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Letter From the Publisher

March 10th, 2011

The National Board for Certified Counselors (NBCC) decided to launch a new academic journal. But not your average, run-of-the-mill journal—our goal was to create an exciting online resource for the counseling profession that would appeal to the more than 46,000 National Certified Counselors (NCCs) around the world and also speak to counselor educators, practitioners, graduate students, researchers, supervisors, and the general public.

Knowing that this new twist on the traditional journal was an ambitious undertaking and would require some out-of-the-box thinking, we formed a journal team. After many lively discussions, we had a raft of creative ideas for making this journal innovative and distinct, as well as informative, relevant and user-friendly.

Not your average, run-of-the-mill journal—our goal was to create an exciting online resource for the counseling profession that would appeal to the more than 46,000 National Certified Counselors (NCCs) around the world

As part of the process, we asked ourselves basic questions. What was our purpose for creating this journal? To promote the practice of professional counseling. How can we do this? By publishing original, peer-reviewed manuscripts covering a wide range of empirical, theoretical and innovative counseling topics, and delivering this journal in an efficient and timely manner.

When the role of publisher came up—and my name with it—I needed to figure out what a publisher does. A little Internet research revealed that a publisher connects writers to readers. That sounded easy enough.

For the very specific and important job of editor, the journal team selected Dr. J. Scott Hinkle, Director of Professional Development for NBCC. His professional knowledge and insight will serve him well in this demanding role.

And now, with our core journal staff in place, we are very pleased to welcome you to The Professional Counselor: Research and Practice (TPC). We are excited to be able to contribute this resource to the counseling profession and look forward to watching it grow and change to meet your needs.

Dr. Thomas W. Clawson
Publisher, TPC
President & CEO, NBCC

Contents

Volume 1, Issue 1

Helping Military Parents Cope

Lynn K. Hall

Increasingly, mental health professionals are providing counseling services to military families. Military parents often struggle with child-rearing issues and experience difficulty meeting the fundamental needs for trust and safety among their children because they are consumed with stress and their own needs. Within this article, military family dynamics are discussed and parenting styles, namely coercive, pampering or permissive and respectful leadership, are explored. The authors conclude by highlighting counseling interventions that may be effective for working with military parents and families.

Keywords: military parents, family dynamics, child-rearing, safety, counseling interventions

In 1994, Donaldson-Pressman and Pressman began tracking families in their practice who had many of the dynamics of alcoholic or abusive families, but had no history of alcohol abuse, incest, physical abuse, emotional neglect or physical absence. The one consistent characteristic of those families was similar to many military families that I worked with, which was that "the needs of the parent system took precedence over the needs of the children" (Donaldson-Pressman & Pressman, 1994, p. 4). It is because of this dynamic that I chose to use the term "parent-focused families" when writing about parenting issues in the book, *Counseling Military Families: What Mental Health Professionals Need to Know* (Hall, 2008). Developmentally, many military parents who are struggling with child-rearing issues have difficulty meeting the fundamental needs for trust and safety for their children because they are consumed with their own needs (Hall, 2008). One of the major challenges of military families is learning how to operate within the larger external system of the military without complaint or unreasonable expectations.

Wertsch (1991) described this dynamic as the stoicism of the military, or the need to be ready, maintain the face of a healthy family, and do what is expected without showing discontent or dissatisfaction. A second important dynamic is secrecy, or not allowing what happens in the family to impact the military parent's career. The third dynamic, denial, also is present in most military families as they make numerous transitions and experience issues like the deployment of the service member (Wertsch, 1991). In order to survive, the non-military parent and children often deny the emotional aspect of these transitions, as well as more "normal" developmental transitions. In many parent-focused military families, particularly when there is a child who is acting out or in other ways exhibiting behavior problems, these three dynamics often lead to other characteristics (Hall, 2008) such as:

1. The belief that the child is the problem, rather than the child may have a problem.
2. The child is given a label, such as lazy or stupid, rather than understanding that the behavior may be the result of a mental health, developmental or learning problem.
3. Children sometimes learn early that, if expressed, their feelings may make things worse so that detaching emotionally becomes quite functional.
4. Once they discover that their feelings will not be validated, they may learn to distrust their own judgments and feelings.
5. The child may take on the responsibility of meeting the emotional and sometimes physical needs of the parents.
6. If either parent is inconsistently emotionally available, children may have difficulty letting down the barriers required for intimacy later in life (Hall, 2008; Donaldson-Pressman & Pressman, 1994).

These characteristics, when played out in military families, are a reflection of the secrecy, stoicism and denial often demanded of these families. Instead of providing a supportive, nurturing, and reality-based mirror, the parents may present a mirror that only reflects their needs, resulting in children who grow up feeling defective (Hall, 2008). "When one is raised unable to trust in the stability, safety, and equity of one's world, one is raised to distrust one's own feelings, perceptions, and worth" (Donaldson-Pressman & Pressman, 1994, p.18).

When we look at the demographics of military families, we see that most military dependent children are born to very young couples who have been removed from their extended support system or other supportive older adults on whom they can rely. For almost all military children, their physical and psychological needs are indeed met during childhood;

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however, when children begin to assert themselves and/or make emotional demands, which often begins in early to middle adolescence, the parental system may be unable to tend to the children's needs. Parents who are under a great deal of stress and perhaps faced with a high level of uncertainty around issues like multiple deployments may find themselves resentful or threatened by the needs of the children. The ability to understand how some families in the military are organized, not just because of who the parents are but, more importantly, who the parents are in the midst of the demands of the "warrior fortress" in which they live, is essential in working with these families (Hall, 2008).

Parenting in a Democratic Society

One counselor explained that military couples are often not faced with the typical life decisions or choices of civilian couples, such as buying a home or relocating because of an available career opportunity (Hall, 2008). At the same time, military couples and families are required to relate to and often spend a great many years living in our mostly democratic American world. This counselor often finds it necessary to point out to parents of adolescents that, while the parents may have adjusted well to living in the authoritarian military structure, rebellious teens often see the world in a different way. A typical military parental response to a rebelling teen is to tighten the rules, becoming more vigilant and rigid. This is often the result of the fear of losing control or their place as the head of the household. "Children of the military, whether they live on base or not, live, at least part of their life, in a democratic society; they go to democratic schools and their parents are serving the mission of defending a democratic nation. It is understandable, then, how those who face strictly authoritarian parenting or home life might be confused and perhaps become rebellious" (Hall, 2008, p. 119).

McKay and Maybell (2004) write about the democratic revolution which they define as an "upheaval in all of our social institutions: government, education, the workplace, race relationships, gender relationships and families" (p. 64). As these authors point out, during the last few decades most social institutions and relationships in the United States have operated from an equality identity that values attitudes of equal values and respect. These societal changes require new attitudes toward oneself and others, as well as a new set of knowledge and skills (Hall, 2008; McKay & Maybell, 2004). The military, on the other hand, has not changed to an egalitarian institution: it never will because it could not survive. But, regardless of how the military organizes itself and its members, the military family still lives, at least to some degree, in a democratic society. This means the individual members of the family will often struggle as they go back and forth between the authoritarian world of the military and the democratic world in which they both come from and continue to be a part (Hall, 2008).

While McKay and Maybell (2004) were addressing the conflict in the greater society over the last few decades, their description of the "tension, conflict, anger, and even violence . . . as we move from the old autocratic tradition to a new democratic one" (p. 65) clearly describes the ongoing challenge for military parents. These are valuable insights when understanding the children and the families of the military, many of whom may view the world outside of the military quite appealing and then begin to rebel against the rigid structure they are forced to live within. This theoretical framework can be a useful tool for counselors in helping families understand the need to move from the external often rigid superior/inferior military structure to a more egalitarian structure in the home that encourages and respects each individual in the family but still maintains the hierarchical need for parental control that is necessary for all functioning families (Hall, 2008).

Helping parents to assess their current parenting style, and then to consider how to modify their parenting practices from patterns that are discouraging for their children to those that are encouraging, can be extremely valuable for family growth and development. Whether this is done in a parent training environment or a family counseling setting, helping parents adjust their style will directly impact their children's behavior. McKay and Maybell (2004) describe three of the most common parenting styles: the coercive parenting style, the pampering or permissive parenting style and the respectful leadership style. Because these authors have years of Adlerian training and writing experience, the reader will recognize that these parenting styles correspond to previous parenting literature written by Adlerian writers. The first two often discourage the healthy development of children; the third is not only respectful, but can be both encouraging and empowering (Hall, 2008).

Coercive Parenting

The coercive parenting style is often the style used to control children *for their own good* and is often the style of

parenting used in parent-focused families, as well as the families of very young parents who have little family support (McKay & Maybell, 2004). It is often the style we find in military parents with children who are rebelling or acting out. The parents maintain control by giving orders, setting rules, making demands, rewarding obedient behavior, and punishing bad deeds (Hall, 2008). McKay and Maybell call this model *limits without freedom*. These parents almost always have good intentions and want to make sure their children avoid many of life's mistakes; their goal is simply to teach their children *the right way* before they get hurt. The need for children to accommodate a subordinate identity may work for a while, at least when the children are young. However, when children want to be acknowledged for their individuality or want to be respected as an individual, this style can result in conflict and power struggles (Hall, 2008). "Kids tend to become experts at not doing what their parents want them to do and doing exactly what their parents don't want" (McKay & Maybell, 2004, p.71). The results of coercive parenting are often kids who either need to get even, resulting in a constant war of revenge, or kids who submit to the coercion and learn to rely only on those in power to make their decisions (Hall, 2008), either of which can be destructive to the healthy development of children.

Pampering or Permissive Parenting

The permissive parenting style (McKay & Maybell, 2004) is used by parents whose goal is to produce children who are always comfortable and happy, by either letting them do whatever they please or by doing everything for them. This parenting style is referred to as *freedom without limits* and is often the style that current popular literature calls *helicopter parenting*. These children often end up considering themselves to be the prince or princess and their parents their servants. They can develop a "strong sense of ego-esteem with little true self- or people-esteem" (McKay & Maybell, 2004, p.72). Often they have under-developed social skills and can become too dependent on others. Parents eventually, however, may resent how much they are doing for their children, leading to conflict and power struggles. With so few limits, children believe they not only can do anything they want, but believe they should be allowed to do anything they want, leading to a sense of entitlement along with a lack of internal self-discipline or self-responsibility (Hall, 2008).

