services that the supervisee renders to the client. I know the Board expects me to be responsible for that and I take that very seriously. I could be held ethically, legally responsible for those services. And then my responsibility to [the supervisee] is to provide the very best supervision that I could provide her and to give of my own knowledge and experience to the best of my ability, and to monitor that . . . .*

**Perceived Professional Needs of Prelicensed Counselors**

Counselor educators, supervisors, and prelicensed counselors discussed professional needs that should be addressed or met in supervision. Participants generally suggested that supportive, semi-structured supervision directed toward their functioning as autonomous counselors was most conducive to prelicensed counselors' professional growth. A counselor educator shared an observation that students leaving her program needed "enough room to grow and enough room to process what is going on." She referred to the "challenge and support model" as appropriate for prelicensed counselors.

Counselor educators also recommended augmentation of academic preparation addressing specific areas of pharmacology, ethics, diagnostic skills, therapeutic goals, and treatment plans. Professors further suggested that prelicensed counselors needed additional guidance and direction in discerning therapeutic boundaries and instruction in integrating theory with practice. Support in learning how to professionally operate with colleagues in an agency and encouragement to network with other counselors and become involved in professional associations were also mentioned.

A supervisor discussed her observation of prelicensed counselors' professional needs. Specifically she noted,

> *With beginning CCAs, especially if they are inexperienced, I believe it is important to emphasize their developing the ability to evaluate their responses, to discriminate between facilitative and nonfacilitative responses (similar to the Carkhuff training model). Not only does this emphasis, in the beginning, help with specific skill-building, but it also encourages, I believe, the CCA to clarify further his or her approach to and philosophy of counseling.*

Another supervisor endorsed the counselor educators' desire for supervisors to assist graduates in undergirding their clinical skills with a practical knowledge of counseling theories. This supervisor stressed, "I want them doing clinical reading along with the work in the consultation room . . . ." He indicated that it was imperative for developing counselors to become fluent in theoretical models so that they could respond to the question, "Why did you do what you did when you did it?" The informant emphasized his expectation by saying, "It becomes real important that folks . . . are not flying by the seat of their pants."

Prelicensed counselors perceived that their professional needs included information, direction, opportunities for professional networking, and support. One emphasized, "I need someone that's available when [I] need him [or her]."

Recognizing boundaries between responsibilities of the client and responsibilities of the counselor was mentioned by informants in all three groups. A counselor educator suggested that inexperienced counselors "get out and they don't have boundaries set up that are healthy for them or sometimes healthy for the client." A supervisor supported that perception when she said,

> *I think in our profession we want to give the best quality of care we can give, but we've got to understand the boundaries of that. And I think that's important. I think teaching a CCA how to put distance yet keep closeness is a very hard lesson to learn. But it has to be learned . . . . As much as you want to help people, you can't change them. They have to change themselves. And all you can do is guide them. I think teaching a CCA how to give the client back the responsibility for [his or her] own behavior is very, very important.*

**Practices and Approaches for Supervising Prelicensed Counselors**

A wide latitude for procedures, structure, and requirements became evident in the data collection and analysis processes. Some supervisory relationships were reported to be initiated with extensive structure and requirements primarily directed by the supervisor. Others were designed for flexibility with primary direction of the supervisory sessions being determined by the prelicensed counselor. A supervisor disclosed a factor that may contribute to the latitude or practice: "I haven't had much dialogue with other supervisors who supervise CCAs . . . so I haven't known what other counselor supervisors of CCAs do."

Initial assessment practices to determine levels of skill upon entering supervision ranged from systematic review of audiotaped counseling sessions and contacts with former counselor educators to less defined observations extended over a period of time. A supervisor discussed his initial strategies for assessment by saying,

> *I sit down and talk with them. I want to find out who they are and where they've been and what their life experiences and what their education background is, and what kind of counseling experience they've had, and as best we can, to identify from their point of view strengths and weaknesses. And if I can get any feedback from refer-*

*ences of supervisors that they have had previously, that becomes an important piece of data . . . .*

*The first four or five times that I work with a CCA I want to really take a close-in look at . . . how they meet and greet and do assessment, and begin to formalize a treatment plan . . . . That's the first part of how I begin – is how* ***they*** *begin.*

A less systematic approach was described by another supervisor:

*Time . . . . I used my therapeutic tools to kind of assess the situation, and see where she was stronger. And that's one thing I've tried to help her do . . . to find out where her strengths are . . . .*

Variation also existed in practices for continued assessment of the applied skills of prelicensed counselors. One supervisor required a quarterly evaluation; more typically, supervisors and prelicensed counselors relied on the licensure board's annual reapplication requirement as the formal assessment. All prelicensed counselors and two supervisors indicated that supervisors provided ongoing informal skills assessment coupled with extensive feedback. Prelicensed counselors repeatedly emphasized the value they placed on extensive feedback provided by their supervisors.

A variety of related requirements was also reported by the respective participants. Two supervisors indicated that they held an expectation for professional reading to accompany formal supervision sessions. Some supervisors required prelicensed counselors to submit audiotapes of counseling sessions only at the onset of supervision; other supervisors did not require any tapes. One informant reported that tapes were submitted for review on a weekly basis throughout the period of formal supervision.

Variation in practices also was discussed in the context of case monitoring. At one extreme a prelicensed counselor said the supervisor discussed each active case each week, while another prelicensed counselor indicated the supervisor actively directed the delivery of counseling services. In contrast, a prelicensed counselor indicated that the supervisor reviewed only cases presented by the prelicensed counselor during supervision sessions.

Participants generally described an individual supervision modality; during two interviews, the participants indicated that weekly individual supervision sessions were supplemented with monthly group supervision featuring a didactic focus. One supervisor offered a preference for working with prelicensed counselors in cotherapy when appropriate.

**The Process of Prelicensed Counselor Supervision**

Supervisors described developmental processes they had observed when working with prelicensed counselors. Accounts generally reflected initial dependence followed by a gradual growth in confidence, acumen, and proficiency. Prelicensed counselors appeared to value the development of their supervisory relationships, most reporting trends toward collegial interactions as the supervisory relationship matured.

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A supervisor described advanced prelicensed counselors as "more relaxed, allowing themselves to become more real." He amplified his experience with an observation of "vast improvement in documentation." Another supervisor said, "On the tape as well as [when] she talks about a case, I can hear the confidence. She's not as tentative." Yet another supervisor characterized the process by saying,

> *I also see that the counselor can anticipate how long it will take, rather than not knowing . . . . That's probably one of the biggest changes. To understand the therapeutic process, and to understand it's going to end someplace, and that you're in fact an important person in the direction of that . . . rather than going by the seat of [your] pants saying, "I don't know what to do with this. I don't know where we're going with this . . . ." The experienced counselor has confidence in him or herself to enact the treatment.*

**Prelicensed Counselor Performance Indicating Successful Supervision**

A general tenor of tentativeness and uncertainty prevailed during discussions addressing indication of successful supervision. Suggested indicators included characteristics and skills such as astuteness in case conceptualization and treatment planning, versatility in the application of theoretical models, mastery of facilitation skills, and judicious understanding of ethical guidelines. Participants also emphasized professional conduct as well as an established professional network as indices of successful supervision.

The following contribution, in which a supervisor delineated criteria he expected prelicensed counselors to attain prior to the culmination of the required supervision, is representative of other statements.

> *I want them to have developed good skills at every level of the counseling process--good assessment and evaluation and diagnostic skills. I want them to be able to really make clear treatment plans, and have that be one that is . . . really the client's treatment plan, the client's direction related to the client's needs, the client's desires and hopes to change in their life . . . .*
>
> *And learn how to . . . do self-supervision, where they can see themselves, where they can make mistakes, where they can see where they struggle, where they can see when they need professional consultation once they become an LPC. So then they have a clear sense of identity, of who they are, what they do, what the ethical and legal parameters are for the profession . . . .*

Another supervisor emphasized process by saying,

> *Have they developed the therapeutic rapport? Is the [supervisee] following through with the homework or the preparation for next session? What is the feedback from the clients? What are the measurement tools being utilized to evaluate gain?*

This informant also stressed self-supervision: "How do they see it going? What are their concerns? What are their triumphs? Their response to the process

is imperative . . . ."

**Characteristics Attributed to Effective Supervisors of Prelicensed Counselors**

Participants from all groups characterized effective supervisors as professional role models who were interested and invested in the professional growth of the prelicensed counselors as well as their clients. Other qualities associated with effective supervisors included the ability to discern and respond to the needs presented by the prelicensed counselors, a commitment to modeling and encouraging involvement with professional associations, and proficiency as a skilled counselor. Participants in all groups emphasized the importance of a supervisory relationship facilitated by supervisors' conveying support, acceptance, positive regard, encouragement, and availability. In this regard, participants consistently affirmed that effective supervisors challenge growth and offer extensive feedback to supervisees.

A counselor educator asserted, "I just really believe in the relationship . . . . The ingredient is the . . . supervisor. That's the ingredient . . . . You can be a good *this* kind of supervisor. You can also be a good *this* kind of supervisor." Similarly, a supervisor said, "More of education is caught than it is taught. So there's a part of my being *with* them and allowing them to be *with* me, and hopefully, they're going to catch something from me that works."

Mentoring affiliation and involvement with professional associations was endorsed by other participants as well. A counselor educator who also supervises prelicensed counselors termed the practice as "professionalization." He explained,

> *And another component . . . is what I call professionalization of the CCA. That is, how do we inculcate this person into the profession, and to be a person who adheres to the philosophy and principles of counselors and the specialty groups? . . . I think there should be an advocacy on the part of the supervisor to get these folks into the professional organizations, active in all kinds of roles, both in service to the professional organization and also [taking] advantage of the services of the professional organization.*

The importance of feedback was consistently stressed by the participants. Prelicensed counselors expressed their desire for clear and extensive feedback. A counselor educator commented,

> *I'd like that supervisor to . . . be instrumental in the growth of the counselor in terms of . . . strengths and weaknesses. I would like to . . . have that supervisor be honest--be critically and professionally honest . . . .*

Three prelicensed counselors also indicated a preference for having supervisors who don't "easily just answer things and make it easy." A specific example was offered in response to a question related to supervisor interventions that had been particularly helpful:

> *I would have to say where he has not given me the answers, but made*

> *me go find them--say, "You've made this judgment. You've made this call. There's something else there. Think about the relationships . . ." and make me do a little of the work . . . . He makes it to where I feel like I'm competent with my own skills.*

Another prelicensed counselor seemed to support this practice as effective when she indicated, "I think it would be helpful to me for them to push me a little and say, 'How do you see handling this case?'".

**Perceptions Related to Ineffective Supervision of Prelicensed Counselors**

The investigator posed questions related to ineffective supervision practices. A prelicensed counselor responded with a specific example that seemed representative of other participants' responses. He related information about another entry-level counselor who was working toward licensure. The informant related disparate requirements and opportunities for professional growth, by saying

> *Although there wasn't any direct supervision. The CCA sent a letter to the state saying, "I've been in this situation two years. This person's an immediate supervisor . . . ." And I felt like this person said, "This is just a requirement I've got to satisfy" and didn't see it as growth.*

Counselor educators corroborated that observation by suggesting that ineffective supervisors would not meet with the prelicensed counselor, rendering them isolated and without support.

A supervisor spoke of a personal style of supervision that he had experienced as ineffective. He called it the "old two-by-four confrontation." The informant elaborated by saying, "They just beat the crap out of you with a two-by-four early on . . . . I learned that you lose a quarter of training for them to get to a point of being okay and trusting you . . . ."

An additional contribution was in the context of power. A supervisor asserted, "The need to be in control or have power over someone else . . . would undermine the person's confidence in doing the job." This seemed consistent with a response offered by a supervisor who discussed "the potential for abuse of power that exists in . . . the supervisory relationship."

**Concerns Related to Professional Ethics**

Participants discussed professional ethics in a variety of contexts. The preponderance of the references to ethical issues was related to appropriate supervisory boundaries and dual relationships. Relatedly, several participants qualified their discussions of supervisory relationships by stressing the absence of therapeutic involvement between supervisors and supervisees. One informant suggested that business associates in a private practice who engage in a supervisory relationship might encounter dual relationship dilemmas. Providing supervision for former counselor education students was also questioned.

Addressing dual relationships, a supervisor asserted, "Under no circumstances do I want to move into a therapy model . . . . It's a fine line for sure, but I think

most of us know when we are moving into that therapeutic model." This supervisor emphasized that he refrained from engaging in social relationships with prelicensed counselors working under his supervision.

Another supervisor disclosed concerns in the context of religious and political orientations. She spoke of possible misuse of power within the hierarchical nature of supervisory relationships by saying,

> *I think there's that potential . . . for the abuse of power if I try to use the supervision relationship to promote a particular political [or] religious view . . . . Another issue I think the Board has to address is whether we are going to deal with LPCs out there who are espousing a particular religious view . . . . I think that that's going to be increasingly an issue, and the code of ethics says very clearly that we don't use the counseling relationship to impose any particular religious, political point of view . . . . I think the supervisory relationship could be used the same way . . . . I think we need heightened awareness about how the counseling relationship and how the supervisory relationship can be misused . . . .*

Specific infractions demonstrated by prelicensed counselors were noted by one supervisor. Breaches of confidentiality, leaving open charts on desks, and using a name inappropriately in public were the bases for these comments. The supervisor emphasized his concern by saying, "Situations like that obviously are not a part of the agreement [and] have to be addressed and redirected . . . . It is a part of the learning process . . . ."

**Training for Supervisors of Prelicensed Counselors**

The importance and value of training for persons supervising prelicensed counselors was endorsed by counselor educators and supervisors. The counselor educator participants asserted that formal training was a necessary prerequisite for attaining levels of competency as a supervisor. Supervisors also expressed a desire for specialized training in counselor supervision.

Supervisors were asked to describe training opportunities that would be helpful to them. One supervisor quickly responded, "Let me answer it in one word: Validation." He elaborated,

> *Ideally, I would like to . . . be provided a format, a structure, with a lot more theoretical base than what I have--something that I can reference to as opposed to my experiences which led me to certain decisions . . . .*

Supervisors also gave examples of questions they would like to have answered. "How much do you watch over them or how much you don't?" "What do you need to cover with a CCA?" "What is our responsibility as a supervisor?" and "What does the board expect us to do?"

**Recommendations for Improving the Supervision of Prelicensed Counselors**

The participants of the study consistently indicated that the processes of super-

vision of prelicensed counselors would be strengthened with more clarity in expectations. This area of deficiency was particularly noted in the comments submitted by supervisors and prelicensed counselors. A prelicensed counselor asserted that she would be more comfortable if supervisors were "held to a higher accountability for some of the people that they supervise to get their license."

Supervisors indicated that the supervision required for prelicensed counselors would be more credible if expectations were clarified. One supervisor said,

> *I would feel more comfortable if they sent me a list and said, "We want to make sure all these things are covered in supervision. Make sure you cover each of these things, and anything else that you feel like is necessary."*

Another supervisor suggested that more people should be involved in evaluating successful completion of the supervision required for developing counselors prior to their being granted a license. This informant said, "We haven't had, as a part of the CCA process, anyone other than the training supervisor to put the stamp of approval on them, and I think that is a weakness."

Counselor educators particularly emphasized that the required supervision would be strengthened with training and increased standards for supervisors. One suggested, "Supervision is a different set of skills within the counseling profession . . . . Most supervisors I know . . . don't even know that there are standards for supervision."