These first two parenting styles can even exist in the same family, where one parent is the authoritarian (in a military family, usually the military parent) and the other is the permissive parent who lessens the rules of the authoritarian parent, particularly when that parent is absent. School behavior often worsens upon the return of the military parent from deployment. If asked, young people will say that everything was fine at home while the service member parent was gone, but now that the parent has returned and started *cracking the whip,* the teens often turn to rebellion or other inappropriate behaviors (Hall, 2008).

Respectful Leadership

The third parenting style is the only encouraging style for children; it is the style of respectful leadership (McKay & Maybell, 2004), or *freedom within limits*. The parents value the child as an individual and value themselves as leaders of the family through the guiding principle of mutual respect in all parent-child interaction. Giving choices is the main discipline approach with the goal of building on individual strengths, accentuating the positive, promoting responsibility, and instilling confidence in the children (Hall, 2008). This parenting style, in both the civilian and military worlds, can help build respectful, responsible children. Emphasizing that parents are not giving up their leadership role in order to parent their children is especially important in military families. Combining that with the concept of "respect" makes sense within the military culture.

A counselor told of an Army officer who brought his 16-year-old daughter to counseling because she was acting out. He insisted that she come home at her curfew time and she quit hanging out with the boys he disapproved. She responded with a typical angry look that caused Dad to come unglued. The counselor asked Dad what his biggest fear was for his daughter, thinking that he would be worried about her becoming pregnant, not finishing school, or any of a number of other possible responses. After thinking and, for the first time, with tears in his eyes, Dad said that she might leave him like her mother did. The spirit of counseling changed at that point. With a look of complete astonishment on the daughter's face, she started crying and told her dad that she thought he wanted her to leave because he couldn't face her after her mom left. The counselor was able to help Dad see that setting rigid rules that had to be tightened up every time they were broken, might not work as the two of them forged a new relationship and he allowed her to mature into a responsible young woman. Helping him find ways to include her in setting limits and in household decisions, as it was now just the

two of them, went a long way in repairing their relationship, as well as in empowering her to make healthy decisions in other parts of her life.

Working with Parents

Helping parents understand how their parenting style impacts child development can often be a counselor's most valuable teaching tool. While it sounds easy, it is not; parents need guidance and direction on how to give choices, when to give choices, and how to be creative in choosing appropriate consequences. Parents have to learn to start small, start young (when possible), and be willing to make mistakes. The Adlerian principle of the *courage to be imperfect* also must be a part of parent education. Parents all want the best for their children; helping them promote responsibility and confidence by making adjustments in their parenting style can help them reach these goals. As early as 1984, Rodriguez wrote that in a rank-privileged and -oriented social system like the military, this mix of *caste formation* and egalitarianism may create a difficult dichotomy, particularly for children and adolescents struggling for their identity. This dichotomy can be exacerbated by the parent-focused nature of the military when parents are concerned about how their child's misbehavior might affect the parent's status in the military. Children become sensitive to this parental anxiety and the anger that follows when they break community rules or military social norms. In some military communities, particularly those that are isolated and where rules are strongly enforced, children have little room to make mistakes or test the limits of authority in a normal, developmental manner, without impacting the family status or the military parent's career (Hall, 2008).

It is important to point out that not all military families struggle with these issues; the great majority carry out their parenting duties extremely well and raise healthy children, often in the midst of difficult situations. Jeffreys and Leitzel's (2000) study noted that a caring relationship and low family stress is associated with resiliency. If children have an emotionally supportive relationship with their parents, they are more likely to demonstrate high levels of self-esteem and healthy psychological development. Their study (Jeffreys & Leitzel, 2000) of military families suggests that family climate promotes the participation in family decision-making and is positive for adolescent identity development. Effective communication patterns facilitate family interaction and are associated with social competence. This finding is reflected in McKay & Maybell's (2004) respectful leadership style of parenting and can help mental health counselors focus their work on helping military parents learn the parenting skills necessary to reach their goals of having competent, healthy and responsible children, as well as coping with the sometimes overwhelming challenges they face while serving in the military.

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Venezuelan Counseling: Advancement and Current Challenges

George Davy Vera

In the worldwide community it is not well known that counseling and guidance professional practices have a long tradition in Venezuela. Therefore, this contribution's main purpose is to inform the international audience about past and contemporary counseling in Venezuela. Geographic, demographic, and cultural facts about Venezuela are provided. How counseling began, its early development, and pioneer counselors are discussed. The evolution of counseling from an education-based activity to counseling as a technique-driven intervention is given in an historical account. How a vision of counselors as technicians moved to the notion of counseling as a profession is explained by describing turning points, events, and governmental decisions. Current trends on Venezuelan state policy regarding counselor training, services, and professional status are specified by briefly describing the National Counseling System Project and the National Flag Counseling Training Project. Finally, acknowledgement of Venezuela's counseling pioneers and one of the oldest counseling training programs in Venezuela is described.

Keywords: Venezuela, history of counseling, clinical interventions, policy, training programs

Venezuela is located on the northern coast of South America, covering almost 566,694 square kilometers (km; 352,144 square miles). It is bordered by the Caribbean Sea and the Atlantic Ocean, Guyana, Brazil, and Colombia, with a total land boundary of 4,993 km (3,103 miles) and a coastline of 2,800 km (1,740 miles). Its population is approximately 29 million and mostly Catholic. Some aboriginal groups practice their own traditional magical-religious beliefs. Since its independence, emigrants from different parts of the world have helped build the country's culture and economy. Diverse populations of Arab, Dutch, Chinese, and Japanese, among others, live in Venezuela.

Even though several ethnic groups prevail in the country today, three groups are clearly distinct from its origin: European white, African black and Native aborigines. After five hundred years of blending, three different culturally and ethnically groups have emerged: Mulato (white and black), Zambo (black and aborigine), and Mestizo (white and aborigine). Although Venezuela has ethnic compositions and mixtures, all Venezuelans have the same rights and duties under the Bolivarian Constitution of 1999. More Venezuelan differences and prejudices are related to social, educational, economic, and political status.

Economically, Venezuela has one of the largest economies in South America due to its oil production; however, a large number of its population remains in poverty. Today, the current administration has created different popular programs, called *missions*, to deal with most Venezuelans' needs including lack of education, employment, health care, and public safety, among others. So far, according to the United Nations (UN) and UNESCO's official reports, Venezuela has reached most of its millennium goals established by the UN. Politically, after several years of turmoil, Venezuelan society reached a normal democratic institutional peace in 2004.

Early Developments of Counseling in Venezuela

During the 1930s, counseling in Venezuela began as a form of educational guidance and counseling concerned with academic and vocational issues using mainly psychometric approaches. Some Venezuelan counseling pioneers were European emigrants. In fact, during the 1940s, some school counseling services were created by Dr. Jose Ortega Duran, an educator; Professor Miguel Aguirre, a counselor; Professor Vicente Constanzo, teacher and philosopher; and Professor Antonio Escalona, a career counselor and professor (Benavent, 1996; Calogne, 1988; Vera, 2009). Because of the education and training of these early pioneers, counseling in Venezuela was conceived as an educational, vocational, and career-oriented service.

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A formal definition of the counseling and training of professional counselors has slowly evolved from the 1960s to today. Because of the oil industry development, Venezuela moved from an agricultural to an industrial economic base. Because of this, the Venezuelan population grew rapidly and rural farmers moved to the major cities, which were demanding more workers, specialized employees, and technicians. Therefore the demand for better education to satisfy new jobs related to industrial demands and pressured the government to create new policies concerning education. One of the new policies regarded counseling and guidance services. Therefore, in the early 1960s the government created the first counselor education training program (Calogne, 1988; Moreno, 2009; Vera, 2009).

By an agreement between the Ministry of Education and the U.S. Agency for International Development (USAID), counseling professors from the U.S. were hired to train school teachers in counseling and guidance. The training focused on personal counseling techniques and strategies, counseling theory and methods, and educational counseling. Because the training emphasized basic counseling knowledge and techniques for school teachers, a vision of counseling and guidance as educational activities within the scope of the school teacher role emerged. Accordingly, counseling and guidance was understood as a technique-based activity oriented to help students with academic, vocational, career, and personal issues. Later, the Ministry of Education requested that the Pedagogic Institute of Caracas create a formal, three-semester educational training program in counseling and guidance.

As a result, in 1962 the Ministry of Education requested that the Pedagogic Institute of Caracas house the first formal counselor education program in Venezuela. Counseling and guidance was conceived as knowledge and intervention techniques to help with students' personal growth and academic performance. The term *Orientación* was chosen to better signify counseling and guidance in Venezuela's Spanish language. Graduates from this program received a college diploma as *orientador*. Both terms, *orientación* and *orientador*, were thus used in the country for the first time.

Another consequence of the counselor education program at the Pedagogic Institute of Caracas was its contributions to a new vision of counseling as a technique-oriented educational program. Therefore, counseling was conceived as a technical occupation that emerged within the scope of education. By this time, counseling had achieved official and public recognition as a social occupation that required proper education and a set of formal conditions for practice. The Ministry of Education used this new vision of counseling to create the first jobs defined as counselor positions within Venezuela's educational system (Vera, 2009).

From Counselors as Technicians to the Counseling Profession

Shortly after the first graduates in counseling started their practice, the Ministry of Education understood that the practice of counseling and guidance was more complex than originally perceived and realized that the high demand for counseling services was calling for rapid institutional answers to counseling-related questions. As a result, the National Counseling System, known as the Counseling Division of the Ministry of Education, was developed. This organizational structure was responsible for all counseling matters countrywide, including hiring conditions, developing counseling services, supervising, and training requirements. From this Division, counseling as a profession was envisioned as a human development model (Aquacviva, 1985; Calogne, 1988).

Because counselor employment was now available within the Ministry of Education, several universities established guidance and counseling training options as a five-year bachelor's degree. Consequently, the first bachelors' degrees in education majoring in guidance and counseling (mención orientación) were granted in the early 1970s. Master's level degrees in guidance and counseling granted by the Pedagogic Institute of Caracas were also awarded during this time.

Some of the early graduates from these programs went abroad, mainly to the U.S., to obtain advanced counseling and guidance education and training at the master's and doctoral levels. Upon returning to Venezuela, they engaged in teaching and training in counseling and guidance at different colleges and some were hired by the Ministry of Education. Other graduates concentrated their energy on organizing counseling professional associations. As a result, American theories, models, and views of the counseling profession in the 1970s and 1980s were fused with Venezuela's view of counseling and guidance (Vera, 2009).

Because most Venezuelan counselors had been educated abroad, a number of trends in counselor education were

adopted. For instance, some bachelors' level counseling education programs were based on a vision of guidance and vocational education (e.g., Venezuela Central University and the University of Carabobo), while other programs assumed a vocational and academic perspective (e.g., Liberator Pedagogical University), and yet others implemented individual, lifelong approaches (e.g., The University of Zulia and the University Simon Rodriguez). Finally, the Center for Psychological, Psychiatric, and Sexual Studies of Venezuela clearly embraced an educational and mental health counseling standpoint in masters' level training. (However, for political and governmental reasons, some of these early programs no longer exist.)

Between the 1970s and 1980s professionalism in counseling was embraced because counseling- and guidance-related organizational movements emerged. Counseling associations were organized and began to promote a vision of counseling as an independent profession from education, psychology, and social work. One of these associations was the Zulia College of Professional Counselors (ZCPC), which was responsible for raising the visibility of professional counseling in Venezuela by creating the first Counseling Code of Ethics, advocating for counseling jobs, and becoming a valid interlocutor between professional counselors and the government.

The ZCPC was established by a group of counseling professors and early graduates from the bachelors' degree of education in counseling and guidance. During the 1970s and 1980s, counselors in this organization started developing a cultural base for counseling knowledge. In particular, ZCPC established professional meetings for discussing counseling profession matters such as advanced education, professional identity, and social responsibility.

By this time, counseling master's programs were available in several parts of Venezuela. Hence, professionalism came to light and important matters for counseling's future development were assumed by counselor educators, practitioners, and associations.

Current Trends: Contemporary Concerns for Professional Practice and Education

Currently, several professional matters regarding counseling are taking place in Venezuela, one being the status of counseling as an independent profession. The Venezuela Counseling Associations Federation (FAVO) will soon introduce a legislative proposal concerning professional counseling practice. If it is passed, Venezuelan counselors will have their first counseling practice law granting counselors' independent professional practice based on research, knowledge, specified training, and educational requirements.

Another important matter is the creation of the Venezuela Counseling System. This system will organize and provide counseling to the population by a diverse delivery of services and programs based on a vision of counseling for personal, social, cultural, and economical enhancement within the context of a humanistic, democratic, participatory, and collective society. The system is designed and based on the Venezuela Bolivarian Constitution, which guarantees human rights related to social inclusion and justice, freedom, education, mental health, vocational needs, employment, lifelong support, and opportunities for individual development and family prosperity. The system is organized into four areas: education, higher education, community, and the workplace or economic sector. The system is already approved by the Ministry of Higher Education and the formal government resolution and implementation process is pending.

The system embraces advanced concepts and new trends related to professionalism, practice, and the social responsibility of counseling professionals. This includes certification for counseling practitioners, supervision, and credentialing via continuing education for professionals in order to ensure quality. Structurally, the system will be connected to all Venezuelan Ministries for functions and planning purposes, but will be independently managed by a national committee appointed by the Ministry of Higher Education, holding advanced degrees in counseling and appropriate counseling credentials.

A third matter is related to counseling training programs. Because the Counseling National System will require a large number of trained counselors in the next ten years, new counseling training programs will be created by public and private universities to ensure the quality of counselor training and to satisfy system requirements. Consequently, the government has requested that counseling experts propose a unique counseling training program based on core counseling knowledge, techniques, supervision, and other key features. For details on the proposed counseling program coursework, see Table 1.

Table 1

Fast Track Bachelor's Degree in Education: Counseling Major

YEAR	I		II	
SEMESTER	I	II	III	IV
Counseling Foundations	The counseling profession	Counseling deontology	Counseling supervision systems	Challenges and trends in counseling
Vocational and Career Development Counseling	Traditional and emerging vocational and career counseling theories	Vocational and career planning choosing theories	Life project and vocation in community and educational contexts	Life project and vocation in workplace contexts
Contextual Counseling Projects, Programs, and Services	Exploration and assessment methods in counseling	Designing and evaluating counseling services, projects, and programs	Counseling projects, programs and services in community and educational contexts	Counseling programs and services in workplace contexts
Individual Counseling and Consultation	Counseling and consultation interview processes	Interdisciplinary counseling and consultation theories, strategies and techniques	Mental health counseling for individuals and communities	Individual counseling and consultation
Group Counseling and Consultation	Group counseling theories and methods	Group counseling in educational contexts	Group counseling in community contexts	Group counseling in workplace contexts
Counseling Internship	Pluricontextual counseling professional services	Counseling professional services in educational systems	Counseling professional services in communities and related centers	Counseling professional services in workplaces and related environments

The proposed National Counseling Professional Program (NCPP) will be at the bachelor's level and four semesters long. A unique prerequisite of this program is that applicants must already hold one of these bachelors' degrees: education, psychology, social work, sociology, industrial engineering, philosophy, pedagogy, or physician.

The proposed NCPP will be organized into core areas and will educate counseling professionals according to the following general objectives:

1. Educate professional counselors to satisfy the needs of the Counseling National System, its subsystems, and any other professional counseling contexts.
2. Develop critical, reflective, dialectical and dialogical counseling professionals. Understand theoretical and conceptual information related to the counseling field and its interdisciplinary sources.
3. Acquire the theory based and applied competencies of the counseling profession in diverse contexts.
4. Understand Venezuelan counseling's historical roots and its international origins.
5. Understand the ethical dimensions of the counseling profession and the legal characteristics of counseling practice.
6. Actively participate in the development of solidarity, participatory and responsible collectivist citizenship.
7. Articulate counseling professional actions with Venezuela's social, cultural, and economic development.
8. Use the cultural and social bases of the counseling profession in creating lifelong counseling services.
9. Bond the training and practices of professional counselors with plans and guidelines for Venezuela's cultural, social, and economic development.
10. Train professional counselors needed for the Venezuelan police.

Other counseling training programs will be developed according to the official training program. Institutions may develop their own specific program, but must include the official requirements.

A last concern is professional counselor certification, supervision, and continuing education. FAVO has worked on these matters since 2004 in collaboration with the NBCC International. FAVO is developing Venezuela's first National Counselor Certification System as well as conceptualizing a national supervision model and continuing education. FAVO granted the first group of national certified counselors in 2010 and is planning for the first group of trained and certified counselor supervisors in 2011.

Final Thoughts

After years of counselor education evolution and counseling services growth, the professionalization of counseling in Venezuela is now happening, but it depends on Venezuelan counseling leaders to develop a strong advocacy movement. Accordingly, Venezuela's current political climate has the extraordinary opportunity to pass the Venezuela Counseling Law Proposal in the National Assembly. This may be possible if FAVO has successes in the implementation of the Venezuela National Counseling Certification System because this can help in the task of alerting Venezuela's professional counselors. Accordingly, counselors' sense of professionalism might spark the enthusiasm needed for involvement in a strong advocacy movement.

Finally, according to experiences in different parts of the world, it can be concluded that not only in Venezuela, but worldwide, the profession of counseling is an emerging phenomenon; therefore, international counseling institutions and organizations need to begin acting on how to face the worldwide challenges for professional counselors.

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The Counseling Program at the University of Zulia: An International Program

George Davy Vera

A personal description of the international counselor education program at the University of Zulia in Venezuela is presented including educational objectives of the counseling degree, various services counselors are trained to provide, and a sample curriculum. This description serves as an example of one international counselor education program that can be used as a model for burgeoning programs in other countries.

Keywords: Venezuela, University of Zulia, international counseling, counselor education, counseling services, curriculum

Venezuela's early counseling pioneers at the University of Zulia, some of whom were trained in the United States (e.g., Dr. E. Acquaviva, Dr. C. Guanipa, A. Busot, M. Ed.; A. Quintero, M.Ed., M. Socorro, M.Ed., D. Campo, M.Ed.), were pioneers responsible for influencing and crafting the counseling and guidance culture at the University of Zulia. Accordingly, I would like to describe one of the oldest and most well known counseling training programs in Venezuela. This program is chosen because many past and present counseling leaders in Venezuela were educated at the University of Zulia.

Initially in the early 1970s, this bachelor's level counseling program was conceived as educational counseling (*asesoramiento*) and vocational guidance (*orientación vocacional*) as a specialization track within the major of Pedagogical Science. Graduates from this program received a Licentiate in Education, Major in Pedagogical Sciences in the area of counseling (*Licenciatura en Educación, Mención Ciencias Pedagógicas, Area de Orientación*). According to the University of Zulia's official archive (1970-2010) on counseling academic and curriculum development, professional services related to individual, vocational or educational counseling and guidance were understood as *orientación*. Therefore, the Spanish word was implemented to better communicate the meaning of professional counseling and guidance. Historically, the academic choice of using this term at the time was congruent with the Ministry of Education's decision in 1962, when the terms *orientación* and *orientador* were officially adopted to describe guidance professionals and counseling practitioners, respectively. The current bachelors' degree is five years long (10 academic semesters, for details see Appendix A).

According to the Academic Updated Curriculum Design (Curriculum Commission of Psychology Department, 1995), the education of professional counselors is conceived upon several key concepts:
- Professional identity reflects that graduates are trained to perform counseling and guidance tasks within the educational system and other professional and organizational agencies.
- Counseling professionals help people develop within the social environment, assist with the processes of psychosocial functioning, and effectively deal with developmental changes and stressful life events.
- Professional counselors trained at the University of Zulia are competent in performing counseling tasks such as:
  - designing, implementing, and evaluating counseling services.
  - developing prevention or remediation programs emphasizing personal, social, academic, vocational, work, recreational, and community needs at any developmental phase using individual or group strategies.

The main educational objectives of the counseling major are:
1. Diagnosing human system characteristics within the educational, organizational, assistance, judicial, and community contexts.
2. Performing counseling and consultation.
3. Designing, implementing, and evaluating services.
4. Generating research in counseling.