Participants alluded to collaboration between university based supervisors and postgraduate supervisors. A counselor educator had observed that students graduate from the masters level programs without a clear understanding of the supervision process. This observation was supported by a prelicensed counselor who said,

> *How do you learn about supervision? Just by the supervisors you've had. So, what supervision is supposed to be--I just don't have the foggiest idea. All I know is what it has been to me.*

A counselor educator concurred. She supported her perception by asserting,

> *Probably the number one concern that I have for . . . students is that I think they need to come out of their clinical experiences with the counselor educators linking them into models, to mentors, to continued professional development, and to* ***really*** *good training experiences . . . .*
>
> *It's a huge omission. I put it down as the area of my biggest concern. I don't even call it a gap. I call it a gorge . . . . What I experience with students is that, toward the end of their program, they become angry. They see what's ahead, and they think, "I've got to make something happen, and I don't know how I'm going to do this. I've got 'this and this and this' in my life and I don't earn a living, and yet I've got to get supervision in three years. Who is going to do this for me? Who would I want to do this? I don't even know anyone*

*well enough to know if I'd want to have them for a supervisor." We tend to drop them at this point.*

This idea was endorsed by another counselor educator who acknowledged a responsibility to model effective supervision so graduates would "know to demand it." She added, "I feel like I have to include that in their education because . . . they don't know what supervision is, and they don't know what should be expected."

## Discussion

Qualitative research methods amassed preliminary descriptive data related to perceived needs and practices for supervising prelicensed counselors in Alabama. However, these procedures for data collection and analysis have noteworthy limitations. Both conclusive interpretation of the data and generalization to the larger public would be inappropriate. Indeed we expect that other supervisors, prelicensed counselors, and counselor educators would offer diverse perceptions and describe inconsistent experiences. Nonetheless, these findings invite consideration and exploration of vital issues that can be generalized to the supervision of prelicensed counselors.

For example, participants corroborated Ryan's (1978) observation that mechanisms for systematic articulation from academic to postgraduate supervision experiences were inadequate. Postgraduate supervision appears to have become a culminating component of the formal training sequence for counselors working in community settings. The counseling profession has established consistent academic training standards with increasing levels of rigor. Less consistency or coordination has been demonstrated for postgraduate training and supervision. What implications for curriculum planning, postgraduate supervision, and collaboration would result if supervision for prelicensed counselors were explicitly viewed as the culminating component of formal preparation?

The participants in this inquiry described a wide latitude of supervisory approaches and requirements. At the same time, they consistently expressed desire for uniformity and clarity in responsibilities attributed to supervisors and standards expected of supervisees prior to the culmination of licensure board required supervision. To what extent would specified parameters for supervision be inconsistent with the counseling profession's advocating professional diversity and specialization of practice? How would standards be enforced and monitored?

Findings of this inquiry also summon continued research to guide the counseling profession in preparing "supervisors to optimize the effectiveness of their trainees, who in turn will increase the well-being of their clients" (Holloway & Hosford, 1983, p. 76). The identification of effective and efficient training opportunities for supervisors or prelicensed counselors begs attention. Further, single subject case studies and outcome based inquiries would enhance our collective knowledge of effective supervisory approaches, practices, and interventions for promoting professional growth of prelicensed counselors. Longitudinal investi-

gations of postgraduate professional growth during the limited span of time between graduation and licensure would lend precision to determining appropriate sequencing of interventions and time requirements.

The counseling profession has demonstrated commendable progress in legitimizing the practice of counselor supervision. However, inquiry and advances in this complex specialized area of practice have introduced dilemmas to resolve and questions to answer. Explicit responses to these dilemmas and unanswered questions will contribute to the integrity of both academic preparation and postgraduate supervision provided for counselors in training.

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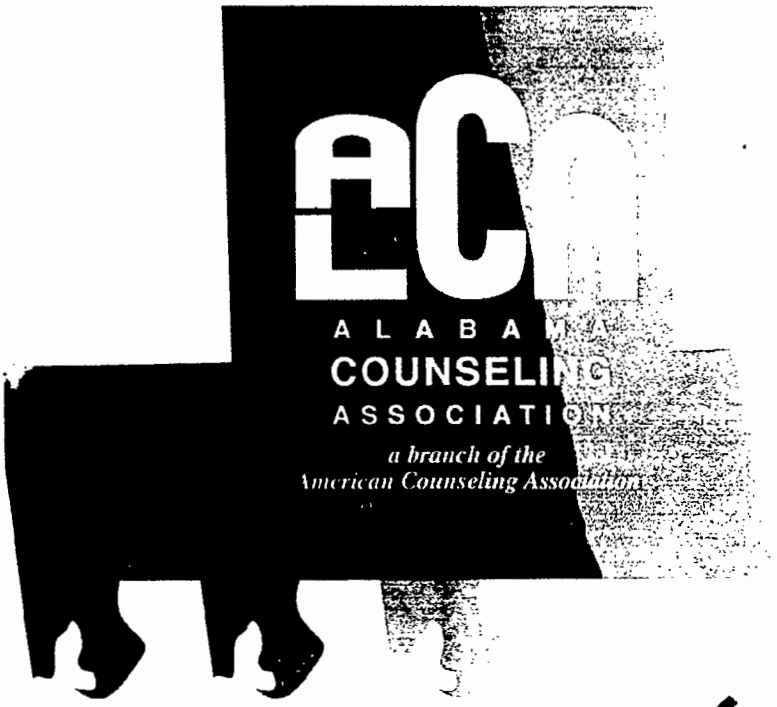


# The Alabama Counseling Association Journal

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# The Alabama Counseling Association Journal

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## *Articles*

# *Editorial from ALCA President Sherry Quan*

As we approach the new millennium, many of us will encounter major challenges similar to those our clients must face: changes in technology, changes in business and industry methodology, social and cultural diversity, voids in experienced leadership, and a "graying America." The counseling profession will concurrently be affected by these same variables. While the profession still suffers from an identity crisis, it becomes even more important for us to disseminate current research and best practices in the field.

A strong need for knowledge continues to exist among our colleagues. The school counselor's role has increasingly become multifaceted with the impetus for reduction of school and community violence. Only a fine line separates the alliance of the mental health counselor, psychologist, and school counselor. The concept of teamwork is not new, but is a skill or organizational technique that will improve our chances of survival in the new millennium.

We can no longer accept the status quo, for doing so may result in our doom. A foundation of preventive counseling practices can only be obtained through our willingness to become proactive with our profession. Collaboration via hardcopy publications and the internet may fill the void in communities where there are limited resources. Each of has an obligation to "publish or perish." Feel free to contact me if you wish to share information, discuss issues, or brainstorm how we may make our journal more viable as we approach a new age of the counseling profession.

*Sherry*

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## Comments from the Co-Editors

Serving as co-editors of *The Alabama Counseling Association Journal* has become a profitable, stimulating, and enjoyable professional experience. We place great value on the high level of trust that was demonstrated by the Alabama Counseling Association when we were asked to accept the editor position. We send our last issue to the printer with ambivalence; yet we're confident that the new editor will introduce Volume 25 with fresh ideas and energy.

Among the unexpected joys of editing *The Journal* were the relationships that developed with the authors through the labor intensive revision process. As we close files, it's fun to observe changes in tenors of correspondence as we flip from the back of the file to those entries stapled on top. We have taken the liberty to share one of the less formal end-of-the-process notes that prompted laughter and delight. An author wrote, "If anyone can turn a sow's ear into a silk purse, it is you guys!" Well, we think that the author kindly overstated our investment in the pretty doggone good article. In turn, we ought to extend that same sentiment to several editors to whom we've submitted manuscripts! We have appreciated the incredible sensitivity shown by several of the authors while we were moving. . . . Perhaps working on the final issue during the holidays provided additional opportunities to share good wishes.

We would be remiss if we did not express our deep felt gratitude to the members of the Editorial Board. Can you imagine receiving an e-mail during the second week of December asking for volunteers to do an emergency review so a manuscript could be considered in time to include in the winter issue? More folks volunteered than we needed. That's commitment! We've often said the feedback provided by *Alabama Journal* Editorial Board members could strengthen manuscripts so they would be quite competitive at the national level. Make no mistake, folks, the *Alabama Journal* Editorial Board consists of highly competent professional writers. Their contributions to the *ALCA Journal* and to submitting authors warrant respect and appreciation.

As we began compiling the articles for the Winter Issue, we were pleased to have entries that addressed a variety of topics. At the same time, something seemed to be missing. We pondered what that missing element might have been, and what we could do to fill it. We reviewed manucripts in early stages of the review process; the unidentified void remained. We then drew from our solution-oriented strategies. To whom have we turned when we had "such minor emergencies" in the past? Of course! Former colleagues! As he always does, Editorial Board Member Darrell Luzzo responded to our request to write a feature article with enthusiasm and optimism! "Sure, I'll do it, but you need it by what date?!" Fortified by Darrell's contagious energy and affirming response, we con-

tacted our dear friend and former colleague, Jan Kratohvil. "Could we print your breaking traditions poem in the *ALCA Journal*?" We're so pleased to conclude Volume 24 with one of her many poems that only friends have been privileged to read prior to now.

Regardless of your area of professional practice, we're confident that you'll be inspired with the ways Darrell Luzzo drew from Michael D'Andrea's RESPECTFUL Counseling Model to enhance sensitivity of career counselors. The Joe Law, Anna Costarides, and Vaughn Millner article should be of interest to counselors in many settings as well. These authors report interesting results of research investigating substance abuse counselors' vocational identity and work related stress. Patricia Kennington's article provides an historical overview of managed care, and addresses related dilemmas and challenges. Marijane Fall elucidates self-efficacy theory and calls attention to ways syntax cues can send ill-advised messages to trainees and clients. We hope you will be as fascinated by John McCarthy's retrospective book review of an archival 1911 text as we were. And, we're confident Dr. Glenda Elliott's comments will prompt reflection, examination, and dialogue related to various ways that professional power can be misused. Indeed, Volume 24, Number 2 of *The ALCA Journal* contains strong "thought provoking articles, theoretical summaries, reports of research, descriptive techniques, . . . discussions of professional issues, . . . and review of books" (quoted from *The Journal's* mission statement).

Thank you for entrusting the *Alabama Counseling Association Journal* to us for the past two years. We extend fond wishes to our many close friends in Alabama, and to the association.

Ken Norem and Sandy Magnuson

# Respectful Career Counseling

DARRELL ANTHONY LUZZO

*This article describes D'Andreaís (1995) RESPECTFUL counseling model and discusses various ways the model can be integrated into career counseling interactions with diverse clientele.*

In recent years, counselors have increased efforts to more fully develop multicultural counseling skills and incorporate the role of cultural factors into their work with clients. This increased attention to multicultural issues has led to a growing literature base on such topics as the impact of ethnic identity in counseling (Helms, 1986), the role of spirituality in counseling (Burke & Miranti, 1995; Hinterkopf, 1994), the counseling experiences of gay, lesbian, and bisexual persons (Chung, 1995; Prince, 1997), and the career development of racial and ethnic minorities (Leong, 1995).

Empirical studies have been conducted, conceptual arguments have been made, and theoretical models have been developed to increase counselors' understanding of effective strategies and techniques that can be used when working with diverse clientele. Back in 1995, at the American Counseling Association's national conference in Denver, Colorado, Michael D'Andrea presented one such model. Using the acronym, "RESPECTFUL," D'Andrea described what he referred to as an"integrative model for counseling practice in a pluralistic society."

## An Overview of the RESPECTFUL Counseling Model

Each letter of the acronym, RESPECTFUL, denotes one aspect of what makes each client we serve a unique individual: R (Religious and Spiritual Orientation), E (Economic Class Standing), S (Sexual Identity and Orientation), P

*This invited feature article was written exclusively for The ALCA Journal by* ***Dr. Darrell Luzzo****. While Darrell is a well known leader in fields of career development and research, he is no stranger to many ALCA members. Darrell has erved on counselor education faculties at The University of North Alabama and Auburn University. He is also a former officer of the Alabama Association for Counselor Education and Supervision, and continues to serve as a valued member of the ALCA Journal Editorial Board.*

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(Psychological Maturity), E (Ethnic/Cultural/Racial Backgrounds), C (Current Chronological Challenges), T (Threats to Personal Wellness and Sources of Social Support), F (Family History and Influence), U (Unique Physical Characteristics), and L (Location of Residence). According to D'Andrea (1995), the more counselors are able to fully integrate each of these factors into their work with clients, the more likely their counseling interactions will be effective and meaningful for clients and counselors alike.

D'Andrea (1995) introduced the RESPECTFUL counseling model to professional counselors in hopes of encouraging them to more effectively meet the diverse needs of clients. It is a model that suggests a process of client and counselor assessment that helps to ensure a more "respectful" interaction between clients and counselors. In essence, RESPECTFUL counseling can play an important role in helping counselors and clients establish and maintain a meaningful therapeutic relationship.

The purpose of this article is to describe the RESPECTFUL counseling model and discuss the ways in which it can be used by counselors when providing career counseling services to persons of all ages. Although this presentation is not comprehensive, its aim is to provide readers with a general overview of the model and introduce readers to strategies that can be used when assessing clients' needs within the context of career counseling.

## The RESPECTFUL Counseling Model: Applications to Career Counseling

### Religious and Spiritual Orientation

According to D'Andrea (1995), religious and spiritual orientation involves understanding how a person's religious and spiritual beliefs influence her or his psychological development and daily functioning. Within career counseling contexts, attending to a client's religious and spiritual beliefs and seeking to understand how such beliefs affect the client's overall psychological functioning is of paramount importance. Although recent advances have made within the counseling field in general to more fully incorporate issues of spirituality (Burke & Miranti, 1995; Hinterkopf, 1994), little research has been conducted to empirically evaluate strategies for integrating discussions of spirituality into career counseling.

There are several ways in which a counselor might begin the process of eliciting religious and spiritual orientation information from clients. D'Andrea (1995) suggested asking clients to talk about their spiritual beliefs and values. When doing so, clients may provide counselors with information that may make it easier to determine the degree to which a client's spiritual/religious beliefs influence her or his life. As a client's religious and spiritual orientation is clarified, career counselors can consider discussing with the client ways in which her or his spiritual orientation might be incorporated into the career decision-making process.

For example, a client who indicates a strong propensity for spending time outdoors, where she can enjoy the beauty of nature and feel a true sense of inner peace, could be encouraged to consider exploring careers (e.g., game warden, forest ranger, conservationist) that might provide multiple opportunities for working in outdoor environments. A client who values a significant amount of "quite time"each day for peaceful meditation and reflection may want to consider career options that would be likely to provide ample opportunities for such experiences. The important thing is to encourage clients to discuss their religious and spiritual beliefs. As a client begins to express her or his religious and spiritual orientation, counselors can more effectively evaluate ways in which such beliefs and values may influence the client's career development.

**Economic Class Standing**

D'Andrea (1995) recognized that the evaluation of one's economic class standing is often based on arbitrary and sometimes even artificial parameters. Although one of the most common ways to evaluate a person's social class is to ask about her or his annual family income, counselors may be able to determine a client's social class via other means as well. When working with children in a school setting, for example, counselors may have access to school records or may know whether or not a particular child participates in the reduced fee/free lunch program. When working with adults, counselors may be able to determine clients' economic class standing of their clients by asking for income information as part of a routine intake interview or by gathering relevant records from clients.

Taking the economic class standing of clients into consideration when providing career counseling services is underscored by some of the principles associated with Maslow's hierarchy of needs. After all, if clients are purely motivated to seek work in order to meet some of their basic physiological needs (e.g., food, shelter), then counselors may want to spend the majority of the time with such clients helping them to develop job seeking skills, such as resume writing and interviewing. If, on the other hand, a client's basic physiological needs are already being met, then a counselor may want to encourage the client to engage in a more extended career exploration process.

**Sexual Identity and Orientation**

Although many counselors initially avoid discussions with their clients regarding sexual identity and orientation, D'Andrea (1995) believes that by incorporating such information into the counseling process, counselors can more effectively assess clients' perspectives and presenting needs. According to D'Andrea, the question counselors need to ask as they discuss this aspect of personality with a client is, "How does this client's sexual identity and orientation impact her or his psychological disposition?" Within the context of career counseling, additional questions become equally relevant: "How might the client's sexual identity or orientation be viewed by the client as a potential barrier to career satisfaction and success," and "Has the client experienced any discrimination or been the target of prejudicial comments on the basis of her or his sexual identity?"