Graduates provide counseling services in different areas of human services:
A. *Personal-social counselors* help clients deal with issues related to social roles and gain more understanding

of themselves within their sociocultural context. The main purpose of the personal-social intervention area is to help clients deal with mental health and personal growth issues and to reach psychological stability. In this area, some helping processes are related to:

- psychological development: self-esteem, decision-making, emotional stability, psychosexual maturity, and intellectual potential.
- social development: interpersonal relationships, work and academic motivation, social adjustment, and ethical values.
- family development: prevention, couples relationships, parents and children, family crisis intervention including divorce, terminal and lifelong sickness, bereavement, and human sexuality.

B. *Academic counselors* help clients deal with issues related to learning and the role of the learner. Helping processes are related to educational adjustment, academic attitudes, cognitive development, academic performance, and consultation with school teachers, families, and communities.

C. *Vocational counselors* focus on individual talents, vocational potential and tendencies, as well as roles within the workplace. Vocational counselors' tasks are mainly focused on several facets, including assessment, decision-making, work development, academic needs, workplace readiness, and positive work attitudes.

D. *Work counselors* provide counseling services to help individuals and organizations with shared objectives to reach mutual satisfaction and development. This area includes process management, career planning and development, work motivation and communication, work-related decision-making, evaluation, conflict resolution, work-service quality, leadership, performance, and teamwork.

E. *Community and recreational counselors* provide counseling services for community life enhancement. Counseling processes in this area include community resources and needs, civic practices, positive utilization of recreation and free time, community creativity, organization and planning, cultural and artistic manifestations, and social transformation.

Graduates are trained in three core counseling professional competencies:

- Human system diagnostics: use of diverse tools for diagnosing human systems and individual psychological, educational, social and developmental characteristics.
- Program and service design: conceptualize and evaluate human processes in order to design and administer counseling services for individuals, groups, communities, and organizations.
- Counseling and consultation: provide professional services concerning human potential development and to meet psychological, emotional, behavioral, educational, social, organizational, and community needs.

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Appendix A

PROGRAM: Bachelors' Degree of Education–Major in Counseling

Semester	Courses
I	Language Workshop Counseling Program I: College Student Academic Success Mathematics Counseling Practicum Pedagogy Self-Development Activities (Sports, Arts, Music)
II	Personality Theories Seminar: Counseling Action Field Thought Processing Development Systemic Approaches to Reality Introduction to Psychology
III	Systemic Focus of Reality Development of Human Potential Venezuela Educational System Legislation Area Historic and Anthropology Educational Psychology
IV	Group Dynamics Didactic Developmental Psychology Research Seminar I Elective I
V	Mental Health and Hygiene (60 hrs Supervised Counseling Preservice) Learning Psychology Foreign Language Area Ecological and Scientific
VI	Methods of Counseling Exploration and Evaluation Counseling Interview (60 hrs Supervised Counseling Preservice) Vocational Development Process Learning Evaluation Elective II
VII	Personal Counseling I (60 hrs Supervised Counseling Preservice) Vocational Counseling Choosing Process Educational Management Counseling Program II: Family, Relationship and Career Development
VIII	Personal Counseling II (60 hrs Supervised Counseling Preservice) Special Didactic: Counseling Program and Services Design Group Counseling Research Seminar II Educational Planning
IX	Family Counseling Human System Development Internship I: Educational and related systems
X	Internship II: Educational, Communities, Health and Business Systems

Social Distance and Mental Illness: Attitudes Among Mental Health and Non-Mental Health Professionals and Trainees

Allison L. Smith
Craig S. Cashwell

Social distance towards adults with mental illness was explored among mental health and non-mental health trainees and professionals. Results suggested mental health trainees and professionals desired less social distance than non-mental health trainees and professionals, and that women desired less social distance than men, with male non-professionals demonstrating the greatest desire for social distance to individuals diagnosed with mental illness. Social distance also is related to attitudes towards adults with mental illness. Implications of such findings are presented.

Keywords: social distance, adult mental illness, mental health professionals, stigma, discriminatory behavior

Stigma has been defined as a product of disgrace that sets a person apart from others (Byrne, 2000). Stigma towards adults with mental illness, defined here as a serious medical condition such as schizophrenia, bipolar disorder, or major depression that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning (National Alliance on Mental Illness [NAMI], 2009), is both a longstanding and widespread phenomenon (Byrne, 2000; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Researchers seem clear that stigma still exists as a detrimental occurrence in the lives of those diagnosed with a mental illness (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004; Perlick et al., 2001). In fact, some have argued that the impact of mental illness stigma is so immense that the stigma can be as damaging as the symptoms (Feldman & Crandall, 2007). In the last decade, there have been attempts to highlight to the general population the topic of stigma towards adults with mental illness. For instance, Surgeon General David Satcher spoke in a recent report of the need to recognize stigma as a barrier within the field of mental health. He suggested that mental health care could not be improved without the eradication of mental health stigma (U.S. Department of Health and Human Services, 1999).

In the mental illness stigma literature, authors have used the construct of social distance (the proximity one desires between oneself and another person in a social situation) to assess expected discriminatory behavior towards adults with mental illness (Baumann, 2007; Link & Phelan, 2001; Marie & Miles, 2008). Scholars have described low social distance as characterized by a feeling of commonality, or belonging to a group, based on the idea of shared experiences. In contrast, high social distance implies that the person is separate, a stranger, or an outsider (Baumann, 2007). It has been suggested that social distance research can provide valuable insight into factors that influence mental illness stigma (Marie & Miles, 2008).

Social Distance and Non-Mental Health Professionals

Factors that are associated with social distance in the general population towards adults with mental illness have been discussed in the literature (Corrigan, Backs, Edwards, Green, Diwan, & Penn, 2001; Feldmann & Crandall, 2007; Hinkelman & Haag, 2003; Marie & Miles, 2008; Penn, Kohlmaier, & Corrigan, 2000; Phelan & Basow, 2007; Shumaker, Corrigan, & Dejong, 2003). One such factor that has been studied as it relates to social distance is gender, both of the target (person with the mental illness) (Phelan & Basow, 2007) and perceiver (person who desires social distance) (Hinkelman & Haag, 2003; Marie & Miles, 2008; Phelan & Basow, 2007).

Researchers (Marie & Miles, 2008; Phelan & Basow, 2007) have found that women tend to be more willing than men to engage in a relationship with someone diagnosed with depression. Marie and Miles (2008) investigated familiarity of the perceiver with various mental illnesses. A significant main effect was found for gender, with women perceivers rating the characters in vignettes as more dangerous than men participants (Marie & Miles, 2008). Phelan and Basow (2007)

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found that gender of the target character was a significant predictor of social distance, with female targets being more socially tolerated than male targets. This may be due to the fact that participants perceive male characters in vignettes as more dangerous than female characters. Hinkelman and Haag (2003) also have assessed how gender and adherence to strict gender roles impact attitudes toward mental illness. Interestingly, adherence to strict gender roles rather than gender was related to attitudes about mental illness. Those with strict gender roles were less likely to have positive attitudes. Thus, gender alone did not account for differences in attitudes; instead it was gender roles that related to attitudes towards mental illness.

Social Distance and Mental Health Professionals

Researchers have suggested that stigma also exists among mental health professionals (Lauber, Anthony, Ajdacic-Gross, & Rossler, 2004; Nordt, Rossler, & Lauber, 2006). Lauber et al. (2004) found no significant differences between psychiatrists and the general population on their preferred social distance from people with a mental illness. Both psychiatrists and the general population indicated that the closer the psychological proximity (e.g., allowing the person with mental illness to marry into their family compared to working with someone with a mental illness), the more social distance they desired. Similar results were found when comparing mental health professionals (i.e., psychiatrists, psychologists, nurses, social workers, and vocational workers) and the general population regarding social distance attitudes (Nordt et al., 2006). Both professionals and the general public reported many stereotypes about mental illness, and wanted an equal amount of social distance towards a mentally ill character in a vignette. Professionals, however, endorsed to a much lesser degree that adults with mental illness should have restrictions to rights such as voting or marriage. The public significantly accepted the restriction of the right to vote more than each professional group.

Professional Counselors and Social Distance

Although professional counselors might work in the same settings as other mental health professionals, the training background of this subgroup includes some noteworthy differences. Relative to other mental health disciplines, counselor training programs are largely, but not exclusively, grounded in developmental perspectives and strength-based orientations (Ivey & Ivey, 1998; Ivey, Ivey, Myers, & Sweeney, 2005; Ivey & Van Hesteren, 1990) as well as humanistic values and assumptions (Hansen 1999, 2000b, 2003), with a primary focus on the counseling relationship. Given these substantial differences as well as authors' (Lauber et al. 2004; Nordt et al., 2006) suggestions that it is idealistic to assume that stigma does not exist among mental health professionals, it is important to consider counselors in comparison to other mental health professions and the general public. Further, particular types of counseling programs (clinical mental health counseling or school counseling) might differ when compared to each other on stigma towards adults with mental illness, given the variations of curriculum and clinical training associated with each.

Previous researchers have examined psychiatrists, psychologists, and social workers, but not professional counselors. Professional counselors should be included in this type of empirical examination, as professional counselors have reported that they are seeing more clients in severe distress (Ivey et al., 2005). Additionally, although attitudes towards mental illness and social distance have been examined in the literature, the relationship between these constructs has not been examined using the current study's instruments. Further, researchers have not examined simultaneously the attitudes and desired social distance of students. Thus, the purpose of this study was to gain a more comprehensive understanding of social distance by including counselors and counseling students in addition to other mental health professionals and students, non-mental health professionals, and students outside of a mental health discipline.

The following research questions (RQ) were developed to organize this study:
    (RQ1)   What differences exist in social distance toward adults with mental illness between mental health professionals in-training, non-mental health professionals in-training, mental health professionals, and non-mental health professionals?
    (RQ2)   What differences exist in social distance toward adults with mental illness between mental health trainees and professionals based on professional orientation (i.e., counseling, social work, or psychology)?
    (RQ3)   What differences exist in social distance towards adults with mental illness between mental health trainees and professionals based on gender?
    (RQ4)   What is the relationship between social distance and other attitudes toward adults with mental illness?