Although there has been relatively little research on the role of sexual orientation and gender identity in career development, recent advances are being made to increase our understanding of such factors and their importance in career decision making (Chung, 1995; Prince, 1997). Career counselors are sure to benefit from reviewing contemporary literature on such topics. Frequent reading of professional journals (e.g., the *Career Development Quarterly, Journal of Career Development, Journal of Career Assessment*) is an important way to remain aware of new insights and relevant empirical research.

**Psychological Maturity**

As nearly all counselors will attest, clients of the same age often think and act very differently. The notion of psychological maturity reflects our understanding that the rate of psychological development varies from person to person. As such, it is important for counselors to avoid assumptions about clients based solely on factors such as age or educational standing.

The field of career counseling has a rich history of addressing the psychological maturity of clients. Some of Donald Super's most substantial contributions to the field have included descriptions of what he referred to as *career maturity* (Super & Thompson, 1979). John Crites, a colleague of Donald Super's, further developed the construct of career maturity, noting that career maturity includes both an affective (i.e., attitudinal) as well as a cognitive component (Crites, 1971). Crites argued that understanding the career maturity of clients is an important and necessary step in developing appropriate career counseling interventions. Nevertheless, many counselors often fail to consider a client's psychological or career maturity when providing career counseling services.

There are several ways counselors might assess the career maturity of clients, including the use of commercially published career maturity assessments, such as the *Career Maturity Inventory* (Crites & Savickas, 1995) or the *Career Development Inventory* (Super, Thompson, Lindeman, Jordaan, & Myers, 1981). Counselors also might consider clinical interviewing as a method for assessing the career maturity of clients. Questions can be asked to elicit information regarding clients' general attitudes toward making career decisions and their knowledge of career decision-making principles.

Clients with a relatively high level of career maturity tend to express little anxiety or concern about making career decisions and exhibit a clear understanding of career decision-making principles (e.g., an awareness of methods for gathering career information, skills associated with weighing the pros and cons of various career options). On the other hand, clients with relatively low levels of career maturity tend to be very anxious about making career decisions and may lack many of the career decision-making skills that are required for effective career development. Rather than assuming that all clients who are undecided about their career direction should complete an interest inventory or take a career exploration and planning course, counselors need to determine the career maturity of clients and gauge the appropriateness of various treatment options.

**Ethnic/Cultural/Racial Backgrounds**

Hundreds of journal articles, book chapters, and monographs have been published in recent years to increase counselors' attention to the role that clients' ethnic and racial backgrounds play in the counseling process. Much of the multicultural counseling literature has focused on ways that counselors can increase their knowledge of the common needs and concerns of persons from various ethnic and racial groups. Although knowledge of between-group differences can be helpful in generating initial perspectives about clients, D'Andrea (1995) believes it is essential that counselors recognize the ways in which persons from the same cultural, ethnic, and racial backgrounds are psychologically different.

Within career counseling contexts, it is important to consider the role of a client's ethnic and racial background. Numerous books and journal articles about the role that one's cultural background plays in career development attest to the critical nature of incorporating a client's racial/ethnic identity into the career counseling process (e.g., Leong, 1995; Leong & Hartung, 1997). D'Andrea (1995) concurs, arguing that people from the same backgrounds typically think, feel, and act differently. As such, D'Andrea encouraged counselors to learn as much as they can about the historical and contemporary issues associated with various racial and ethnic groups while – at the same time – ensuring that each client is treated as a unique individual with unique presenting issues and concerns. An examination of within-group differences simply should not be ignored when working with individual clients.

There is evidence to suggest that clients' racial identity may be a particularly salient factor in career development (Helms & Piper, 1994). As such, counselors may want to pay particular attention to clients' understanding of racial identity and explore with each client the manner in which racial, ethnic, and cultural factors may have influenced early career decisions. By doing so, counselors can empower clients to more fully appreciate and incorporate racial and ethnic identity into the career decision-making process.

**Current Chronological Challenges**

According to D'Andrea (1995), this aspect of the RESPECTFUL counseling model focuses on specific developmental tasks and challenges that clients are expected to master from a chronological perspective. Erikson's model of psychosocial development is an example of the type of theoretical framework that supports the notion that chronological challenges occur at specific age periods. D'Andrea (1995) believes that as we move to a more complex understanding of human development, it is important to consider the unique challenges that impact the various stages of childhood, adolescence, and adulthood.

It is often helpful when working with clients to assess the predictable challenges and "crises" that individuals normally experience at particular points in the lifespan. This is especially true when providing career counseling services to clients of varying ages. In 1989, the National Occupational Information Coordinating Committee (NOICC) teamed up with the National Career Development

Association (NCDA) to develop a list of guidelines that counselors could use to determine the developmental appropriateness of various career counseling strategies. Those guidelines, commonly referred to as the National Career Development Guidelines (NCDGs), include a set of career development competencies that persons are expected to master throughout their lives.

At each developmental level, the career development competencies are organized into three main areas: self-knowledge, educational and occupational exploration, and career planning. Within each area, there are several competencies students are expected to achieve. For example, in the self-knowledge domain, the NCDGs indicate that elementary school students should have knowledge of the importance of self-concept, possess skills to interact with others, and be aware of the importance of growth and change. Counselors who want to ensure that their career development programs and services are developmentally appropriate for the clients whom they serve should consult the NCDGs and develop interventions accordingly (NOICC, 1989).

**Threats to Personal Wellness and Sources of Social Support**

According to D'Andrea (1995), this aspect of the RESPECTFUL counseling model involves an intentional effort to identify not only the specific stressors in the client's life but to gain a clear understanding as to why the client considers such stressors to be personally challenging or problematic. Within that context, D'Andrea believes that it is especially important to evaluate the major sources of social support available to each client. Determining the degree to which a client's peers, family members, and co-workers are available to serve as sources of emotional, psychological, and physical support can help a counselor determine appropriate methods of intervention.

When providing career counseling services, counselors need to consider the general anxiety and stress that clients are experiencing. As noted earlier, clients who are under extreme stress or anxiety may not be psychologically prepared to engage in the career decision-making process. It would be much more beneficial to help such clients manage their stress and develop effective strategies for reducing anxiety than it would be to interpret an interest inventory or teach them how to use a computer-assisted career guidance program.

As clients engage in the latter stages of career exploration and planning (e.g., making a tentative career decision, exploring educational alternatives), it becomes increasingly important for them to perceive strong social support for career decision making. As such, counselors can encourage clients who are making tentative career decisions to establish and/or maintain a strong social support system. Counselors can be especially instrumental in helping clients recognize the value of social support systems and identifying potential support persons in their lives.

**Family History and Influence**

This component of the RESPECTFUL counseling model involves assessing the ways that clients' family systems influence their lives. The well-established

systems theories and therapeutic interventions based on such theories are particularly relevant to this aspect of the RESPECTFUL counseling model. When assessing the role that family history plays in clients' lives, D'Andrea (1995) suggested clarifying what clients mean by the term "family" and engaging in activities to help clients recognize how family dynamics have affected their psychological development and well being.

A variety of strategies and techniques can be used within career counseling contexts to incorporate family history and related influences into the career decision-making process. At the very least, counselors need to ask clients to reflect on the job histories of family members. Identifying the careers of clients' parents, siblings, and even extended family members (e.g., grandparents, aunts/uncles, cousins) can help clients become aware of the manner in which family members have influenced some of their early career decisions. Creating genograms that display the occupational histories of various family members can provide clients with an interesting perspective when considering the role that family members have played in their career development.

**Unique Physical Characteristics**

This component of the model focuses on those unique physical characteristics that cause stress or may be a source of personal pride for clients (D'Andrea, 1995). As counselors who have worked with persons with physical disabilities can attest, clients who possess unique physical characteristics are often influenced by the ways that others respond to them. The reactions of others to one's physical characteristics – both positive and negative – often influence the way a client develops psychologically (McWhirter, 1994). Within counseling contexts, then, it is important for clients to evaluate the ways in which their physical traits may be influencing their identity and expectations for the future.

Although career counselors and vocational psychologists have recently increased their attention to the role that disabilities play in career decision making (Enright, Conyers, & Szymanski, 1996; Hitchings, Luzzo, Retish, Ristow, & Horvath, 1998), there has been no concerted effort to evaluate the role that physical characteristics – in general – play in the career exploration and planning process. Nevertheless, it seems appropriate for counselors to work with clients who possess certain less desirable physical characteristics (e.g., blindness, obesity, paralysis) to ensure that career goals are not unnecessarily compromised because of a perceived weakness or a lack of ability that may not be based on factual evidence. Similarly, it is important that career counselors help all clients to consider personal abilities as well as areas of skills deficit when narrowing career options.

**Location of Residence**

The final component of the RESPECTFUL counseling model involves gaining an understanding of the ways in which the location of a person's residence may influence her or his development (D'Andrea, 1995). Although it may ini-

tially seem as if the location of one's home may not have a substantial impact on one's development and well-being, it doesn't take long to realize that the impact of living in a rural area is probably very different than the impact of living in an urban or a suburban area. D'Andrea (1995) encouraged counselors to consider the different types of needs, stressors, interests, and sources of support that people in different geographic locations experience throughout their lives.

The influence of location of residence seems appropriate to consider in career counseling in at least two ways. First, there is substantial evidence suggesting that the career development experiences of persons who grow up in rural areas is vastly different than the career development experiences of persons who grow up in urban and suburban areas (Rojewski, 1993). Rural youth, for example, tend to possess somewhat lower levels of career maturity and express a greater need for basic information about the world of work than their peers who live in urban and/or suburban areas do (Rojewski, 1993, 1994). Consequently, counselors should be sure to evaluate the career maturity of clients within the context of clients' location of residence. If a counselor regularly works with rural populations, it would be appropriate for that counselor to become well acquainted with the literature available on the career development of such persons. Similarly, if a counselor's clients tend to come from urban areas, then maintaining an awareness of career development literature pertaining to such persons should be an important part of the counselor's professional development.

A second way in which location of residence can be an important factor to consider in career counseling involves assessing the degree to which a client is geographically mobile. Although many persons are willing to relocate hundreds or even thousands of miles to secure a satisfying and rewarding job, many others do not consider relocation a viable alternative. Family circumstances, financial restrictions, and a host of other factors may limit the degree to which a person may be able to consider relocation for a job opportunity. Rather than assuming relocation is an acceptable alternative, counselors need to determine a client's willingness to do so.

## Concluding Comments

D'Andrea's (1995) RESPECTFUL counseling model provides counselors with a promising framework for incorporating a variety of important issues into their work with clients. Although this article has primarily focused on the application of the RESPECTFUL counseling model to career counseling, it is clear that the model has widespread application to a variety of counseling contexts. Counselors are encouraged to integrate the various suggestions presented within this article when they work with clients of all ages, backgrounds, and perspectives. Likewise, researchers are invited to conduct research to validate the use of the RESPECTFUL counseling model with diverse populations. Doing so will undoubtedly improve counselors' efforts to provide effective counseling services to *all* persons.

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# Vocational Identity and Stress: A Study of Vocational Identity and Occupational Stress Among Substance Abuse Counselors

JOSEPH G. LAW, JR., ANNA H. COSTARIDES, AND VAUGHN S. MILLNER

*This study assessed the vocational identity, interest patterns, and occupational stress of 34 counselors who were administered the Vocational Preference Inventory (Holland, 1985), My Vocational Situation (Holland, Daiger, & Power, 1980), and Occupational Stress Inventory (Osipow & Spokane, 1992). Respondents scored within the same range as the normative samples for each of the instruments noted above. Implications for counselor training are discussed.*

Within the counseling and career psychology professions, there seems to be renewed interest in vocational choice (Brown & Brooks, 1990; Chartrand, 1991; Gati, Garty & Fassa, 1996; Hackett & Lent, 1992; Hafer, 1992; Hood and Johnson, 1991; Power, 1991) and occupational stress (Bowman & Stern; 1995; Kelloway & Barling, 1991). Osipow and Spokane (1992), pioneers in the field of occupational stress research, emphasized the need for research on person-environment fit and stress, as well as the impact of occupational stress on work-related behaviors. Others, such as Quick, Murphy, and Hurrell (1992), focused on distress in the workplace, individual stress responses and symptoms, and occupational mental health risks. Two areas of concern to counselors that have been treated as somewhat unrelated are occupational stress and vocational identity. Both topics have been studied, but little has been done to merge the two streams of research findings.

Vocational identity, for the purpose of this study, is defined as "a clear and stable picture of one's goals, interests, personality and talents" (Holland, Daiger & Power, 1980, p. 1). Referring to the process by which one converts self-concept into a career identity, vocational identity is demonstrated by means of lifetime career patterns (Herr, 1981). The term identity, in the context of career theory, has emerged over the last decade (Vondracek, 1992) and refers to social roles which help to establish one's sense of self (Frone, Russell, & Cooper, 1995). Of specific concern to researchers as well as counselors are problems experienced by role

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ambiguity and work pressure. Frone et al., in assessing identity theory with a community sample of 1,616 adults, found that role ambiguity and work pressure may influence one's cognitions regarding role performance, thereby affecting one's self-concept.

Occupational stress can erode quality of life and reduce effectiveness in the workplace (Altmaier, 1995; Bowman & Stern, 1995). Holland (1985) believed that individuals develop preferences for certain types of activities and interests that lead to the development of certain types of coping skills in the workplace. Considerable empirical support is available to support Holland's theory (Hackett, Lent, & Greenhaus, 1991). According to Holland's approach, how well individuals respond to work-induced strain depends on the interaction of personality and vocation as well as the congruence between personality and job environment. Using a sample of 235 college freshmen, Eagan and Walsh (1995) examined the relationship between coping skills and person-environment congruence. Results demonstrated those specific coping strategies such as social support and escape avoidance may be associated with congruence as well as gender. For instance, escape avoidance was used less with congruent male students than other groups. Providing additional support for the relationship between vocational identity and stress, a sample of 215 nurses demonstrated that job stress and stressors such as role ambiguity were related to employees' job satisfaction, organizational commitment, psychosomatic health problems, and turnover motivation (Jamal, 1990).

Those working in human service fields, particularly mental health professionals, may be vulnerable to emotional exhaustion (Kirkcaldy & Siefen, 1991). Moreover, substance abuse counselors tend to have types of job stress specific to the human service field. Because there is no single etiological factor of alcoholism, counselors must be aware of the influence of environment, heredity, psychological factors, and cultural factors (Straussner, 1993). Often working with clients in crises, substance abuse counselors must also be knowledgeable about different treatment modalities and may fulfill a variety of roles within the therapeutic relationship (Bepko, 1985; Doyle, 1997; Straussner, 1993). For instance, a high percentage of substance abuse counselors are also recovering from a substance addiction (Doyle, 1997) and may be involved in the same Alcoholics Anonymous support group as the client, thereby creating challenges which would not ordinarily occur in other counseling relationships. Ethical dilemmas involving uncertainty and conflict are frequently associated with stress and conflict within the helping professions (May & Sowa, 1992).

Thus, it is important to examine vocational identity as it may relate to occupational stress and coping resources, especially in counselors helping those with substance abuse problems. Additional information regarding these relationships may lead mental health professionals to greater insight for the purposes of client assistance as well as counselor self-examination.

The primary aim of this study was to extend the literature on occupational stress and vocational identity. Specifically, the purpose of the study was to inves-

tigate the relationship of vocational identity to occupational stress, strain, and the coping patterns in a group of substance abuse counselors. It was hypothesized that a clear sense of vocational identity in substance abuse counselors would be positively related to positive coping skills. The second goal of the study was to glean information about substance abuse counselors' vocational identity and coping skills.

## Method

### Sample

Participants were 34 white counselors attending a substance abuse workshop in a medium-sized (population 300,000) southern city. They ranged in age from 25 to 65 years, with a mean age of 45 ($SD$ = 9.1years). Sixty-eight percent were female and 42 percent were male. Education ranged from high school graduates (three participants) to eight years of college (three participants). The mean for years of education was 16.3 ($SD$ = 1.8 years). Eighteen participants (56.3%) held at least a master's degree in counseling or a health-related field. Four held bachelor's degrees, and four had attended college but had earned no degree. With the exception of four, all participants were employed in public or private agencies, which primarily counsel substance abuse clients.