Method

Participants: The total sample included 188 participants. Of these, 62.8% (*n* = 118) were female and 37.2% (*n* = 70) were male. The majority of respondents described themselves as Caucasian (89.4%, *n* = 168) with other participants identifying as African American (4.2%, *n* = 8), Asian Pacific Islander (2.1%, *n* = 4), Hispanic (2.1%, *n* = 4), Multiracial (1.1%, *n* = 2), and other (1.1%, *n* = 2). Age of participants ranged from 21 years to 65 years (*M* = 39.63, *SD* = 13.23). Response rate of the participants could not be determined, since participants responded to the survey online via a link provided in an email.

The total sample was divided into four subgroups. The first group, the non-mental health student group, included a sample of students (*n* = 20) who were enrolled in graduate programs in business administration at a mid-sized university in the southeast United States. Business students ranged from 21 to 53 years of age (*M* = 36.05, *SD* = 9.19).

A second subgroup included counseling students (*n* = 17), social work students (*n* = 20), and psychology students (*n* = 21). These students were enrolled in master's level graduate training programs and were in at least their second year of graduate study. Counseling students ranged in age from 21 to 48 (*M* = 27.94, *SD* = 5.97). Social work students ranged in age from 22 to 31 (*M* = 30.45, *SD* = 8.56). Psychology students ranged in age from 21 to 32 (*M* = 24.29, *SD* = 2.72). Three programs of each discipline (counseling, social work, and psychology) at midsized universities in the Southeast United States were used to recruit volunteers. These students comprised the mental health student group.

The third subgroup included 76 mental health professionals who self-identified as counselors (*n* = 24), social workers (*n* = 20), or psychologists (*n* = 32) who were working in the mental health field and had been employed as such for a minimum of one year. Professional counselors ranged in age from 27 to 61 (*M* = 45.42, *SD* = 10.79), professional social workers ranged in age from 28 to 64 (*M* = 53.30, *SD* = 9.45), and professional psychologists ranged in age from 28 to 65 (*M* = 47.16, *SD* = 12.25). Mental health professionals ranged in years of mental health experience from one to 20 years (*M* = 14.32, *SD* = 6.25).

The fourth subgroup of interest included 34 non-mental health professionals. These were professionals who were working in a non-mental health field (business) in the southeast United States. Only professional level participants were included in this group to provide some control for education level as a potential confounding influence. Non-mental health professionals ranged in age from 25 to 64 (*M* = 43.76, *SD* = 10.62).

Instrumentation

Social Distance Scale. Social distance was measured by a modified version of a Social Distance Scale developed from the World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia (2001). Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola (2005) modified this scale to assess social distance regarding attitudes toward mental illness, as the original scale was designed to measure social distance specifically towards adults with schizophrenia. Gureje et al.'s modified version was used in the current study. Six statements assess various levels of intimacy. For example, the first question asks, "Would you feel afraid to have a conversation with someone who has a mental illness?" Answers are given on a 4-point likert-type scale ranging from definitely (1) to definitely not (4). Item scores are added together to get a total social distance score, with high scores indicating less social distance and lower scores indicating more social distance. The Social Distance Scale had sufficient evidence of internal consistency (α= .81) with the current sample.

Community Attitudes Toward the Mentally Ill. The Community Attitudes Toward the Mentally Ill (CAMI; Taylor & Dear, 1981) was used to assess attitudes towards adults with mental illness. The CAMI was developed from the Opinions of Mental Illness Scale (OMI; Cohen & Struening, 1962) and is a 40-item self-report survey that uses a 5-point likert-type scale (5 = "Strongly agree" to 1 = "Strongly disagree"). Four scales are included on the CAMI: Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology. Authoritarianism is defined by the belief that obedience to authority is necessary and people with mental illness are inferior and demand coercive handling by others. Benevolence is defined as being kind and sympathetic, supported by humanism rather than science. Social Restrictiveness involves beliefs about limiting activities and behaviors such as marriage, having children, and voting among people with a mental illness. Community Mental Health Ideology is defined as a "not in my backyard" attitude toward adults with mental illness, or the belief that adults with mental illness should get treatment, but not in close

proximity to me (Taylor & Dear, 1981).

Evidence for internal consistency of the CAMI was clear for three of the four scales with the current sample: Community Mental Health Ideology (α= .86), Social Restrictiveness (α= .80), and Benevolence (α= .81). Only the Authoritarianism subscale (α= .62) was problematic in this research.

Marlowe-Crowne Social Desirability Scale. The Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) was included in order to assess the extent to which participants were answering in a socially desirable manner to further validate the attitudes captured by the CAMI and the Social Distance Scale. The MCSDS is the most commonly used social desirability assessment (Leite & Beretvas, 2005) and has demonstrated strong reliability. The original authors obtained a Kuder-Richardson reliability coefficient estimate of .88 (Crowne & Marlowe, 1960). A Cronbach's alpha of .85 with the current sample provides evidence of reliability with this sample.

Procedure

Potential participants were invited to respond to the survey via electronic email. Email addresses of potential mental health professional participants were obtained from comprehensive statewide lists of the various subgroups of interest. To collect the sample of students, graduate students were contacted via various departmental listservs. Non-mental health professionals were reached through an alumni listserv obtained from a non-mental health training program. Participants were told that the following survey was designed to investigate attitudes towards adults with mental illness. Included in the email was a link to the survey, which was housed at a commercial online site for electronic survey research.

Results

As a preliminary analysis, scores on the Social Distance Scale and the CAMI were correlated with scores on the MCSDS to investigate whether participants were answering in a socially desirable manner. It has been suggested by authors (Leite & Beretvas, 2005) that a low correlation between the Marlowe-Crowne Desirability scale and the scale of interest indicates honest responses. No scores of interest correlated significantly at a .05 level with scores on the MCSDS. This provides evidence that social desirability did not have a substantive role in participant responses and that participants answered questions on the Social Distance Scale and the CAMI with a reasonable level of honesty.

To answer RQ1 and RQ3, a 2 X 2 X 2 ANOVA (professional level [trainee vs. professional] X status [mental health vs. non-mental health] X gender [female vs. male] X Social Distance) was used to investigate the desired social distance toward people with a mental illness. This analysis assessed for main effects based on professional level (trainee vs. professional), main effects based on status (mental health vs. non-mental health), main effects based on gender (female vs. male), and possible interaction effects between professional level, status, and gender. There was a significant main effect found for status F (1, 184) = 16.44, $p < .05$, η^2 = .08. Mental health trainees and professionals had higher mean scores on the Social Distance Scale (M = 3.4, SD = .38) than non-mental health trainees and professionals (M = 3.0, SD = .54). Results indicated a main effect for gender F (1, 184) = 6.63, $p < .05$, η^2=.04. Women desired less social distance than men (M = 3.38, SD = .39 vs. M = 3.13, SD = .54) and an interaction effect for gender X mental health status F (1, 184) = 12.17, $p < .05$, η^2=.07. Marginal means revealed that the non-mental health male sub-group was most important in separating the groups. There were no other significant main or interactive effects.

A 2 X 3 ANOVA (professional level [trainee or professional] X professional orientation [counseling, social work, psychology] X Social Distance) was used to investigate the differences in desired social distance. Results indicated that there was a main effect for professional orientation F (2, 184) = 17.67, $p < .05$, η^2 =.16. Univariate follow-up analyses indicated that participants with the professional orientation of counselor and psychologist desired significantly less social distance (M = 3.40, SD = .34; M = 3.40, SD = .4, respectively), than those who identified as social worker and non-mental health professional (M = 2.89, SD = .62; M = 3.06, SD = .49).

Finally, although attitudes towards mental illness and social distance have been discussed in the literature (Gureje et al., 2005; Taylor & Dear, 1981), the relationship between attitudes towards mental illness and social distance towards mental illness had not been explored using the CAMI and the Social Distance Scale. Therefore, bivariate correlations were

calculated. Because multiple bivariate correlations were being conducted, a more stringent alpha level of .01 was used. There was a significant negative relationship between social distance and Authoritarianism (r (186) = -.52, p < .01) and social distance and Social Restrictiveness (r (186) = -.64, p < .01). There was a significant positive relationship between social distance and Benevolence (r (186) = .51, p < .01) and social distance and Community Mental Health Ideology (r (186) = .60, p < .01).

Discussion

Previous researchers have examined social distance attitudes of mental health professionals and trainees with samples of psychiatrists, psychologists, and social workers, but not professional counselors. In addition, researchers had not examined simultaneously the attitudes and desired social distance of students. Both the mental health professional group and the mental health trainee group included professional counselors, a group previously excluded from this research.

Authors had suggested that those associated with the mental health field hold the same social distance attitudes towards adults with mental illness as the general population (Lauber et al., 2004; Nordt et al., 2006). Results of the present study suggested that non-mental health trainees and professionals desired more social distance than those associated with the mental health field. This implies that members of the general population hold more negative attitudes toward those with mental illness than mental health professionals and trainees. These results are encouraging and imply that training programs and experience might have a positive effect on reducing social distance towards adults with mental illness. Regarding gender and social distance, a consistent finding in previous research (Marie & Miles, 2008; Phelan & Basow, 2007) suggested that women desired less social distance than men from those diagnosed with mental illness. Results from this study are consistent with those findings.

Since mental illness stigma can be as damaging as the symptoms (Feldman & Crandall, 2007), professional counselors can advocate for adults with mental illness in order to lessen stigma. These messages can be shared with the general population through national groups such as the National Alliance for the Mentally Ill and the National Mental Health Association, as well as through international programs such as the World Health Organization and NBCC International's Mental Health Facilitator Program. Further, professional counselors might broach the topic of social distance with their clients, as sharing thoughts and feelings related to discrimination as a result of stigma might be therapeutic for those who are dealing with the phenomenon.

Professional orientation was of particular interest in this study. As counselors come from distinct training programs that largely, but not exclusively emphasize developmental perspectives and strength-based orientations (Ivey & Ivey, 1998; Ivey et al., 2005; Ivey & Van Hesteren, 1990), how this subgroup compared to other disciplines was of interest. If there were noteworthy differences in the ways in which professional counselors viewed adults with mental illness, for example, results could serve as an indication that counselor training is indeed unique in the way that professional counselors view clients, as the aforementioned literature has suggested.

Findings suggested that professional counselors and psychologists desired less social distance than both social workers and non-mental health professionals. Despite distinguishing aspects of counselor training (i.e., developmental, strength-based orientation), however, there were no significant differences in attitudes of professional counselors and counselor trainees when compared to those in the psychology field. The lack of difference between counselors and psychologists may be attributed to similarities in training. Alternatively, though, it may be that the types of people drawn to counseling and psychology programs are more similar than different, and that the similarities might not be based on training.

Social work trainees and professionals and non-mental health professionals desired significantly more social distance. This might imply that there are some fundamental differences in the training and coursework of social workers as compared to other professional orientations. For example, it is possible that the focus on macrosystems, more uniquely the purview of social work, leads to an external orientation to change relative to an individual or microsystem approach more common to counseling and psychology. Thus, this focus on larger systems might be a differentiating factor related to proximity to persons with mental illness. Conversely, training and coursework might not be differentiating factors related to social distance. Perhaps students already possess social distance preferences when they enter into mental health training programs.

Of particular interest was how the gender of mental health professionals impacted desired social distance towards adults with mental illness. There was a significant main effect found for status as well as for gender. This finding is consistent with previous literature (Marie & Miles, 2008; Phelan & Basow, 2007) that suggested that women desired less social distance than men from those diagnosed with mental illness. In addition, there was an interaction between the two variables. The social distance scores of women were highly similar between mental health professionals and non-mental health professionals. For men, however, there was a substantive gap based on status. Men who were not mental health professionals desired the highest level of social distance. Although there is a within-group difference, this suggests that targeted advocacy efforts might be tailored to men in the general population who seem to desire a greater social distance from people diagnosed with mental illness.

This study looked at social distance attitudes of participants as one group in order to explore the relationship social distance had with other attitudes towards mental illness. It seems that social distance and other attitudes towards mental illness are related. All correlations were in the hypothesized direction. There was a significant negative relationship between social distance and both Authoritarianism and Social Restrictiveness. There was a significant positive relationship between social distance and both Benevolence and Community Mental Health Ideology. This is because higher social distance scores indicate less social distance while higher mean scores on the CAMI indicate more of each attitude. Scores on the more negative attitude subscale of the CAMI, such as Authoritarianism and Social Restrictiveness were related to more social distance, while more positive attitudes on the CAMI such as Benevolence and Community Mental Health Ideology were related to less social distance.

This implies that social distance, or proximity to adults with mental illness, can be related to attitudes. People who hold more negative attitudes towards mental illness, such as Authoritarianism (belief that people with mental illness are inferior) and Social Restrictiveness (limiting the rights for people with mental illness) might manifest this in behavior such as the desire for more social distance. More positive attitudes towards mental illness such as Benevolence (a kindly or sympathetic attitude towards mental illness) and Mental Health Ideology (the belief that mental illness deserves treatment but "not in my back yard") are related to the desire for less social distance. Those who hold a more positive attitude towards adults with mental illness will tend to be more comfortable with situations such as working at the same place of employment or maintaining a friendship with someone with a mental illness. Since the two constructs are related, perhaps advocacy efforts need to be geared towards both attitudes and social distance in order to combat mental illness stigma. For example, only focusing on attitudes might miss the proximity associated with stigma toward an adult with mental illness. These efforts might especially be geared towards those in the general population, since this study suggested that non-mental health professionals and students desired the most social distance.

Mental health professionals of any type can begin to consider social distance as it relates to attitudes towards adults with mental illness, since the construct of social distance can be used to assess expected discriminatory behavior towards adults with mental illness (Baumann, 2007; Link & Phelan, 2001; Marie & Miles, 2008). As well, professional counselors might begin to explore their own comfort level with proximity and closeness to adults with mental illness, since it relates to attitudes. Counselor educators might consider including people with mental illness as a marginalized group in multicultural training and challenging students to examine their knowledge and self-awareness related to mental illness. Although results of this study suggested that mental health professionals desired less social distance than those in the general population, other recent research has suggested that it would be too simplistic to assume that mental health professionals do not indeed hold stigmatizing attitudes (Nordt et al., 2006).

Limitations and Future Directions

As with all research, the current study has limitations that both contextualize the findings and provide direction for future research efforts. First, replication with larger and more diverse samples is warranted. It is unknown the extent to which respondents in this study differ from non-respondents. In particular, it is possible that there is a systematic bias (either positive or negative) among those who chose to respond to the study request. Future researchers should include a more racially diverse sample, as these findings are based on the responses of participants who largely identified as Caucasian.

Additionally, replication and extension efforts are warranted that use alternative methods of measuring social distance, which is important for at least two reasons. First, the current study relied solely on self-report and, although

responses were not overly influenced by social desirability, it is unknown to what extent a mono-method bias exists. Future researchers could use other methods of assessing social distance to account for this potential bias. Furthermore, the present study is limited because of the cross-section scope of the data. Scholars interested in social distance might longitudinally examine mental health trainees before and after training to better understand the developmental nature of social distance and stigma towards adults with mental illness. Specifically, it would be useful to know what types of experiences impact one's desired social distance and stigma. Such a longitudinal study also would provide information about whether mental health trainees enter their training program already desiring less social distance than the general population. While previous researchers explored attitudes towards mental illness before and after a single course during mental health training, thus assuming attitude changes were a result of the course, future research might survey students at the beginning of the training program, before starting any coursework, and at the end of training in order to investigate social distance over time. If desired proximity remains the same, this might imply that mental health students naturally possess less stigmatizing attitudes and are drawn to helping professions rather than assuming that low levels of desired social distance are an artifact of training. Further, future research could examine different types of counseling students, so that any differences related to particular types of counseling programs (i.e., clinical mental health counseling or school counseling) would be revealed. Given the variations of curriculum and clinical training associated with each, differences in attitudes might suggest attitude changes as a result of curriculum and training.

The topic of gender and social distance may be an area for continued study. Qualitative designs might assist researchers in gaining a deeper understanding of desired social distance of men and women, and whether gender is most important in understanding desired social distance with adults with mental illness. Depending on themes that might arise related to social distance, counselors can aim advocacy efforts and anti-stigma campaigns to assist with this.

Conclusion

Many people have attempted to highlight to the public that stigma towards adults with mental illness is as damaging to those diagnosed as the illness itself. Missing, however, is a comprehensive understanding of the stigma process. In this study, the focus was on social distance as it relates to stigma towards adults with mental illness. Factors such as mental health training, professional orientation, and gender seem to result in differences related to social distance. Individuals not associated with the mental health field continue to have mental illness stigma, as previous research suggested. Results of the current research can assist in a deeper understanding of the factors involved in the phenomenon. With a deeper understanding of social distance and stigma, practitioners can create advocacy efforts and targeted interventions with the overall goal of eradicating mental illness stigma.

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Bringing Life to e-Learning: Incorporating a Synchronous Approach to Online Teaching in Counselor Education

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Recently, many counselor education programs have considered whether and how to offer courses online. Although online counselor education courses are becoming increasingly common, the use of synchronous (real-time) teaching approaches appears to be limited at best. In this article, we provide a context and rationale for incorporating online synchronous learning experiences, discuss the use of simple technologies to create meaningful educational experiences, and present one model for combining synchronous and asynchronous instructional approaches online. We also share our perspectives on the contributions of synchronous learning components, reflect on student and instructor experiences, and discuss issues to be considered in developing online counselor education courses.

Keywords: online teaching, counselor education, synchronous learning, implementation, technology

Use of technology in counselor education is commonplace today. Email, PowerPoint presentations, and online grading are accepted and utilized on a daily basis. In addition, many counselor educators use online teaching platforms such as *Blackboard* as a way of incorporating asynchronous communication, discussion, and resources to enhance face-to-face (F2F) courses. In this hybrid model of instruction, the asynchronous component is utilized but a significant part of the course is taught in a traditional (F2F) classroom. What is less prevalent, however, is the use of computer-mediated communication (CMC) in place of F2F classroom meetings. Online synchronous discussion (OSD) is one approach to CMC that includes a range of activities which occur online in real time, including chat and instant messaging. These technologies allow participants to have conversations much as they would if they were physically in the same space. The purpose of this article is to review the literature on the effectiveness of CMC, to provide an example of how online synchronous discussion (OSD) (combined with asynchronous use of *Blackboard*) has been used effectively in counselor education, and to discuss the possibilities and limitations of this approach. This article is intended for those with little or no experience in online teaching as well as for those who have primarily used asynchronous teaching approaches online.

Technology in Counselor Education

Although technology is not the primary focus of this paper, some introductory definitions of terms are necessary to approach this topic. Distance education is an overarching term used to describe teaching that includes the use of various technologies in order to serve students who are not physically present in the classroom. Often, this involves using audio- or videoconferencing tools to allow people from various locations to participate in a course. In video- or teleconferencing, students may report to various satellite classrooms in order to access the technology. Students in each classroom can then view both the instructor and other students (Woodford, Rokutani, Gressard, & Berg, 2001). Computer-mediated communication (CMC), which involves the use of computers and web-based technology as teaching tools, can be divided into two types. Online asynchronous discussion (OAD) involves learning that is not restricted to classroom time and that can be accessed at any time; often, this includes discussion boards, email, and postings of course materials on an Internet-accessible site (e.g., webpage or *Blackboard* course pages) (Jones & Karper, 2000). Alternatively, online synchronous discussion (OSD) involves audio, text, and/or video connections through the Internet for real-time communication (Slack, Beer, Armitt, & Green, 2003). Because the advantages of distance education often include the opportunity for students to attend class completely on their own schedule, many distance education courses depend on asynchronous approaches to instruction since these do not require that all students and the instructor be in the same space (physical or virtual) at the same time.

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Two studies have examined the use of technology in counselor education programs. Wantz et al. (2003) surveyed CACREP-accredited counselor education programs on their use of distance learning and found that the majority of programs reported not using distance learning and that these programs had no current plans to implement these types of courses into their curriculum. A second group (Quinn, Hohenshil, & Fortune, 2002) examined the use of technology in general by CACREP-accredited programs. Although technology frequently was utilized within a traditional classroom setting, few respondents reported offering online courses in their programs. It appears that advancement in the use of CMC has been slow within the counselor education community.