### Instruments

All of the participants were administered the Occupational Stress Inventory (OSI) (Osipow, & Spokane, 1992), followed by My Vocational Situation (MVS) (Holland et al. 1980), and the Vocational Preference Inventory (VPI) (Holland, 1985). The theory on which the OSI is based recognizes that (a) work roles have the potential to create perceptions of stress, (b) various coping mechanisms are employed to combat the perceived stress, and (c) the success of stress amelioration depends, in part, on the interaction of personal variables (Osipow, 1991). The OSI, which consists of 140 items answered on a 5-point scale, covers three basic scales: occupational stress, occupational strain, and coping resources. The instrument is designed to quantify the stressor acting upon an individual, the resultant psychological strain, and the coping resources used to combat that strain. The first section is called the Occupational Roles Questionnaire and has the following scales: Role Overload (RO), Role Insufficiency (RI), Role Ambiguity (RA), Role Boundary (RB), Responsibility (R), and Physical Environment (PE). Collectively, these scales represent occupational stress. The second section of the OSI comprises the Personal Strain Questionnaire, and contains four scales: Vocational Strain (VS), Psychological Strain (PSY), Interpersonal Strain (IS), and Physical Strain (PHS). Section three comprises the Personal Resources Questionnaire. Four scales make up a measure of coping resources. They are as follows: Recreation (RE), Self-Care (SC), Social Support (SS), and Rational/Cognitive Coping (RC). The OSI has adequate reliability for the domains, with internal consistency coefficients ranging from .89 to .99 (Osipow & Spokane, 1992). There is evi-

dence of validity (Osipow & Spokane, 1992), although additional studies are needed, particularly in comparisons of coping scale scores for those differing in racial-ethnic composition (Osipow & Spokane, 1994).

A popular instrument, MVS (Holland et al., 1980), is used for assessing vocational identity. Mauer and Gysbers (1990) studied the MVS for use in identifying career concerns of university freshmen and found evidence for clusters of concepts within the MVS, including anxiety, confidence, self-assessment and occupational information. In another study, Munson (1992) used the MVS to study the relationship of vocational identity, career salience, and self-esteem in high school students.

MVS has three scales that are designed to assess vocational identity (VI), need for occupational information (OI) and barriers to vocational choice (Barriers) (Holland et al. 1980). MVS (Holland et al. 1980), developed to meet the need for a diagnostic approach, reflects Holland's belief that most difficulties in career counseling occur because of a client's sense of vocational identity, lack of occupational information, and perceived barriers. The OI and Barriers scales, considered checklists, assess only four items per scale. OI and Barriers have support for internal consistency reliability, with alpha coefficients ranging from .45 and .78 for male college students and workers and .65 for female college students and workers (Holland et al., 1980). The VI section consists of 18 items and also has been shown to have high internal consistency for high school students, college students, and workers, with coefficients ranging between .86 to .89. In addition, Lucas, Gysbers, Beuscher, and Heppner (1988) found evidence of construct validity for the VI scale of the MVS in examining college freshmen and adults.

The third instrument, employed to assess vocational identity, is *Holland's Vocational Preference Inventory (VPI)* (1985). VPI assesses vocational interests for 84 occupations, yielding scores on six occupational themes: Realistic (R), Investigative (I), Artistic (A), Social (S), Enterprising (E), and Conventional (C) (referred to hereafter as RIASEC). RIASEC themes, developed by Holland (1973) and considered to be part of one of the most influential career models in vocational interest literature (Rounds & Tracey, 1996; Ryan, Tracey & Rounds, 1996), have facilitated the merger of individual interests with personality dispositions (Betz, Harmon, & Borgen, 1996). For example, a common RIASEC code for counselors is SAE (i.e., Social/Artistic/Enterprising) (Gottfredson & Holland, 1996).

VPI's reliability and validity have been well researched and discussed by many authors (Brown & Brooks, 1990; Holland, Gottfredson, & Baker, 1990). Holland (1985) stated that VPI's internal consistency for males and females is homogenous. Two week test-retest reliability coefficients for adult females range from .65 (Enterprising) to .83 (Conventional). For National Merit Finalist males, two week retest reliability coefficients range from .41 (Infrequency) to .62 (Enterprising). Predictive validity of the interest scales are either equal to or exceeding other interest inventories (Holland, 1985). The other scales (Infrequency, Acquiescence, Control, Masculinity, and Status) have moderate construct validity (Holland, 1985).

### Procedure

Participants were asked to participate in a study of occupational stress and vocational interests. All 34 counselors subsequently volunteered to participate in this study. The OSI, MVS, and VPI were administered in a group format by the senior author. Following test-taking, the first two authors offered individualized feedback regarding the results of the tests.

Results were analyzed using the Statistical Package for the Social Sciences (Kinnear & Gray, 1994). Correlations among the scores on all three instruments were computed and those significant at the .05 level were singled out for further study.

## Results

To assess the sample's characteristics, means were compared to normative data for the MVS, the OSI, and the VPI. In addition, t tests were performed to determine the relationships between counselors and the instruments' norm groups. Finally, correlational analyses were employed to assess relationships among OSI measures and Vocational Identity scores.

The mean score on *Holland's Vocational Identity Scale* was 13.7 ($SD$ = 3.2). The sample mean was compared to the normative sample, which had a mean of 12.9 ($SD$ = 2.4). A t-test for independent samples resulted in no significant difference ($t$ (41) = .965, $p$>.05) between the sample group of counselors and the MVS norm group.

The sample's mean score on the OSI was 122.61 ($SD$ = 33.6) for Occupational Stress, 79.2 ($SD$ = 23.8) on the Psychological Strain scale, and 137.3 (SD = 18.3) on the Personal Resources scale. These means were compared to data provided on a sample of 549 working adults in the OSI manual (Osipow & Spokane, 1992). Counselors' mean scores on the Psychological Stress scale were significantly lower than those in the OSI sample ($t$ (579) = 2.48, $p$<.01, one-tailed test). There were no significant differences demonstrated between the counselor and OSI sample means on the Psychological Strain or Personal Resources scales.

Table 1 shows the correlations between Vocational Identity scores and each OSI scale. Correlations ranged from -.38 to .22. The only significant relationship was Role Boundary ($r$ = -.38, $p$<.05). The negative association indicates that those with role boundaries exhibited clearer vocational identity.

In addition, correlation analyses were conducted among the three OSI measures of Psychological Stress, Personal Strain and Personal Resources (coping) and the Mauer and Gysbers' (1990) factors of Vocational Identity, Confidence, Self-Assessment, and Anxiety. (See Table 2). Stress was positively associated with Strain and Coping whereas Coping was negatively associated with Strain. Confidence was associated with Vocational Identity and Self-Assessment. Self-Assessment scores were correlated with Coping and Confidence. Finally, Anxiety scores were correlated with Vocational Identity, Confidence, and Self-Assessment.

To recapitulate, counselors who exhibited more strain demonstrated the use of fewer personal resources. However, counselors aware of their strengths and

weaknesses displayed more coping skills and confidence. Confident counselors also expressed a stronger sense of vocational identity. Moreover, counselors expressing uneasiness about their career choice were confident of their abilities.

To assess characteristics of substance abuse counselors, an analysis of three-letter codetypes on the VPI was performed, indicating that 34 counselors reported Holland's Social scale among their top three scores. Twenty-five reported Artistic, 18 noted Enterprising, 15 chose Investigative, 4 reported Realistic, and 2 held Conventional among their top three preferences. The counselors' mean scores were within one standard deviation of the mean yielded on norms for the supplementary scales of Self-Control, Masculinity-Femininity, Status, Infrequency, and Acquiescence.

## Discussion

These findings should be viewed carefully in light of the usual cautions about sample size, restriction in terms of locale, and the fact that self-report measures are subject to social desirability effects. In addition, generalizability is limited to individuals with similar demographic characteristics. For instance, because all participants were Caucasian, results may not be generalized to diverse populations.

A methodological limitation of the study is the comparison of the subject population means to the dated norm group means. Older norms used for between group comparison limit the generalization of the study's results. More recent norms would further the implications of this study.

A second methodological limitation concerns the variation of sample size between the group sample and the norm group. Because t tests are best performed with groups of equal size, caution is necessary in interpreting results of the study.

One of the purposes of the present study was to accumulate information about substance abuse counselors' coping skills and vocational identity. Based on the mean scores of the OSI, the counselors in this study were not suffering from role overload, role insufficiency, or any of the other measures of psychological stress. They expressed satisfaction with their physical work environments. In fact, occupational stress was significantly below the mean for the sample reported in the OSI manual. The counselors reported that vocational, psychological, interpersonal, and physical strain were all within normal limits. In addition, personal resources, such as recreation, self-care, social support, and rational cognitive coping skills, were all within the OSI's norms, indicating that this study's sample of substance abuse counselors demonstrated adequate personal resources.

Intercorrelations among each OSI scale were moderate to high, indicating a substantial relationship among the variables of stress, strain, and coping resources. Mauer and Gysbers' (1990) Confidence factor correlated highly with the overall Vocational Identity score, suggesting a marked relationship between the two variables. It may be surmised that those substance abuse counselors who expressed confidence also demonstrated a strong vocational identity. This finding is supportive of Holland et al.'s (1980) belief that a clear sense of one's goals and tal-

ents leads to confidence in one's decision-making ability.

Overall, vocational identity was found to have little relationship to occupational stress with the exceptions of role boundaries and self-assessment. The significant, inverse relationship between vocational identity and role boundaries suggests that counselors with a strong sense of vocational identity were aware of conflicting role demands or loyalties in the work setting. Consistent with previous research on role conflict of substance abuse counselors (Bepko, 1985; Straussner, 1993), this finding extends the observations regarding role ambiguity and job satisfaction (Jamal, 1990). Perhaps this finding also reflects support of Doyle's (1997) observation that recovering substance abuse counselors often are engaged in dual relationships with clients.

Self-Assessment was significantly negatively correlated with coping, a Vocational Identity factor. The basis for a significant negative relationship between self-assessment and coping is unclear. It may be that the counselors in this study with a weaker sense of awareness and estimation of personal strengths and weaknesses than others were more likely to demonstrate coping resources. This could indicate that counselors without a clear sense of their values and skills may experience more stress, thus a need for more coping resources.

The low correlations computed may be due to a restriction in range. Most of the sample reported low levels of occupational stress and fairly strong scores on Vocational Identity. This finding could result from counselors being in an occupation congruent with their Holland codetype (and presumably consistent with their temperament).

In summary, the results of a measure of Vocational Identity (MVS), occupational stress (OSI), and occupation-temperament fit (VPI) for a group of counselors characterized the sample as well-adjusted in their jobs, feeling little occupational stress or strain, and having a strong sense of vocational identity. The one exception includes those counselors with unclear boundaries who demonstrated a greater use of coping resources.

This study's results have practical implications for counselor educators. Because substance abuse counselors surveyed appeared to be well adjusted vocationally and psychologically, counselor educators may be heartened that the populace is being served by counselors who have the coping resources to meet their clients' needs. Further, the study's findings underscore the need for counselor education programs to emphasize a close match between their students' vocational interest patterns and their choice of major. For instance, counselor trainees may benefit from taking a standardized interest inventory and discussing the results with a faculty member. Those students whose scores are not congruent with the most frequent counselor profiles should be able to discuss the implications of this in terms of future potential for job stress and strain.

The present results also have implications for substance abuse counselors. Our findings suggest that substance abuse counselors with a strong sense of vocational identity may benefit from awareness of role boundaries. Substance abuse

counselors may consider acknowledging and discussing these role boundaries with the administrators of clinics as well as with potential clients.

Identifying the impact of role boundaries on vocational identity, as we have begun to do here, has research implications. Further research of dual relationships in substance abuse settings may help to clarify determinants of job stress in the substance abuse work setting. In addition, further study of the relationship between self-efficacy in the job setting and dual relationships may provide substance abuse counselors with pertinent information as it relates to job stress.

A more complete understanding of the relationships between vocational identity and occupational stress among substance abuse counselors requires analyses with more recent group norms used for comparison purposes. Also, it should be noted that the recruitment sample does not represent the general population. Future studies, using current norms and assessing a large, diverse group of substance abuse counselors, may enhance generalization. Despite these limitations, the study provides initial insight about relationships between vocational identity and coping resources of substance abuse counselors.

**TABLE 1**
**Correlation between Scores on Occupational Stress Inventory and Vocational Identity**

| OSI Scale | r |
|---|---|
| Role Overload | -.21 |
| Role Insufficiency | -.41 |
| Role Ambiguity | -.27 |
| Role Boundary | -.38** |
| Responsibility | -.04 |
| Physical Environment | -.12 |
| Vocational Strain | -.13 |
| Psychological Strain | -.33 |
| Interpersonal Strain | -.25 |
| Physical Strain | -.12 |
| Recreation | -.02 |
| Self-Care | .08 |
| Social Support | .22 |
| Rational-Cognitive | .19 |

*$p<.01$ **$p<.05$

**TABLE 2**
**Correlations among Vocational Identity Factors Identified by Mauer & Gysbers and OSI Scales**

| | 1. | 2. | 3. | 4. | 5. | 6. | 7. |
|---|---|---|---|---|---|---|---|
| 1. Stress | 1.00 | | | | | | |
| 2. Strain | .65** | 1.00 | | | | | |
| 3. Coping | .71** | -.70** | 1.00 | | | | |
| 4. Vocational Identity | -.34 | .19 | -.24 | 1.00 | | | |
| 5. Confidence | -.22 | .01 | -.15 | .90** | 1.00 | | |
| 6. Self-Assessment | -.38 | .31 | -.37* | .59 | .41* | 1.00 | |
| 7. Anxiety | -.13 | -.03 | -.07 | .64** | .55** | .43* | 1.00 |

*p<.05 **p<.01

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# The Ethical and Social Justice Dilemma Of Managed Behavioral Health Care

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*The current environment of managed behavioral health care has created dilemmas for counselors when economic decisions have competed with their professional practice and threatened reduction in availability and quality of behavioral health care. Elements in the development of managed care will be explored in relation to systemic economic and regulatory changes. These changes have necessitated the examination of complex ethical and social justice decisions. Counselors have been called upon to serve as advocates and collaborators for increasing clients' quality of care, education about behavioral health care, and a pro-active stance in the behavioral health care delivery system.*

"A rising tide carries all ships" seems an appropriate metaphor for the effect managed care has had on the behavioral health care system. Though mental health care accounts for only a small portion of total U.S. health care expenditures, the same competitive principles which shaped the delivery of physical health services under managed care have prompted rapid development of managed behavioral health care (Landress & Bernstein, 1993). Market driven competition and cost containment are now the predominant forces influencing relationships among third-party payers, public and private behavioral health care professionals, and clients. The presence of these forces has necessitated changes in philosophies, practice, and paradigms of service delivery for private and public providers (Appelbaum, 1993). Relevant surveys (English & Marino, 1998; "Survey Reveals," 1996) have revealed professionals' increased fears about dramatic changes in the field and their ambivalence and resistance in responding to a managed behavioral health care market.

Restructured public and private behavioral health care systems, reductions in funding, and the short-term treatment model are realities that are here to stay (Lazarus, 1994; Marino, 1995). Managed care has become part of the relationship equation that formerly involved only client and counselor. The rules have

**Note.** The term behavioral health care includes mental health, mental retardation, and substance abuse services.

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changed especially in regard to financial management. Both previous and present service delivery systems may fail to demonstrate benefits for counselors and clients (Bazelon Center, 1995; McFall, 1995). Managed behavioral health care treatment policies risk ending therapy just as it is beginning for the client (Appelbaum, 1993). Counselors are faced with subtleties of ethical and social justice issues that may be difficult to identify and articulate.

In this article, the basic concepts of managed behavioral health care and the ethical and social justice concerns posed by its implementation are explored. The implications of managed care on professional integrity, clients' well being, rights versus needs in involuntary treatment, shift in paradigms, and counselor education, research, and action are addressed. Recommendations for action focus on professional integrity, financial interests, clients' refusal of treatment, the medical model of treatment, and taking a pro-active stance. Collaborative models that retain a degree of independence for providers of services and their clients are explored (Egnew, 1996).