A Conceptual Framework for Online Teaching

Garrison, Anderson, and Archer (2000) created a conceptual framework that includes the required components of what they considered to be a powerful online educational experience. Their model, termed a community of inquiry, included three aspects of the educational experience: *Social Presence*, *Cognitive Presence*, and *Teaching Presence*. *Social Presence* refers to the ability to bring student and instructor personalities into the learning community. Included in this social component are expression of emotion, open communication, and development of group cohesion. *Cognitive Presence* is the ability to construe meaning from the educational experience, with critical thinking or inquiry being the major focus. Finally, *Teaching Presence* refers to the design, delivery, and facilitation of the course content. This component includes three aspects: instructional management, creating understanding, and direct instruction. Garrison et al. suggested that all three components are necessary for a successful online course.

Research on OSD

Studies of online learning communities have been conducted in various realms. Shea (2006) surveyed students participating in various online courses and found that the stronger the *Teaching Presence*, the stronger the overall learning community. Students rated the classroom community higher when their instructors were more active facilitators, including keeping students on task, creating an open and accepting learning climate, and acknowledging student input and contributions. Results of another study (Perry & Edwards, 2004) revealed that effective online instructors both challenged and affirmed their students, and that high levels of *Cognitive Presence* and positive *Social Presence* directly added to students' positive reactions to online learning. Clearly, research to date supports the potential for successfully creating a community of inquiry online.

Other researchers have conducted studies examining the effectiveness of synchronous learning experiences online (OSD). Wang (2005) found that the use of open-ended and comparison questions in a real-time online classroom was effective in engaging students and fostering cognitive development. Another study (Walker, 2004) helped identify those teaching strategies that could help develop critical thinking and debate in an OSD-based course. Participants in one debate course indicated that Socratic strategies such as open-ended responses, including challenges and probes, were most likely to elicit student response, and that encouragement and countering also were helpful. Slack et al. (2003) found that online discussions where group cohesion had occurred promoted cognitive development in students better than in classes that lacked cohesion. This suggests that instructors must give attention to rapport building in their OSD classes in order to increase levels of critical thinking and involvement. Finally, Levin, He, and Robbins (2006) surveyed preservice teachers before and after their participation in a series of OSDs. Prior to the online discussions, the majority of participants believed they would prefer asynchronous discussion; afterwards, however, the majority indicated that they actually preferred synchronous discussions online. Reasons given for this change in preference included the opportunity to receive immediate feedback, the real-time pace of the discussions, the convenience of having the entire chat completed in one sitting, and the challenge of having to think critically and learn from peers. In addition, participants in OSD demonstrated higher levels of critical reflection than did OAD participants. These studies demonstrate the potential effectiveness of OSD and point to the importance of appropriate facilitation in order to promote student growth.

Although Garrison et al. (2000) stated that "all three elements [*Social Presence*, *Cognitive Presence*, and *Teaching Presence*] are essential to a critical community of inquiry for educational purposes" (p. 92), they also noted challenges involved in developing such an online community of inquiry. These authors proposed that "… the elements of a community of inquiry can enhance or inhibit the quality of the educational experience and learning outcomes" (p. 92). In addition, they clarified that the kind of OAD they addressed, although collaborative, was quite different from F2F environments. It is this difference from traditional F2F learning that makes the obstacles in using online courses to

train counselors unacceptable and virtually insurmountable. Because counseling is a person-to-person experience, it can be particularly difficult for counselor educators to envision how counseling students could be trained and evaluated effectively through a text-based, online experience where course participants cannot see and interact with each other in real time.

The online group course described in the following section was designed to address all three of Garrison et al.'s (2000) elements of a community of inquiry by combining synchronous and asynchronous experiences that much more closely simulate an F2F educational experience. Moreover, our experience has been that use of readily-available technology has allowed us not only to more closely simulate face-to-face classroom experiences, but also to take advantage of features unique to the online experience.

The Online Course: Group Counseling in Schools

To meet the needs of practicing school counselors for additional post-master's degree training in school counseling, the counselor education program at one southeastern university created an online-only Post-Master's Certificate (PMC) in Advanced School Counseling. This program was designed to provide working school counselors with 12 hours of additional training that also would qualify them for a significant salary increase in the state system. Over a two-year period, four graduate-level courses were developed for this program. The first of these courses, Group Counseling in Schools, was created and used to pilot test an instructional model for the remaining courses. To do this, the first author worked closely with university instructional technology consultants to create an online learning environment that could be process-based and provide a student-focused learning environment in which student participation was critical to the quality and success of the course itself. The result was an online course that incorporated both OAD and OSD components.

The Asynchronous Component (OAD)

Blackboard is well known and widely used as an educational platform "for delivering learning content, engaging learners, and measuring their performance" (http://www.*Blackboard*.com/Teaching-Learning/Learn-Platform.aspx) in higher education. *Blackboard* is primarily an asynchronous learning platform which offers a format that provides for easy posting of course information and a wide variety of course resources. Features include a discussion board with forums that provide opportunities for students to respond to prompts, discuss issues, and share ideas in an OAD where postings can be made and responded to at any time. *Blackboard* currently is used widely to supplement F2F instruction. In our online group course, *Blackboard*'s discussion board is used to allow students to take more time to reflect on their learning and encourages them to think more critically about online experiences and course material. Because instructors typically do not participate in these discussions, both responsibility and control are shifted to students for the quality and content of their postings. We have been very interested to see how learning conversations develop as students learn to respond not just to instructor-generated prompts, but also to each other, sharing support, differing perspectives, and experiences. Instructors' review of the weekly postings is then used to help guide course content and discussion in the OSD component of the course.

The Synchronous Component (OSD)

LinguaMOO (MOO) is an interactive, synchronous learning platform that is available in its basic form for free (see http://www.ericdigests.org/1997-4/moo.htm), with technical support provided by each individual institution. MOO was developed as a community that is designed to simulate F2F environments in many ways using technology that is affordable and easily implemented. MOO is text-based and utilizes a very basic chat environment. More capable, commercial software packages that are now becoming widely used include *Elluminate* (a free, virtual, collaborative web-conferencing system; http://www.*Elluminate*.com) and *Saba Centra Classroom* (which offers a complete set of features for recreating interactive classroom learning experiences online; http://www.saba.com/products/centra/details.htm). Both of these packages add greatly enhanced capabilities for using audio, video, whiteboards, and graphics as part of online class meetings, providing a wide variety of tools to use in creating a virtual environment for learning.

In the online MOO class, when students come to class, they enter the instructor's room, which is the virtual classroom.

Each person who enters the online classroom is visible to everyone else already in the room. As with F2F classes, MOO meetings often begin and end with informal chatting among students and instructors. The visual format of MOO is simple and would be familiar to anyone who has participated in online chats. The computer screen is divided into three sections: two sections on the left display the ongoing discussion and provide a place for students and instructors to compose their comments. In addition to text, MOO also provides an emote feature that can be used to add nonverbals and emotions (similar to text-based emoticons) to the discussion, giving participants a different way to express themselves or add expression to their comments. The right half of the screen is used to present PowerPoint slides that support, guide, and facilitate online discussion, as well as provide structure and content for the class meetings. In addition, MOO allows for recording the transcription (complete with links to PowerPoint slides) for each class, permitting students to review what occurred in class if they missed a class or wanted to revisit a discussion topic. This feature also frees students from having to take notes during class.

Class meets for two hours per week during the regular semester. Like F2F courses, class is scheduled for a particular day and time. Thus, students must commit to being able to attend the online class meetings at the same designated time each week; just like F2F, everyone has to attend class at the same time. Unlike F2F classes, however, students do not have to travel, search for parking, and arrive at a physical classroom on time. Both instructors and students have the flexibility to log into class from any location with an Internet connection. Although the same faculty member has taught this course from its inception, different advanced doctoral students, typically with strong background and expertise in school counseling, have been assigned to co-teach each time the course was offered.

Implementation of the Course

A required F2F meeting is scheduled on campus prior to the beginning of the group counseling course. Although the primary purpose of this meeting is to train students in use of the technology to be used in the course, additional benefits include: making social connections with students and instructors; developing a basis for *social presence*; and getting a feel for the instructors' teaching style. Starting in a familiar F2F format and using a standard classroom environment to acquaint students with new technology, a new learning format, and each other seems to work well. In addition, students frequently comment on the importance of this first F2F session for having a successful experience in the course; their F2F experiences help reduce anxiety and create a basis for group cohesion and support throughout the PMC program.

Combining Synchronous and Asynchronous Modes of Learning

In this online course, OAD and OSD approaches are combined to create the total learning environment. *Blackboard* tends to elicit more formal, traditionally academic, and reflective responses as students reply to instructor prompts (and each other) on the *Blackboard* discussion board. Prompts typically come from readings and OSD discussions. By contrast, MOO has the vitality more characteristic of a F2F class meeting, with more social and informal discussions and responses. Use of PowerPoint slides online helps structure class and provides content to supplement required reading. Like F2F, synchronous online class meetings have immediacy and are fast-paced. The chat aspect of class means that comments, responses, and interactions can move very quickly, challenging students (and instructors) to pay attention. The quick back-and-forth in the chat format requires that traditional academic expectations about such details as spelling and grammar be suspended, helping to create a more relaxed climate online. Also, active participation online requires much shorter comments and responses than in F2F classes because the faster pace requires faster posting of responses and shorter amounts of text for others to read. Thus, online class sessions are reading- and writing-intensive.

Cognitive Presence

In discussing the *cognitive presence* component, Garrison et al. (2000) emphasized the "potential for facilitating deep and meaningful learning in a [virtual learning] environment" (p. 93). We use MOO to provide opportunities for high levels of in-depth interaction during class. The nature of the OSD component is that it requires verbal participation online in order to be actively engaged in class. Students who are not actively posting in the discussion are invisible in class. This is unlike F2F experiences where students can contribute minimally or choose to be passive learners. In MOO, all students contribute very actively to discussions. In interactions with instructors online, students are encouraged to take responsibility for their own learning, share their knowledge with others in the class, and combine what they know from practice with new or revisited concepts in class. Thus, instructors strive to address the teaching elements proposed

by Newman et al. (1996), including actively encouraging and inviting new ideas and perspectives as well as helping link together theories, facts, applications, and professional experiences.