## Behavioral Health Care in a Managed Care System

The former fee-for-services system lacked benchmarks fo determining improvements in clients' mental health. Numerous authors (Appelbaum, 1993; Landress & Bernstein, 1993; McFall, 1995) have explored the economic, social, and political foundations of managed care and its use as a method of health and behavioral health care reform. The following content areas illustrate the characteristics of managed behavioral health care and related ethical social justice issues.

### Managing Care Versus Managing Costs

Managed care systems have the capability of improving services as well as the potential to cause harm to persons having high-cost mental health needs. A managed care company or system provides comprehensive care and determines which services will be delivered. A key characteristic is that some degree of financial risk for enrolled clients is carried by the organization (Bazelon Center, 1995). Capitation, prearranging financial payments, and limiting services are methods used to manage costs.

Professional counselors have complained that case managers, wishing to implement cost saving policies, interfere in their practice by limiting the number of sessions with clients and by dictating the terms of treatment plans (Landress & Bernstein, 1993; Marino, 1995). In the former fee-for-services system, counselors were "rarely . . .required to justify a treatment or to document its effectiveness before receiving at least partial reimbursement from insurance companies" (McFall, 1995, B1). As part of the gate-keeping process, clients are often required to explain their mental health problems to case managers (Hymovitz & Pollock, 1995). This may jeopardize confidentiality and intrude into the relationship between counselor and client. Therefore, it is not surprising that counselors per-

ceive the purview of managed care to be focused on controlling their professional practice.

Counselors working in publicly-funded behavioral health care agencies, community mental health centers, or juvenile criminal justice programs are not immune to economic shifts in governance (Allan & Nisenbaum, 1996). Budman (1995) stated that the "largest remaining" (p. 49) growth area in managed behavioral health care is the public sector. Past emphasis on process and program has shifted to outcome accountability, a client-focused service delivery system, and decentralization of resources and managerial control from state mental health agencies to local governing boards (Budman, 1995; Winfield & Pope, 1995). Several states have sought to integrate two or more of their behavioral health care programs (substance abuse, mental health, mental retardation and developmental disabilities, or all divisions) with Medicaid waivers in order to cover uninsured clients and to transfer financial risk to managed care organizations ("Growth," 1995). The beneficial result of these efforts will permit more clients to receive services. However, a possible negative consequence may be that publicly-funded clients will be restricted to receiving services from health maintenance organizations which limit membership to Medicaid recipients and have been found to give substandard care (Woolhandler & Himmelstein, 1994).

**Economic Engines**

If counselors want to influence the effects of managed care, an understanding of the economics behind behavioral health care reform is necessary. The former fee-for-services and open-ended state funding systems were arguably too expensive (McFall, 1995). Both lacked accountability and invited practitioner abuse. Landress and Bernstein (1993) observed that health care accounted for more than 12% of the gross national product and costs were increasing at more than 10% per year. Medicaid costs have doubled since 1988 and now comprised 20% of states' budgets (Monack, 1995). In 1992-93, Medicaid costs increased by 29% (Landress & Bernstein, 1993).

As an indication of the overall governmental and corporate response to diminishing resources and increased demand for services. Landress and Bernstein (1993) projected that managed care will exert some control over 90% of health care benefits in the near future. Focusing on behavioral health care, McFall (1995) asserted, "because mental patients are not a large, wealthy, well-organized, or influential political constituency, they are a *tempting target* [italics added] for cost cutters" (p. B1). In fact, 85% of companies employing over 1,000 people have contracted out their behavioral health coverage to managed care companies specializing in mental health (Hymowitz & Pollock, 1995). Marino (1998) reported a dramatic decrease in the level of behavioral health services covered by medium and large employers in the past ten years. In the public sector, several states are considering, have applied for, or have been granted Medicaid "super" waivers that allow for a complete reshaping of Medicaid programs for high-cost, high-risk groups (Monack, 1995).

Corporate financial gain, with the potential consequences of less effective treatment and greater long-term costs, stimulated the "gallop toward [the managed care] oligopoly" (Woolhandler & Himmelstein, 1994, p. 265). With up to a 15% profit margin, managed care companies have been profitable and few in number (Hymowitz & Pollock, 1995). In 1993, ten firms controlled 70% of the HMO market (Woolhandler & Himmelstein, 1994). By 1998, mergers and acquisitions resulted in, "control of more than half the lives covered under managed behavioral care plans," by two companies, Magellan Health Services and FHC/OPTIONS ("Consultants," 1998, p. 1).

**Public Benefit and Private Dollar**

The combined effect of cost containment practices, capitation, outcome accountability, and case management on private and public behavioral health care has been a blurring or blending of policy boundaries that once kept the two systems distinct (Budman, 1995). Given the task of brokering the most care for the least cost, both managed care companies and local boards governing public behavioral health care services have the option of contracting with private or publicly funded agencies. Private practitioners may be required to see clients they have not typically treated. The potential client population includes those who are poor, those who suffer from chronic mental illness, and those who formerly had only community mental health as a resource. Community mental health centers may begin to serve clients who used to be seen exclusively in the private sector (Budman, 1995). Consequently, an innovative benefit to clients has emerged as privately funded group practices and public behavioral health care systems are being shaped to conform to a buyer or consumer-empowered paradigm rather than operating from the provider's perspective (Monack, 1995).

When state behavioral health care bureaucracies restructured their Medicaid programs and engaged third-party administrators, dollars meant to serve those eligible for the public benefit were transferred into private managed care control. Client advocates consider this to be misappropriating public funds meant to benefit those in need (Mills, 1995), while managed care proponents claim potential opportunities to provide innovative services to vulnerable populations (Monack, 1995). In addition, some states developed plans for decentralization through county or regional boards while in other schemes, state-managed behavioral health care agencies negotiated directly with third-party administrators or man "Tennessee Reconsiders," 1995). For example, California incorporated inpatient and outpatient services funded by Medicaid into one system administered at the county level ("California Medicaid," 1995). Georgia decentralized its entire mental health system in 1992 by creating nineteen regions (reduced to thirteen in 1997) which are governed locally by citizen boards of clients and have authority to contract with public and private providers (House Bill 100, 1993).

Aspects of managed care such as scrutiny of services provided, outcome accountability, and client satisfaction have improved the quality and accessibility of behavioral health care (Bennett, 1995). Managed care and local governance

have given clients and advocacy groups a venue to articulate unmet needs within the behavioral health care system (Uttaro & Mechanic, 1994). Recently introduced as federal legislation, the Patient Access to Responsible Care Act reflects public and legislative initiative in overseeing the managed care and behavioral health care systems on behalf of clients (Barstow, 1998a). However, as Applebaum (1993) has asserted, counselors are legally responsible in decisions about clients' care while there is "little relevant case law and almost no relevant statutes," holding managed care companies liable for treatment decisions made by case managers (p. 252). In a milieu of managed behavioral health care, counselors must reflect on the benefits and risks to clients and themselves in making ethical and social justice decisions in their professional practice.

## Ethical and Social Justice Issues in a Managed Care Environment

The professional environment for counselors has changed with the emergence of a managed care infrastructure. Changed relationships with clients, referral groups and companies, and governing agencies has resulted in an unsettling working atmosphere (English & Marino, 1998) and the need to re-strategize former decisions. Five areas of reflection on ethical and social justice decisions will be explored as well as a following section on recommendations concerning suggested actions.

### Professional Integrity and Managed Care

A question for all mental health, community agency, and even school counselors is whether they can work within a system or systems of managed behavioral health care and still maintain ethical integrity (Corey, Corey, & Callahan, 1998). The American Counseling Association's *Code of Ethics and Standards of Practice* (1995) is based upon and emerges from a paradigm of primary responsibility "to respect the dignity and to promote the welfare of clients" (p. 2). Traditionally, counselors have viewed themselves as advocates for "the enhancement of human development" (ACA Code, 1995, p. 1). The most dire predictions about the future of behavioral health care have described the situation as chaotic, confused, and an unfair denial of care to those most in need. Professionals with a more optimistic outlook have called for collaboration, education for counselors and clients about managed behavioral health care, and an increased role for clients in treatment and policy decisions (Corey et al., 1998).

### Clients' Well-Being

In their discussion of counseling in a managed care system, Corey et al. (1998) noted that "the failure of mental-health professionals to control rising costs has led to the increase in external control by the managed care industry" (p. 128). These authors contrasted the problems experienced by counselors under a managed behavioral health care system with potential positive outcomes. Problems included redefinition of the role of the therapist, limited sessions, under-treatment, and the emphasis of profit to the detriment of quality services. Positive out-

comes consisted of increased effectiveness and efficiency, attention to clients' goals, accountability to clients, the public, and funding entities, and improvement in skills and service delivery. For counselors, a critical ethical issue posed by Corey et al. (1998) might be the choice between protecting financial interests and continuing to attend to the best interests of their clients under a managed care system.

As previously mentioned, clients may be required to forego their right to confidentiality in order to receive services. With a continued stigma against behavioral health care and the prevalence of computerized management information systems, clients' jobs and well-being could be placed in jeopardy based on who has access to records and how future decisions concerning care and pre-existing conditions are made (Appelbaum, 1993). This has placed the counselor in the difficult position of simultaneously advocating for the clients' right to protection, being in compliance with the regulations of the managed care company so they may receive referrals, and working to preserve the therapeutic relationship with techniques and methodologies that have proven to be a best-fit for clients' needs. Corey et al. (1998) concluded that clients have had little voice in decisions made about them under both the fee-for-services or the managed care systems.

**Rights Versus Needs in Involuntary Treatment**

A 35-year history of contentious arguments within and without the helping professions, suffering of clients and their families, and court decisions pitting advocacy groups against professionals and lawyers accentuates the intractable controversy between clients' right to refuse treatment and their behavioral health care needs (Rappaport, 1986). Despite the rhetoric, failure to care for clients who are chronically, mentally ill can be traced to clients' refusal of services, to nonexistent services, and to limited, inappropriate, inadequate, or inaccessible services (Chafetz, 1990; Seeger, 1990), but not to the basic tenets of managed care as it has presently been implemented (Monack, 1995). It is also unlikely, given the economic motivations which sustain managed care, that solutions for the rights versus needs dilemma will arise from the managed care administration of the behavioral health care system.

Without a definitive determination of client's danger to themselves or others, courts have historically upheld their right to refuse treatment (Aviram, 1990). Yet, managed care companies have become a fourth element in the relationship among client, counselor, and court in involuntary or, outpatient commitments because their primary consideration has been cost containment while providing quality service. Petrila (1995) described the issue for counselors as the use of coercion with involuntary clients. Outpatient commitment policies may require providers on manager care panels to offer services for which they may be unprepared. There may be significant financial risk to managed care companies in coverage for clients who receive court-mandated outpatient commitments. Counselors may face an ethical dilemma of having to give less consideration to reluctant clients' rights to refuse services in order to fulfill contracts for enumerated covered lives. Consideration for community concerns about safety and order may be less a pri-

ority for managed care companies whose administrative offices are distant from local service provision.

**Shift in Paradigms**

The demands of a managed care system have presented a philosophical challenge as well as potential conflicts in financial and job security, advocacy, and negotiations with third-party gatekeepers. Fearing that their jobs may be in jeopardy if case managers' decisions are disputed (Marino, 1995), counselors have been required to relate to clients in unfamiliar ways (Haiman, 1995). Fink (1995) summarized the current turmoil in the field by asserting, "Our practice has become bottom-line driven, and our values are changing" (p. 753), and this has occurred with almost no input from clinicians, academicians, or researchers. Conversely, in taking a pro-active stance toward managed care change, Bennett (1995) stated that a shift in traditional values and paradigms was needed. In Bennett's view, therapists' practice of prioritizing the needs of patients has evolved to prioritizing those of populations.

What may be even more unsettling for counselors who subscribe to and have been taught a medical model philosophy of treatment has been evidence of a paradigm change that centers on consumer involvement and choice in treatment decisions (Haiman, 1995) and the external case managing of care and cost decisions (Scallet, 1995a). The shift from an "illness" model to one of "wellness" (Scallet, 1995b) and change from artisan-healer to consultant and catalyst (Bennett, 1989) has compelled counselors to adopt multiple professional roles. Yet, how many counselors have had exposure to seminars or courses in ethics which focus directly on changes in philosophy, paradigms, and public and private role responsibilities prompted by the implementation of managed behavioral health care (Corey et al., 1998)? Additionally, counselors are not generally exposed to the notion of serving as community advocates for recipients of behavioral health care outside their private practices or particular agencies (Schmidt, 1996).

**Counselor Education, Research, and Action**

For many counselors, the change to a managed care service environment means the inclusion of new role responsibilities such as business manager, care negotiator, and political activist not to mention the management of increased accountability and documentation (Landress & Bernstein, 1993). However, in a survey of counselors and counselor educators, Hannon (1995) found that knowledge of managed care was lacking. Along with learning about multiculturalism, diversity and gender issues, and treatment planning, counselors need to be educated about managed care, political economics, advocacy, and collaboration and networking (Schmidt, 1996).

With the exception of behavioral and cognitive behavioral therapies, research into the efficacy and efficiency of counseling theories and techniques has been remise in providing demonstrated effectiveness to public and professional concerns (Corey, 1996). No longer will professional intuition justify treatment plans

(Bennett, 1995; Corey et al., 1998). The vagueness of behavioral health "cures" (Hymowitz & Pollock, 1995) requires counselors to demonstrate the effectiveness of their interventions. McFall (1995) described the dilemma by stating, "Unless we train students to provide demonstrably effective care at a competitive cost, we will train them for obsolescence" (p. B2).

Along with more education about managed care and a research focus on accountability, counselors are experiencing an increased expectation for involvement in community advocacy (Schmidt, 1996). Demands for action and response to unmet needs such as employment, housing, and restoration to their roles in the community were found to be of critical concern for clients, employers, and advocacy groups (Uttaro & Mechanic, 1994). Choice of therapy, technique, or the newest psychopharmacological discovery was of less interest to users of services. Consumer satisfaction and service accountability may require counselors' active involvement in holistic treatment plans in which career and job counseling, resource referral, and community advocacy are as important as therapeutic strategies (Bennett, 1995).

In a managed care environment, public and private behavioral health care is held accountable to the same standards and outcome measures as physical health care and viewed as a "product" in the market place. Working together, counselors have options to influence the control managed care companies and governance entities now exercise over the profession. Ethical considerations and maximum quality practice of care for clients must also be maintained.

## Recommendations for Action

Each of the five areas discussed presents both dilemma and opportunity for professional growth. Suggestions for counselor collaborative action are offered with the intention of prompting continued discussion and reflection.

### Integrity

The recognition of managed care as a complex issue with less clarity about ethical and social justice issues and implications for ethical conflict is an important starting place for responsible action by counselors, other concerned professionals, clients, and advocates. Managed behavioral health care has been viewed as either a mechanism for needed reform or a nuisance and potential cause of harm to counselors and clients (Faenza, 1995; Fink, 1995). The dialectical question, quality, accessible behavioral health care (thesis) versus controlling costs and assuring accountability (antithesis), necessitates counselors' functioning in the paradoxes created by a managed care system (synthesis). Counselors need to learn the philosophy, business, and language of managed care while at the same time serving as advocates for their clients and for effective legislative reform and controls on the managed care industry (Barstow, 1998b). The best way for counselors to work in a managed behavioral health care environment may be to actively shape and change that environment.

**Financial Interests**

Collaborative decision making between counselors and their clients and efforts to educate both about managed care may provide a solution for counselors to protect their financial support and best serve their clients. When clients are informed about the number of sessions permitted and the liabilities of record keeping requirements (Corey et al., 1998), they may choose to limit their participation and may themselves become advocates for more client protection. In addition, networking and establishing organized systems of service delivery among behavioral health care professionals can result in balancing cost and providing quality care because counselors make management decisions, determine therapeutic options, and include clients in care and policy decision making (Clay, 1998). However, counselors must keep in mind that forming cooperative ventures in which some measure of local control over policy and financial decisions is retained may require crossing traditional lines of communication and interdisciplinary boundaries among the helping professions.

Another aspect of safeguarding counselors' financial interest rests in an appreciation of global economic trends. This will be critical in understanding the control managed care exerts over health care reform. Counselors will be required to understand not only their own sphere of economic concern but also more comprehensive economic influences such as national political and legal proceedings. In attempting to keep up with the changing parameters and innovations of managed behavioral health care, counselors will also find it necessary to read weekly newsletters and monthly trade journals in addition to the professional and academic publications they already monitor. Even the language of managed behavioral health care and its economics reflects a difference in focus and will need to be understood by counselors if they are to compete in the market place. Terms such as carve-in and carve-out, consumer, performance indicators, capitation, and public and private partnerships may not seem relevant to counselors focused on individual therapy. Continued professional growth and development are necessary requisites to avoid McFall's (1995) predicted "obsolescence."

**Refusal of Treatment**

Counselors have always had the responsibility of preserving the rights of the client to seek or refuse treatment, ensuring confidentiality, and considering the rights of the public for protection and civil order (Corey et al., 1998). Because managed behavioral health care has been implemented differently in each state, counselors need to advocate for federal and state regulation. Clients' rights must be protected and quality treatment that provides accountability and a continuum of care ensured. Becoming an effective advocate is not a tangential activity or an automatic outgrowth of completing a graduate degree in counseling. Advocacy as such must be taught along with community action problem solving and consultation.

Providing alternative treatment models may afford a counter to the impasse between clients' rights and needs for treatment and professionals' management of chronic mental illness. Home visits, primary intervention and prevention, and an

expansion of specific community-based services tailored to the clients' treatment requirements are possible solutions to alleviating unmet needs of clients. In an optimal implementation of managed care, behavioral health services have become more accessible, aggressive, and community-based. An example is the growth in use of mobile, home-care Assertive Community Treatment teams which provide a bridge from hospital to community for clients who suffer from chronic mental illness (Budman, 1995). Professional counselors need to be educated in meeting the need for new models of treatment and to be in the forefront of the implementation of these pro-active innovations.

**Medical Model of Treatment**

Counselors must ask themselves how the shift from a provider-focused system to that of a client-focused behavioral health care structure has broadened the implications for ethical decision-making and has changed their relationship to their clients. A client-centered system has the potential to result in collaboration among professionals, clients, and advocates concerning all aspects of behavioral health care, treatment planning, policy and decision making, allocation of resources, and service delivery changes. Counselors can use their counseling and teaching skills to facilitate an inclusion of clients as equal partners into the behavioral health care system. This means that counselors will need to re-conceptualize their roles and focus of their work to include community-wide and interdisciplinary projects. There is also a role for school counselors as community consultants and advocates for their students in the behavioral health care environment (Schmidt, 1996).

**Pro-active Stance**

Applebaum (1993) has cautioned that "definitive answers [to questions of legalities] are not possible" (p. 252) because managed care is such a new phenomenon in the behavioral health care field. Yet, counselors have been politically active through professional organizations on national and state levels on behalf of clients and in efforts to clarify issues concerning treatment and policy. For example, the Coalition of Mental Health Professionals and Clients has lobbied legislatures and professional organizations to speak out about the negative impact of managed care ("Group Organizes", 1995). The American Counseling Association has been working with advocacy groups in support of a client's bill of rights and supported the recent introduction of the Patient Access to Responsible Care Act (Barstow, 1998a).

Counselors as designers of research projects and educational interventions can serve as resource persons to help clients, colleagues, and other professionals understand managed care and to elicit their help in advocacy efforts. An area of activism for counselors is the development of workshops specifically designed to examine and explore ethical issues in managed behavioral health care issues. The efficacy of counseling theories, techniques, and practices in meeting clients' psychological and behavioral change needs must be supported by research and demonstrated client satisfaction. As Woolhandler and Himmelstein (1994) asserted, opposition alone is insufficient in responding to the challenge of managed care.

Clients will ultimately determine managed care's place in behavioral health care. This has become evident in the activities of advocacy groups such as the National Coalition of Mental Health Professionals and Consumers, the National Alliance for the Mentally Ill, and the National Mental Health Association. In addition, there is growing interest in client-to-client evaluation of services and agencies providing behavioral health care.

An additional area of pro-active interest involves the formation of professional collaborative efforts. These groups can serve as quasi-managed care entities to conserve local resources and ensure quality care and cost containment.

## Public and Private Partnerships.

Locally based efforts to form collaborative partnerships among public and private agencies provide a promising solution in balancing the controls of managed care and in providing the best care for clients (Clay, 1998; Egnew, 1995). These collaborative efforts offer managed care companies an opportunity to negotiate with one organization for comprehensive services. They may be composed of private agencies, public community mental health centers, state- financed psychiatric hospitals, private hospitals, and private practice groups. The affiliations, usually functioning as Subchapter S corporations, form and sell their specialized services as one provider to a managed care company (Murphy, 1995). The partnership ventures have allowed the separate members acting as a whole to concentrate on their most successful service delivery area, to keep resources on a local level, and to preserve a greater share in decision-making about practices and collaboration with clients.

Clay (1998) reported two versions of provider-run organizations that afford autonomy and local control and also the same ethical dilemmas inherent in managed care service delivery. Health New England is run by psychiatrists managing speciality mental health groups. They acknowledge the same pressures to contain costs and maintain quality services as other public and private organizations. The Georgia Network of Psychologists (GNP) has formed a for-profit company to provide a "kinder, gentler managed care company that would be patient- and psychologist-friendly" (Clay, 1998, p. 20). Yet, the GNP remains a managed care concern which may emphasize cost over quality. Additionally, GNP risks potential conflict of interest by serving as part of the state-wide association and as a managed behavioral health care company.

Seen as works in progress, public and private partnerships and professional collaborations have proved to be complex (Monack, 1995). Public and private partnerships are difficult to negotiate because of legislative control of public sector entities and the legal ramifications of providing public and private financed behavioral health care (Egnew,1996). However, these partnerships and provider-run organizations have offered a means to buffer managed care especially on a local level and to pursue the research required to validate behavioral health care theories and practices.

## Conclusions

Counselors are facing changed relationships with clients, colleagues, funding sources, and a new system and philosophy of behavioral health care delivery. They must evaluate every aspect of managed behavioral health care in both the public and private sectors while adjusting to market place competition in a formerly exclusive helping environment. There may be demands to work with different subpopulations of clients. Counselors may be challenged about ethical decisions they make in regard to cost-containment and what is best for their client. There will be philosophical changes from viewing one's work strictly as a helping professional to assuming the roles of negotiator, organizer, business manager, and community advocate. Thoughtful reflection on the nuances of the ethical dilemmas prompted by managed behavioral health care can inform advocacy and action with and for clients and the counseling profession.

The rapid rate of change and adaptations in response to a developing managed care environment has tended to obfuscate the subtle dilemmas for counselors. Ethical issues for counselors cannot be framed solely in terms of the bottom- line, impersonal economics which appears to be the underlying philosophy for managed care. The intrusion of case managers, limited sessions, and loss of professional control in counselor to client relationships have been critical and important issues. But managed behavioral health care has forced counselors to consider a larger political and economic arena.

The issue is not so much whether maintaining ethical integrity under a managed system of behavioral health care reform is feasible. While it may be possible to function outside a managed care system, the more pressing moral imperative has compelled counselors to address residual ethical and social justice issues which previously occupied a low priority or were dismissed as intractable, complex problems better left to courts and ethicists (Faenza, 1995). These include escalating costs, lack of accountability, efficiency, effectiveness, and poor quality of care for clients least able to afford or advocate for services.

Counselors' ethical codes have originated from a professional commitment to clients and personal psychological growth, development to the fullest extent of human potential, and dignity and respect for all clients and society as a whole. Counselors are now being asked to safeguard their clients' rights while working within and, shaping a managed behavioral health care system. They must understand marketplace economic and political forces and simultaneously enter into a society-wide struggle to maintain social justice and ethical integrity for all clients of behavioral health care (Corey, 1996). Managed care is evidence of social change that can enhance benefits or become detriment for the poorest or wealthiest clients. This will clearly call forth from the counseling profession an increased level of advocacy and cross-disciplinary collaboration.

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# A Twist in the Paradigm of Counselor as Helper

MARIJANE FALL

*This article discusses the implications of self-efficacy theory for counselors and students of counseling who identify themselves as "helpers." A short discussion of self-efficacy theory is followed by an examination of "helpful" and "self-efficacy increasing" responses of a counselor. The article concludes with ideas for research and implications for practitioners and counselor educators.*

## A Twist in the Paradigm of Counselor as Helper

Literature often portrays counselors as helpers (Kell & Mueller, 1966; Ivey, 1991) and change agents (Egan, 1990; Pedersen & Carey, 1994). Indeed, upon asking practicum students why they entered the profession, I heard, "I seem to be good at helping people solve their problems," "I want to help people," "People always come to me with their problems, and I seem to know what to do to help them." Only one response out of 10 lacked the verb "help" with the implication of "fixing" another person's problems. This "counselor as helper" perspective may be problematic when increasing client self-efficacy is important. After a brief description of self-efficacy theory, hypothetical dialogs of counselors are examined to evaluate the effects of various counselor responses on client self-efficacy. The article concludes with implications for counselor educators and practitioners and ideas for research in this domain.

## Theory Revisited

Self-efficacy is defined as an individual's belief in personal ability to perform in ways that meet his or her needs (Bandura, 1997). While the theory was originally proposed by Bandura in 1977, it is still widely researched and utilized. Central to the theory is the belief that self-efficacy is domain specific and serves as a mediating variable between an individual's knowledge and skills and an individual's beliefs about personal ability to perform in an area. Thus, performance in a particular area is affected by an individual's judgment about self-efficacy. This judgment is the end result of a cognitive weighing of information from previous performances, the modeling of others, verbal persuasion, and physiological

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indices (Bandura, 1977). Previous research has linked these four influential sources of information to self-efficacy judgments in children (Fall, 1994; Fall, Balvanz, Johnson, & Nelson, in press), and in adults (Bandura, 1997).

The first influence, personal performance, substantially influences personal performance on a task or behaviors (Bandura, 1997; 1986), with successful performance raising a person's self-efficacy level (Bandura, Adams, & Beyer, 1977). The performance enables a person to see that he or she actually has put knowledge and skills into action. "I've done it once, so I can probably do it again," might be the message.

The second influence to self-efficacy level, the modeling of others, allows an individual to see that others with comparable personal skills, can do this specific task. Bandura, Adams, Hardy, and Howells (1980) found that seeing others perform successfully can raise an individual's self-perception of efficacy in personal ability to perform similarly. Research showed that peer models were the most influential (Schunk, 1987). "If Joey can do it, I probably can," might be the message gained from watching a model.

The third influence to self-efficacy judgment is the verbal reinforcement of others. "Marge says I can do it, says I have the ability to do it, so maybe I can," might be an individual's interpretation.

Physiological indices are the fourth category of influences. Anxiety and stress levels give messages about whether or not an individual appears to be able to perform a task. The message may take the form of such indicators as sweating palms or increased heart rate and comes to signal a person that he or she is in a tense situation where failure may result. Bandura and Adams (1977) found that when emotional arousal was eliminated, self-efficacy was heightened and performance improved. "My hands are sweating, my heart is pounding, and I'm always in trouble when those things happen," might be the translation.

## Application of Self-Efficacy Theory to Counseling

The beginning counselors mentioned in the opening paragraph may not be assisting the client in ways that increase self-efficacy as a problem solver and a coping individual. Instead, the counselor may satisfy a personal need to help others by taking over for the client, making decisions, and appearing as a knowledgeable authority that prescribes client actions to address client concerns. Counselor self-efficacy may increase due to successful performance (coming up with successful ideas to help the client), reinforced by verbalizations of the client ("I don't know what I'd do without you to help me"). Client self-efficacy may stay the same, minimally increase (due to the modeling of the counselor), or decrease (someone else had to "help" the individual). Thus, counselor self-efficacy may increase, but client self-efficacy will not be enhanced. For most of us, this is not a desirable outcome.

An examination of each of the four influences of self-efficacy judgments will serve as examples of hypothetical positive and possible negative interactions

between counselors and clients. Cl designates the client's words; Co "Helpful" designates the "helpful" counselor's words, and Co "SE Increase" contains the words of a counselor wishing to increase client self-efficacy.

**The Influence of Successful Performance**

Cl: I can't talk to him. I never say it right. Nothing ever works.

Co "Helpful": I saw him out in the waiting room. Would you like me to speak to him about this problem and see if the three of us could begin to work it out?

Co "SE Increase": I can tell that this is really hard for you. But I remember that you called me and made an appointment. That was hard, but you did it. Let's pretend that he is sitting in this opposite chair. Tell him what you told me about this problem.

In the first counselor response, it is the counselor who gains in successful performance messages because it is the counselor who takes action. The message to the client is that others have to help. Thus, counselor self-efficacy may be increased, but client self-efficacy will stay the same or, at best, minimally increase over time from watching the successful modeling of the counselor. In the second response, the client is being assisted in performing the needed action. There will be a performance influence on self-efficacy judgment.

**The Influence of Vicarious Experiences**

Cl: I just can't do this.

Co "Helpful": Perhaps I can help.

Co "SE Increase": Perhaps others in the group who have been able to overcome this might model how they reacted when a spouse was going to become combative.

The first counselor is rushing to aid the client. Client self-efficacy is not positively affected. In the Co "SE Increase" response, the message is that others who are similar to the client have been able to accomplish the task.

**The Influence of Verbal Reinforcement**

Cl: I never dare tell someone when I need help. The other day your receptionist made a mistake on the bill, and I didn't dare tell her. She probably thinks I'm crazy because I come here!

Co "Helpful": I'm sure that isn't the case, but I'll speak to her and tell her you need to straighten something out.

Co "SE Increase": It sounds like it's hard for you to speak up to someone. You were very clear with me when you called to schedule an appointment. What made that situation different for you?

The above example shows verbal persuasion. The counselor gives a message that the client cannot personally cope in the first response. The second response is characterized by acceptance of the client as a responsible individual who can

do things for herself. The counselor is verbally giving a message that can influence self-efficacy judgment.

**The Influence of Physiological Influences**

| | |
|---|---|
| Cl: | I'm feeling really anxious again. I don't think I should talk about the death. |
| Co "Helpful": | Let's talk about your son. That seems to be an easier topic for you. |
| Co "SE Increase": | It's important that you can now verbalize that. Perhaps it is a time to start that deep breathing that you are doing at home and relax before you talk of your husband's death. |

In the first response the counselor takes the pressure off and probably changes the physiological state of the client by changing the subject. The vicarious message is that the client is unable to manage the anxiety. In the second response, the client is encouraged to take charge of the physiological response that is giving a message that he or she is unable to handle this topic. The relaxed breathing should lower the anxious state and send a performance message to the client that this is personally manageable.

The examples show how easy it might be to give a message that could contribute to a decrease in client self-efficacy level over time. There is an inconsistency between the original career goal of counselor as fixer of all problems and the theory of self-efficacy. Another inconsistency exists: Others, such as family members and friends, also believe that counselors fix clients. Thus, there is further reinforcement for a counselor who takes on the role of "helper who fixes everything." This counselor behavior that is expected by others, does not contribute to beliefs that increase self-efficacy.

## Implications and Next Steps in Research

Many counseling students and practicing counselors respond in a positive way to both (a) the pressures for the counselor to "fix" the client and (b) to the "need" to help others which was the impetus to begin an educational program for the profession. These individuals learn new ways to assist clients, learn about their personal needs, learn how to separate these needs from counseling, and learn to eliminate the helper behaviors that increase dependency and decrease self-efficacy. However, many individuals do not learn this. Counselor educators and supervisors can respond in ways that facilitate learning.

1. Masters-level students can become aware of self-efficacy theory and how it relates to the counseling process for both counselors and clients. A journal reading assignment of the theory and writing a reaction paper may begin the process of integration of the knowledge. Practitioners may wish to increase their knowledge in this area as well.
2. Professors and supervisors can stress the role of counselor as change agent, not changer of people, and counselor as facilitator for individual change,

not fixer of problems. Masters level students who have come from a teaching or social work background may be accustomed to taking charge of client responses and actions. They will need to learn to allow clients to have control of the answer. Individuals who have come from a psychology background may have less trouble with this concept but will need frequent reinforcement.

3. A student in counseling practicum needs clients from the populations the student intends to work with upon graduation. If the student will be working with children as a school counselor, at least one practicum client should be from that population. The same practicum student can be facilitative with one client population and less so with another. For example, it is my experience that the need to "do for" is more prevalent around children and elderly people in counseling situations. Supervisors need to be continually asking students to reflect on how counselor actions are helping, or not helping, populations being counseled.
4. Practitioners or students, who will be working with a specific population, will preferably be supervised by qualified individuals in that area. While this match between supervisor and interest area is often met in internship, it may not be met for the practitioner or practicum student. As one example of this point, practitioners who work with the elderly will preferably have clinical supervisors with experience counseling the elderly. Due to developmental, cognitive, and social-level differences, working with the elderly populations requires a unique awareness. A supervisor with no experience working with senior adults might not understand the theory and application of adult education.
5. Clinical supervisors (Su) can refer directly to self-efficacy theory when assisting supervisees. Examples are given below.
   - Su: You have told me of the goals for counseling this client. How are you attempting to assist the client in meeting these goals, and is it consistent with self-efficacy theory?
   - Su: Was the intervention that we just watched consistent with building self-efficacy?
   - Su: How might you help the client feel more efficacious?
   - Su: What is your belief about your ability to facilitate this client's growth? How is that affecting your counseling?
6. Practitioners and students can watch video tapes of their counseling sessions and identify responses of the counselor that can add to positive efficacy judgments of clients' abilities to cope and to take action to help themselves. Brainstorming possibilities with another individual can also add to a practitioner's repertoire of interventions.

While the list above is small, it is the beginning of thinking about the construct of self-efficacy and integrating it into counseling style. All counselors will not follow the same theoretical framework, nor do we wish for that. However, a

counselor needs full awareness of the impact of counselor actions. Future research can contribute to this awareness. For example, it would be interesting to compare pre and post self-efficacy test results for individuals in counseling vs. a control group with no counseling. Research shows that children receiving six sessions of a play therapy intervention score higher on a self-efficacy measure (Fall, Balvanz, Johnson, & Nelson, in press). Would adults show similar results?

A second area of possible research interest to practitioners could compare language, "helping" interactions, and self-efficacy scores using pre and post testing with clients. One group of counselors could be trained to use language and interventions that appear to increase self-efficacy of clients. The second group of counselors may have no training concerning self-efficacy. Comparisons between the number of efficacious statements made by the counselors, the number of counselor "helping" responses that the client could have performed him or herself, and pre and post-self-efficacy scores could prove fruitful.

Last, there are many questions that might be asked. One reviewer wondered what questions counselor educators ask potential students about helping others, or allowing others to help themselves. Are there variables that appear to affect change in the helping perspective? As questions are asked, pondered, and answers explored, we will move closer to understanding the role of self-efficacy in counseling interventions.

## And So the Twist

It is ironic that the personal values that attract people to the profession of counseling can work against personal effectiveness in helping clients. Yet, that is possible. Helping others may become twisted around from a desired value, to one which is counterproductive to the increase of self-efficacy if counselors do for clients what clients can do for themselves. Educators and supervisors need to address this undesirable twist, less the twist cause a break in effectiveness.

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# Review of Health and Longevity: Mental Health and Developmental Issues from 1911

John McCarthy

Richardson, J. G., Scholl, B. F., Ford, W. H., Vanderbeck, C. C., Noguchi, H., Powell, W. L., Noble, G., Van Werth, Hoff, M., Mencki, A. O., Meyers, W. W., Craig, W. F., Stafford, A. M., Davis, E., Daniell, A. W., Roeber, E. F., Latauche, J., & Iwasaki, S. (1911). *Health and longevity.* New York: Home Health Society.

As the new century nears, people are eagerly anticipating what will be in store. Prognosticators speculate on what political trends, new inventions, and breakthroughs in technology will bring in changing the country's lifestyle. The word "millennium" arises frequently in commercials and other promotions. The listing of "careers of the next century" is eyed with wonderment, as occupations never before considered become reality. Even the White House has launched a contest for a logo for the new century.

With this in mind, it is important to remember that one way of perceiving the future is by examining the past. In regard to the counseling profession, an examination of J.G. Richardson and colleagues' *Health and Longevity* offers insights into the roots of counseling during a time when the profession was coming into its own.

At about the same time as Beers, Davis, and Parsons were pioneering the areas of mental health reform, school counseling, and career counseling, respectively, Richardson and his international team of 18 fellow medical professionals set forth on a 1382-page compendium that was touted as the "absolute authority on every subject." Their work offered 15 chapters and included material on nearly every medical, physiological, social, and mental issue imaginable. From sections on "gas lighting" to "evil effects of exposure to draughts" to "movements of spermazoids," the authors compiled an extensive array of health-related issues at a time when the average lifespan was approximately 50 years.

Of particular interest is the notion that many mental health issues of today were covered by these medical – not mental health – professionals. The status of mental health treatment at that time was clearly rooted in areas not covered in most introduction to counseling courses of today. Their "mental healing" section contained subtitles that include Mesmerism, hypnotism, mind cure, Christian

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Science, and telepathy. Nonetheless, even for the early part of the century, Richardson et al. recognized the importance of mental health and of some type of "talking cure," claiming that no volume on medicine was complete by addressing drugs exclusively. Further, they noted, "The mind, which tells us of our sufferings, is the path along which relief and recovery often travel" (p. 1298).

The inclusion of telepathy in this section is noteworthy. Richardson et al. cited the example of a person sleepwalking in a dangerous area as support for the idea that a medium existed that was "adapted to the sight of the mind" enabling people to see things "beyond the sense of ordinary light" (p. 1307).

Two anecdotal pieces of evidence were offered in support for telepathy. One involved two people joining hands. A third person pricked the first person with a pin. The second person, whose hands were joined with the first, was able to feel the pain at the exact point in the body where the pin touched the first person's body. The authors also suggest that telepathy was present in marital relationships when on person's mood became consistent with the troubled partner and failed to improve until the other's mood brightened.

The section on "mental science" makes the progress of the counseling profession over the past 90 years even more evident. This section encompassed the subjects of "phrenology, physiognomy and palmistry." Once again the importance of understanding the mind was made clear. By not comprehending mental science, the authors maintained, the profession could never begin to understand human beings. Being open to such areas was imperative as well, for, in the previous 20 years, physicians would have declared hypnotism to be impossible and would have ridiculed palmistry. By 1911, however, medical professionals recognized hypnotism "as one of its most important studies" and admitted that "the different formations of nails indicate different diseases" (p. 1323).

Phrenology, the belief that certain bumps on one's head indicated specific personality characteristics, seemingly led to stereotypes, some of which are evident in today's world. This section was divided into three broad categories: the propensities of animal organs, the intellectual faculties, and the moral or spiritual sentiments.

The area of physiognomy addressed facial expression. For instance, Richardson et al. noted that the expression of people from France was "concentric, rapid and gay." The authors associated English expression with being "haughty and stern" and referred to German expression as "heavy, benevolent, and always ungrateful" (p. 1329). The face depicted conditions of health, degree of beauty, moral and intellectual worth, and race. The "good face" had a "permanent expression of benevolence and the absolute absence of all hypocrisy," while the "evil face" was "false" and was typified by those who incessantly avoided eye contact for "the invincible fear" that "others may read within him [sic]" (p. 1330). Characteristics were also outlined for faces that exude intelligence, stupidity, amativeness, friendship, mirthfulness, spirituality, and combativeness.

Palmistry was divided into chirognomy (hand and finger shapes and how they relate to hereditary influences of character) and chiromancy (the lines and mark-

ings of the palm and how they depict past, present, and future events). Consistent with previous typologies, seven kinds of hands were reviewed. The psychic hand, for example, was considered the most attractive, but was reflective of idealistic persons who trusted anyone who was kind to them. Further, the authors suggested that people with the psychic hand lacked logic, discipline, and order in their lives.

Not overlooked was the role of feelings ("passions") as they related to mental health. Richardson et al. devoted a section to this topic, though they confessed, "Of nothing do we think we know so much while in reality we know so little" (p. 680). Love was characterized as the strongest of the passions, existing in men more strongly with respect to one another and more strongly in women with respect to men. The authors reviewed women as superior in their ability to love, for through heredity and education, they had "finer feelings" and their "native element" is love (p. 699). In attraction, the authors believed that "civilization" reversed the gender roles. In "civilized societies" it was the women who attempted to increase their attractiveness, while, in "savage societies," it was the men who did so. The most attractive features that both men and women sought were in others' hair, hands, feet, and eye expression.

Other passions included grief, which had the ability to "soften some people and harden others" (p. 680), and fear, of which "peculiarly gruesome" ones were aroused by certain kinds of vermin and "black things, and especially dark places, holes, caverns, and so forth . . . " (p. 687) . . . . The passion of sociability was harmed by solitary confinement, a great evil for people. Authors cited James, who had asserted that secretiveness was a "blind propensity" that was "so stubborn and ineradicable" that it did not deserve to be considered an instinct (p. 689). The "passion for hunting" was to be expected in boys raised "naturally," especially in the country. Festivals and ceremonies brought out the passion for play in adults. Admiration was described as "wonder mixed with love," while pity was marked by "sympathy with pain" (p. 690). Other passions included avarice, gratitude, and pride.

The authors described the overarching position as one in which feelings were manifested in behaviors, which seems consistent with contemporary behaviorism. The authors contended that one can control and develop passions by acting the opposite of the passion. If frowning, the advice was to smooth the brow. Similarly, if talking in a high tone, a person should lower the pitch. By doing the opposite, Richardson et al. maintained that negative emotions, such as anger, were temporary and that people retained the capacity to lead happier lives once episodes ended.

Richardson et al. deserve applause for their foresight and emphasis on mental health issues in their compendium of *Health and Longevity*. Though some of their material has been unsubstantiated, their stance on mental health being an integral component of overall health rings consistent with the mindset of today's mental health professionals. Even in the early part of the century, Richardson et al. appeared to negate dualism in the mind and body as they endorsed a mind-body paradigm.

Most importantly, though, the authors' work points to our ongoing struggle to understand human beings, particularly from a mental perspective. This challenge is just as alive today as it was when this book was published. Richardson et al.'s work has provided the counseling profession with an additional base to understand the direction from which it has come and a guide to where it might proceed.

# Lest We Abuse Our Personal Power in Counseling and Supervision: An Interview With Dr. Glenda Elliott

SANDY MAGNUSON

*This article contains the essence of professional insights recorded during interviews with Dr. Glenda Elliott. She discusses her synthesized approach to counselor education and supervision which is based essentially, but not exclusively, on the core conditions defined by Carl Rogers. She addresses theoretical integration, evaluation, and ethical concerns. Dr. Elliott emphasizes the potential for abuse of power within the contexts of counseling and supervision.*

Dr. Glenda R. Elliott's quiet and extensive contributions to counselors and the profession of counseling are well known to those of us who live in Alabama, as well as to many counselor educators across the Southern Region. Indeed, "Dr. Elliott has served as an example of what professionalism is to her students and colleagues. . . ." (Frost, 1996, p. 5). Her contributions were formally recognized by The University of Alabama at Birmingham in 1975 when she received the Ingalls Award for Excellence in Teaching, and in 1991 when she received the President's Award for Excellence in Teaching. Dr. Elliott was also the recipient of The Alabama Counseling Association Professional Development Award in 1992 and Distinguished Professional Service Award in 1995.

Dr. Elliott was a counselor educator at The University of Alabama at Birmingham from 1973 until 1994. She is a Certified Clinical Mental Health Counselor, a certified clinical supervisor, and a former member of The Alabama Board of Examiners in Counseling. In addition to working with clients and supervising entry-level counselors in her private practice, Dr. Elliott continues to teach as an adjunct professor at The University of Alabama at Birmingham.

## Lest We Abuse Our Personal Power in Counseling and Supervision: An Interview With Dr. Glenda Elliott

Sandy: After we visited about postgraduate supervision in 1995, I commented to a friend, "Dr. Elliott's perceptions and insight related to postgraduate supervision are so rich! I feel so fortunate but also somewhat guilty, as if I were monopolizing a wealth of valuable information that ought to be shared with others." So, I was most pleased when you said I could interview you again for an article.

Dr. Elliott: Thank you for the opportunity to continue our discussion.

Sandy: I was particularly interested in how you conceptualize supervision and how you negotiate the evaluation responsibilities within person-centered supervisory relationships. I was also struck by your keen sensitivity related to the potential misuse of power in supervisory as well as other relationships. I'm eager to learn more about that.

Dr. Elliott: I appreciate the opportunity to be interviewed and to reflect on these questions. Thinking about the interview has resulted in the recall of meaningful memories and stimulated the refinement of some ideas.

## Historical Perspective

Sandy: How were you initially attracted to the person-centered approach to counseling?

Dr. Elliott: When I first went to graduate school in the early 60s, my first counseling theory text was Patterson's first edition of *Counseling and Psychotherapy* (1959) in which Patterson put forth the case for client-centered psychotherapy. My graduate work throughout the 60s corresponded with the emergence of and emphasis on the client-centered approach in counselor education programs throughout the country.

What stands out in my mind as the real link for me with the client-centered approach was Ed Wheeler who was my practicum supervisor at the University of Georgia where I finished my master's degree. He received his doctorate at the University of Florida under Art Combs. The text for the practicum was *Individual Behavior* (1959) by Art Combs and Donald Snygg, the classic text on the perceptual/phenomenological approach to psychotherapy and the understanding of human behavior. The 1959 edition was a revision of the first edition (Snygg & Combs, 1949). Of interest to me is the fact that even though Combs had been a doctoral student of Rogers, Rogers acknowledged Combs as having influenced his development of client-centered therapy (Rogers, 1951).

My being drawn to the client-centered approach was, I believe, a function of my age and the time I went to graduate school (mid to late 60s). There was a coming together for me of the time, the place, and the theory. I was introduced very early to the perceptual/phenomenological approach and I resonated with it. It just made sense to me. I believe we select theories that help us make sense out of our experience.

Sandy: What was it about the approach that made so much sense to you?

Dr. Elliott: One of the reasons it made sense to me relates to my own personal history. I grew up as an only child, living in a small, isolated rural community. My only sibling, a sister, was born when I was almost 12. Therefore, I needed

reflection and validation of my experience--someone to enter and share my world with me. The client-centered approach with its phenomenological emphasis answered that need. I really resonated with a perspective that emphasized the importance of understanding and validating the other person's experience, seeing the world the way another person sees the world, and creating a safe environment for sharing and talking about those experiences.

Another influence during the same time I met Ed Wheeler at Georgia happened in a vocational development course. There were supplementary readings that were not career readings per se. Two that stand out in my mind were Victor Frankl's *Man's Search for Meaning* (1959) and Betty Friedan's *The Feminine Mystique* (1964).

Sandy: I am intrigued by that combination!

Dr. Elliott: I found much validation for my experience as a female and my developing identity as a woman in *The Feminine Mystique* (Friedan, 1964). *Man's Search for Meaning* (Frankl, 1959), with its existential perspective, spoke to my total being. Of course, the existential view and the client-centered approach fit together. So, these two books comprised another important influence.

In the fall of 1968 I went to Kent State to pursue my doctoral work. Carkhuff's (1969) *Helping and Human Relations* was published in 1969. I used Carkhuff's Indexes of Communication and Discrimination in my dissertation (Elliott, 1971; 1978). As you know, Carkhuff's model is based heavily on the work of Rogers and Truax. The basic core conditions of the helping process central to client-centered therapy are the foundation of Stage One of the model. Of course, I liked the model very much and have used my own adaptation of it for some time in my teaching, counseling, and supervising. I was pleased but not surprised to read recently that research of effective counseling practice continues to support the importance of relationship factors, particularly empathy (Lambert & Cottani-Thompson, 1996).

## Integrating the Core Conditions in the Counselor Education Curriculum

Sandy: How would you design the counselor education curriculum to include the person-centered model without minimizing the importance of other approaches?

Dr. Elliott: Until recently, my primary identity was that of a counselor educator. Secondarily, I was a counselor with a small, part-time private practice. My approach to counseling and teaching is holistic. Through the years I have integrated elements of other theories, with client-centered remaining an essential cornerstone. This integrated synthesis coincided with my view of myself as a counselor educator. That is, as a counselor educator, I believe it "fit" for me to be

someone who synthesizes and, at the same time, attempts to foster students' development by encouraging them to pursue the theory or theories that "work" for them and helping them develop/clarify their own approach to counseling.

The program in which I have taught is a masters and educational specialists level program. When I was on the faculty we offered an adaptation of the Carkhuff model that came to be known as the Egan Model or the Human Relations Training Model. We said, "This is the model we propose. We encourage you to select the theory of your choice such as Reality Therapy, REBT, Adlerian, etc. and integrate it with the model."

Sandy: I have found integration to be a difficult task for my students. Do you provide assumptions or principles as a foundation for theory integration?

Dr. Elliott: In my teaching and supervising, I ask students and supervisees to accept the validity of the basic core conditions as one of the cornerstones of their counseling. Then I encourage them to construct their own particular approach by a process of interacting with the various theoretical models and then fashioning what really fits for them.

I still think this approach is valid. It respects individual differences among students and at the same time it reflects the belief that it is essential that students be able to establish a therapeutic relationship based on the basic core conditions. Those values were formed early for me, and they have remained.

Sandy: How would you respond to Patterson's (Freeman, 1992) suggestion about permitting students to select theories classes according to the orientation presented by the instructor?

Dr. Elliott: I take issue somewhat with Patterson's (Freeman, 1992) saying that counselor education programs should offer two or three major theories with faculty members who are expert in each theory, allowing students to choose their supervisor according to theory preference. I think Patterson's view may more easily be implemented at the doctoral level.

## Potential Misuse or Abuse of Professional Power

Sandy: When we first visited about supervision I was particularly intrigued by your references to hierarchical relationships and the inherent potential for supervisors to misuse their supervisory power. I had a sense that this was an issue you had initially recognized in other contexts.

Dr. Elliott: In 1991, I started teaching a class on the dynamics of child sexual abuse and the implications for counseling. In workshops I attended on sexual abuse, and in the literature I was reading, sexual abuse was often defined as the

abuse of power. However, my most significant understanding of the abuse of power came out of my own personal experience, including my personal relationships, as well as my experiences as a client. As a result, then, of all these influences, I began to take a closer look at the way I could possibly abuse power in my relationships, both professional and personal.

My view on the misuse of power in the counseling and supervising relationship represents a convergence of our growing awareness of the dynamics of sexual abuse and sexual harassment, our becoming more conscious of dual relationships, and my examining the ways I might possibly abuse power in my own personal and professional relationships.

I am particularly indebted to the Jungian concept of the polarity of the opposites and the propensity for splitting the archetypes (Guggenbühl-Craig, 1979). In the case of counselors and supervisors, I have come to understand our vulnerability to splitting the archetypal polarities of healer-patient, counselor-client, supervisor-supervisee. In the splitting, it seems we are prone to identify with the side of the polarity perceived to be more powerful--the healer, counselor, supervisor, etc. All of these perspectives have led me to see most of our professional relationships as hierarchical and, thus, ripe with the potential to abuse power.

Sandy: As supervisors and counselor educators our roles are inherently hierarchical. How can they not be? When we're seeing clients, an unequal hierarchy is present, depending to some extent on how we structure our therapeutic relationships. I think our clients typically look to us as "superior," even if we don't see ourselves or intentionally place ourselves in a superior role. We seem to be placed in that position of power whether or not we claim it or climb on to it.

Dr. Elliott: That power, the superiority, is also projected on to us. It's something that can't be helped. And, if I need to see myself as the all-knowing supervisor who has nothing more to learn, I will willingly carry the projection! I will identify with the supervisor side of the polarity to the exclusion of the supervisee side. Thus, the groundwork is laid, I believe, for the potential abuse of power.

Sandy: Considering the multiple roles and responsibilities attributed to supervisors, and placed in the context you articulated, the potential for the potential abuse of power is enormous. How do you monitor it?

Dr. Elliott: Guarding against that potential for the abuse of power brings me back to the person-centered approach. Being grounded in the core conditions of the person-centered philosophy minimizes, I believe, the tendency to abuse power. If I am truly trying to enter into the other person's world and understand that person's experience from his or her frame of reference, if I truly respect the other person and that person's right ultimately to be self-directing, and, if I am congruent in extending these conditions, I will be less likely to impose my will on the

other person. It is here that I make the bridge between my theoretical approach to counseling and supervision and my ideas about the potential for the abuse of power in our counseling and supervising.

Sandy: During one of the interviews you talked about your work with counselor trainees who are learning to work with offenders. You talk with them about their attitudes toward the offenders, and you use that concept to enhance awareness of the their own potential for misusing power. As I remember, you ask them to examine possible ways they have previously abused power.

Dr. Elliott: That's right. I typically invite them to explore ways that power can be abused in hierarchical relationships and to consider times they might have done that. Usually I acknowledge my own inappropriate uses of power by saying something like, "I know I have . . . ." And then we would move to "How can we guard against that? What's the best protection?"

A primary protective method I advocate is to stay grounded in the basic core conditions. If I'm truly trying to be empathic, if I truly extend unconditional positive regard and acceptance, and if I can be genuine and congruent--which requires a great deal of self-awareness--then I will minimize the potential for abuse of power.

## Adhering to Professional Standards and Maintaining Congruence

Sandy: It sounds as if you endeavor to be sensitive and alert to possibilities of abusing your supervisory power. At the same time, you have acknowledged your responsibility to assure that your supervisees meet minimum standards. It seems the supervisory stance you have described would be relatively easy in the roles of consultant and teacher. When it comes to assessment, gatekeeping, and protecting clients, I'm not so sure.

Dr. Elliott: I take very seriously my responsibility as a supervisor to assure that my supervisees meet certain standards both in terms of competency and adherence to ethical standards. In the exploratory stage of our relationship and as we develop the supervision contract, I make clear my expectations, including our adherence to the *ACA Code of Ethics* (1997) and *ACES Ethical Guidelines for Counseling Supervisors* (1993). In following ethical standards, I invite and encourage my supervisees to identify and analyze ethical issues in ways similar to the model put forth by Kitchener (1986), including her emphasis on the basic moral principles of autonomy, nonmaleficence, beneficence, and justice. I also propose these same principles in the class on child sexual abuse as guidelines for ethical reasoning in counseling clients with sexual abuse issues.

In terms of being congruent with the person-centered core conditions and my

responsibility for evaluating the competence of my supervisees, I have incorporated elements of the original Carkhuff training model and Interpersonal Process Recall (Bradley, 1989) in synthesizing my approach to supervision. Essentially I present my synthesized model and then ask, invite, and encourage my supervisees to evaluate their own work. Together, then, we review their analysis and evaluation.

Sandy: How does that look in an actual supervision meeting?

Dr. Elliott: My usual stance is to encourage my supervisees to first devise and construct improved responses to client interaction. I might ask, "What would you say differently? How would you have said it differently?" And I make it clear with my practicum students in the beginning that I am more concerned about how they evaluate their tapes than I am concerned about what they are doing. I often say, "Of course I am going to be listening to your tapes to make sure that you are at least not saying something harmful to the client. I have the responsibility to be sure that you are performing in a way that is not going to be hurtful. In the beginning I am going to really pay attention to your self-evaluation. One of the things that we are going to work on is how you can improve your own self-evaluating/self-critiquing skills." Thus, I strive to develop with the students a more mutual kind of evaluation. Ultimately I am encouraging students and supervisees to activate and access the supervisor within themselves. Indirectly, I am encouraging them not to split the archetype but to begin to identify with the supervisor within as well as the supervisee!

Sandy: How do you respond when they are not able to demonstrate desired levels of skill?

Dr. Elliott: Usually they come in and say something like, "OK. Here is a response that I know really missed the mark . . . . I didn't respond to the feelings" or "I just ignored what the person said . . . . This is what I would have said . . . ." And I might say, "I'm right with you on that." If the student misses something or the alternate response, in my opinion, is still less than adequate, I say something like, "Well, I heard something different in what the client was saying, and an alternative response I would suggest is . . . ."

Sandy: How do you arrive at a final evaluation?

Dr. Elliott: It is something that we arrive at together. At the end of practicum I ask students to prepare a written self-evaluation and to bring it to the last session. We start with that. And I bounce off that. I typically say, "I really would underscore what you are saying here. I saw that as one area that you really did improve on. Yes, I agree these are the skills . . . ." I always structure the task by saying, "Include in your self evaluation the skills you need . . . that need improving . . . that you need to work on."

Along these lines then, ideally, they would ultimately assume responsibility for their own gatekeeping, and when they know they are not functioning right, to recognize it, get help . . . get their own therapy. By teaching them early how to discriminate facilitative from inadequate responses, they are beginning to access the supervisor within themselves.

That doesn't mean to the exclusion of other supervision.

Sandy: That could be a component of self-monitoring . . . self-growth and responsibility for growth and self-evaluation for persons who are in counseling. I'm thinking about how enriched supervision would be if the supervisee did assume more and more responsibility for his or her self-evaluation. The supervisor would facilitate the supervisee's becoming an expert in self-critiquing and self-monitoring. It seems that that would be ideal!

## Responding to Needs of the Supervisee and Adhering to Ethical Guidelines

Sandy: How do you bridge the ideal with your responsibility to uphold the ethical standards?

Dr. Elliott: The critical importance of the supervisor's self-awareness is obvious and paramount in my perspective on supervision. As a clearly hierarchical relationship, the supervisor-supervisee relationship holds much potential for the abuse of power. Early on and to varying degrees most supervisees are dependent on me for guidance, direction, and support. For some, the desire to please me may go beyond the need to be evaluated as competent. If I am not very aware and careful, these needs of the supervisee can play directly into whatever needs I have for power and control. Thus, I can become vulnerable to the temptation to impose my will on the supervisee.

Because I am also psychotherapeutic (Bradley, 1989) in my approach to supervision, I am sensitive to transference and countertransference issues. If I observe the possibility of a supervisee's personal issues entering into the counseling process, I will offer my observation and sometimes suggest that the issue may be more of a personal therapy issue for the supervisee than a supervision issue. Because I see countertransference issues as ripe with the potential for the abuse of power in the counseling relationship, I strongly emphasize the importance of self-awareness on the part of the counselor/supervisee. I make all of these concerns and expectations, along with disclosure of my theoretical orientation, known to potential supervisees when we have our exploratory interview regarding supervision. In this way, informed consent is derived.

Sandy: What are some supervisory actions that you monitor to prevent misusing your power?

Dr. Elliott: For example, I could impose my will by insisting that the supervisee agree with my interpretation of the dynamics occurring between the supervisee and client or between the supervisee and me. I could insist that the supervisee try the same response or intervention that I would try with a client. If I have unresolved personal issues similar to those of the supervisee or the supervisee's client, I am vulnerable to projection of my own issues into the supervision process. Another example might occur in discussing client or supervisee issues that are religious or political in nature. I may try to impose my own religious or political perspective on the supervisee and "encourage" the supervisee to influence his or her client to take the same perspective.

Sandy: You mentioned this issue in our first visit. I was hoping you would be willing to elaborate on your views.

Dr. Elliott: I am concerned about Licensed Professional Counselors or supervisors who identify themselves as proponents of a certain religious or spiritual orientation. While I strongly believe in the right of religious freedom and the right to practice one's religion, I question the "right" of a counselor or supervisor to use the credential of a state regulatory agency to practice counseling that promotes a particular religious perspective. In this context, I would also question the use of a certification by a professional organization such as NBCC or AAMFT whose code of ethics prohibits the imposition of one's personal values on clients or supervisees. I think it is possible that the use of these credentials to lend legitimacy to a religious or political view could be a subtle but significant abuse of power.

If counselors or supervisors want to "promote" a particular religious or political viewpoint, I certainly believe they have the right to engage in such practice under the auspices of a religious institution or political organization. However, I do question their use of the state license and certain certifications (e.g., NBCC or AAMFT) to promote their practice. Not only do I believe individual counselors and supervisors need to address this issue; I also believe the issue needs to be addressed by our licensing boards and professional organizations.

Sandy: If you were training counselor supervisors, what would you advocate as strategies to monitor use of power or prevent its misuse?

Dr. Elliott: I believe it is essential that counselors and supervisors be knowledgeable of and committed to our ethical standards, including the moral principles mentioned earlier that underlie the ethical reasoning process. Educating ourselves regarding the subtle as well as obvious ways we can misuse our power is another way. Also, grounding our counseling and supervising in the basic core conditions of the helping process helps protect us against the potential to abuse power. Above all, I believe self-awareness is the key in preventing or minimizing the misuse of power inherent in the counseling or supervising relationship. Self-

awareness enables me to be congruent. That component of being an effective counselor or effective supervisor is how aware I am of myself and what I'm experiencing, and what my own issues are, and how all of that enters the counseling or supervising process.

Sandy: Becoming knowledgeable and committed to standards is quite tangible, as is attaining a grasp of the foundational moral principles that undergird our standards. To some extent, a solid understanding of the core conditions is palpable. Self-awareness is elusive.

Dr. Elliott: Enhancing one's self-awareness is an on-going and never-ending process. Being willing to seek consultation and supervision is vitally important. I strongly support the concept and practice of supervision for the supervisor. It keeps me in touch with the supervisee within myself and the never-ending process of learning. Also and perhaps most importantly, having been and continuing to be, at least periodically, in therapy for oneself is essential, I believe, in becoming and continuing to a competent and ethical counselor or supervisor.

## Concluding Comments

Sandy: Once again, I am stimulated by the diversity and rich quality of your perceptions and insight. Thank you for enabling me to share our conversations with others. In closing, I'm wondering if you would define the values on which your work as a counselor, as a counselor educator, and as a counseling supervisor is predicated.

Dr. Elliott: I value deeply the uniqueness of the individual while at the same time recognizing the commonality and interconnectedness of all living beings. This twin value relates to the value I place on both autonomy and interdependency. I hope it is obvious in my relationships that I value collaboration and cooperation over competition and dominance. An implied value would be mutuality.

I value and believe in the inherent capacity of the individual to be ultimately self-directing, given the presence of the core conditions so eloquently delineated by Rogers (e.g., 1951, 1961) – unconditional positive regard, empathy, and congruence. I value self awareness, becoming an increasingly more conscious human being. I hope my acting on these values lessens the chance I will project my own unresolved issues onto others. In this way, I hope I make my own individual contribution to the healing of society, both present and future.

I believe in the value of service, and I hope both my professional and personal service is not only helpful to others, but also I hope it honors the people who have been of service to me.

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# Breaking Tradition

JAN KRATOHVIL

Giving up depression
was a pretend impression
in my family-of-origin in life.

For to transcend oppression
is the worst transgression
against all the family's rules of strife.

For if YOU become happy, how are WE to be?
and you're shaking your fist at what we taught!
To betray 8 generations of die hard fatalists
is to state our misery was for naught.

So shame on you, if you feel better,
and how dare you hurt your poor mama
to do this cognitive-behavioral thing that you do
and follow the ways of Dalai Lama.

Don't feel good for long,
do you hear what I say?
Happiness is not our rendition.
Don't make it,
Don't be you,
Don't be sane,
And don't play.
You are breaking our family tradition!

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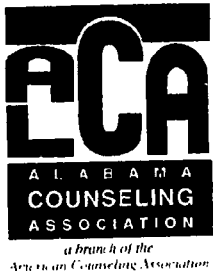


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