With this expectation of active verbal participation online, many students are challenged to modify their usual classroom style. For example, introverts who might be hesitant to share comments in an F2F class often shine online. Conversely, strong extraverts can feel constrained online by having to compose their comments and keep them shorter and more focused. Students quickly adapt to this change and most tend to be active in every class meeting.

Throughout the course, we utilize various techniques to promote critical thinking. Similar to F2F classes, open-ended questions are frequently posed to students. Often, probes are used to stimulate further discussion on a topic. In addition, we frequently make encouraging comments such as "interesting idea" or "well put" to let students know that their ideas are important to the discussion and highlight these contributions for other students. These encouragers reinforce student contributions to class, help promote additional conversation, and help highlight important points in the transcript. Even more than in an F2F class, it is vital that instructors plan for how to use their teaching skills to promote *cognitive presence* online. In the synchronous online learning environment, critical thinking results from instructors' intentional encouragement, supportive comments, and challenging questions.

Social Presence

Garrison et al. (2000) hypothesized that "high levels of *Social Presence* with accompanying high degrees of commitment and participation are necessary for the development of higher order thinking skills and collaborative work" (p. 93). To create a community of inquiry, students must feel they can be "real" people in the virtual classroom. As noted earlier, we use the on-campus training to help students feel comfortable and competent with the technology. Then, in the first class online, instructors ask students to reflect on their own professional experiences, modeling use of humor, restatement, encouragement, and positive reinforcement along the way. These techniques help build a level of *social presence* in the online classroom.

As students have successful experiences in the online environment, they find ways to contribute their personalities, ideas, and expertise in the virtual classroom. As that happens, the technology becomes just another tool for learning and sharing information, ideas, and resources with each other. The shared experience of doing something new and the commonalities students have as school counselors also help to foster social connections and relationships online. One strong indicator of success in developing the social component online is that students frequently share both professional and personal issues with each other, at the beginning and end of class as well as (appropriately) throughout discussions. Students typically develop strong connections with the group and its members that provide a working foundation for their ongoing development as a group during the PMC program. As Garrison et al. (2000) have observed, "*Social Presence* marks a qualitative difference between a collaborative community of inquiry and a simple process of downloading information" (p. 96).

Teaching Presence

Clearly, there is a critical need to establish a strong *teaching presence* online, since this has been described as "the binding element in creating a community of inquiry for educational purposes" (Garrison et al., 2000, p. 96). One challenge for counselor educators is to provide familiar kinds of structure, leadership, and facilitation online. We have found that the synchronous learning environment lends itself very well to using group facilitation and process skills to stimulate and involve students in very active ways. We present prompts, share selected information, encourage students to think critically about material, and help students relate course material to their own experiences and work settings. For teaching that is more instructor-centered and more lecture-based, MOO is limited and somewhat lacking. As a platform for process-based learning experiences, however, MOO provides the basic elements to create an online experience that can offer a viable alternative to F2F instruction. In fact, what actually takes place in an online class is largely the same as what would happen in an F2F version of the class; the primary adaptations have to do with effectively using technology to do these things online.

Garrison et al. (2000) noted the importance of students having time to reflect on information as a critical part of the learning process. In our course, students have built-in time to reflect and discuss during online meetings. This reflection

time, however, is limited, and must be intentionally included in the class structure by the instructors. Enhanced reflection can occur through *Blackboard* discussion board postings (OAD) and by requiring students to review and comment on transcripts from online class meetings following online class sessions. With co-instructors for this course, there typically are two instructor/facilitators online in the class. As with co-leading groups, this allows one instructor to serve as lead facilitator to guide the process and cover content while the other instructor keeps a closer eye on student responses and responds to their questions and comments, often playing a major role in supporting and reinforcing student contributions. Because the lead instructor role often shifts midway through a class, each instructor has the chance to be more upfront and facilitative in one part of the class and more of the active listener and supporter in another.

Some examples can illustrate how we create a strong *teaching presence*. First, class size is limited to 12 students. This small number helps the instructors keep track of the students in the class; since students cannot be seen, it is important to watch users' screen names to ensure that everyone participates. In addition, the smaller class size allows activities to be completed without consuming the entire class time. Activities also are used to engage students and model facilitation skills. For example, in one class students are asked to design a tattoo for themselves and discuss its meaning. The instructors use this activity to demonstrate group processing skills by modeling reflections, open-ended questions, and facilitative comments. This type of activity helps lead to *cognitive presence* through strong *teaching presence*. Finally, everything done in the class is purposeful, just as in an F2F classroom. This attention to goals and purpose helps maintain students' interest, keeps students focused and involved during the class, and helps us maintain a strong *teaching presence*.

Reflections on Course Format and Learning Experiences
Benefits to Students and Instructors

Surprisingly, one of the benefits for students is a much higher level of consistent, ongoing participation than would be possible in an F2F classroom. One reason is that in a chat (MOO) format, everyone can essentially be talking at the same time, something that can be managed in an online environment, but would create total chaos F2F. In addition, the chat format allows students to address instructors and each other directly to ask questions, share observations, or make suggestions. In many ways, students can have much more contact and interaction with instructors and their peers in the virtual classroom, and we see this as a major benefit of this online learning environment.

Because of the ongoing dialogue in class, students can more readily affect the pacing and depth of material covered in class by having ongoing input into the educational process. We also encourage students to bring their real-life experiences to bear on the material (and vice-versa). This is particularly appropriate for working adult students who consistently have been found to value opportunities to blend experience with new information in the classroom. Many other benefits to students have been mentioned previously, including the opportunity for everyone to participate, availability of class transcriptions, easy access to the class on the Internet, and the ability to use PowerPoint slides to both guide discussion and inject instructors' personalities into the class (e.g., through selective use of photos, images, or quotes).

Instructors share many of the benefits noted above for students. The most obvious instructor benefit may be the flexibility of being able to teach from any location with reliable Internet connections (e.g., the lead author has taught this class from New Zealand and Italy). Also, guest presenters can easily participate in the class no matter where they are located geographically. One class featured a guest presenter from India who shared information about her culture and responded to students' lively questions. Additionally, the simple format of MOO allows instructors the opportunity to exercise their creativity by adding color, graphics, photos, and design elements to visually enhance and enliven the online experience. These creative elements also can help to stimulate and harness the live energy and the excitement of collaborative learning experiences. Graduate student co-instructors have found that teaching online has given them additional teaching skills they can market as new counselor educators, in addition to influencing how they view both online and F2F teaching. Even for the experienced faculty member, the online teaching experiences have positively affected how he plans for and conducts F2F classes.

Student Feedback on Online Experiences

As we reviewed student evaluations from several semesters of this online course, the most striking thing was how similar ratings and feedback were to student evaluations of F2F classes taught by the counselor educators. In

addition, very little mention was made about the technology used for class; the few comments that were made were positive. The vast majority of student comments focused on instructor effectiveness, skills, and knowledge. Related to *teaching presence*, students commented positively on organization of the course, group leadership/facilitation, clear communication, and instructors' knowledge. In the area of *cognitive presence*, key themes were instructors' ability to stimulate interest in course content and stimulation of critical inquiry. Finally, students addressed *social presence* in the course with comments about instructors' approachability and helpfulness, respectfulness, and ability to foster group cohesion.

Precautions and Practical Considerations

We believe there are three keys to success with online learning: (1) incorporate an energetic and well-planned interactive component; (2) keep things as technically uncomplicated as possible; and, (3) provide necessary training and tech support (e.g., backup) upfront. Students regularly cite the importance of the initial F2F technology training and the comfort of knowing they can contact university tech support if they experience difficulties. As noted above, the MOO platform provides basic tools for creating live classes online without many of the frills that can make things unnecessarily complicated and intimidating to students. Classes really come alive with the interactive component that MOO offers, due in no small part to instructors' establishing a norm for active and enthusiastic participation in online sessions. Instructors also act as if these classes are F2F, using familiar language (e.g., "see you next week," "see you in class") and familiar structures (agendas for class, balance of information-giving and discussion, even having a break midway through class) that subtly replicate familiar F2F instruction experiences.

To be able to accomplish all three areas of presence (teaching, cognitive, and social) identified by Garrison et al. (2000), instructors must be very intentional in designing and conducting the OSD component. For example, to teach effectively in this environment, instructors need to closely monitor student participation so that they can see those who are sitting quietly in the online classroom and encourage or call on them to bring their voices to class discussions. We have found it very helpful to have co-instructors to help keep up with the flow of discussion, maintain energy in the online classroom, and reach out to quieter or less involved students. To create and maintain *cognitive presence*, instructors need to be very intentional in cultivating an environment of critical inquiry, including asking good, critical questions and encouraging constructive dialogue among students and instructors. *Social presence* primarily involves encouraging students to connect with their peers and with instructors in class, and can include appropriate use of humor, liberal use of names, and attention to time for socializing at different points in class (beginning, end, break).

Conclusion

Numerous approaches exist for offering and teaching online graduate courses. If the primary goal is communication of large amounts of information, the approach described in this article likely will not be the most effective or efficient option. Counselors and counseling students, however, like to be able to interact with each other—whether F2F or online—and the MOO/*Blackboard* (OSD/OAD) approach to teaching and learning online allows for much discussion and processing of course material. Over the past several years, we have found that student responses to this online format have been overwhelmingly positive. Even students fearful or skeptical at the beginning, readily become active and engaged class members. This approach has worked particularly well with more advanced students where their F2F coursework prepared them with fundamental counseling knowledge and skills. It is our belief that a community of inquiry can be established effectively in an OSD format and that the elements of teaching that counselor educators hold dear—social contact and interaction—can be created successfully in an online environment. The increasing availability of more sophisticated platforms for synchronous online class meetings (e.g., *Elluminate* and *Saba Centra Classroom*) should make it even easier for counselor educators to use OSD for online only or hybrid courses in their programs. For us, the ability to interact with students online in real time has been a key to making online instruction come alive in ways that rival what we do in our F2F classes.

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The Effect of Parenthood Education on Self-Efficacy and Parent Effectiveness in an Alternative High School Student Population

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Adolescents defined as at-risk typically lack healthy models of parenting and receive no parenthood education prior to assuming the parenting role. Unless a proactive approach is implemented, the cyclic pattern of dysfunctional parenting— including higher rates of teen pregnancy, increased childhood abuse, low educational attainment, intergenerational poverty, and lack of steady employment—will continue. Parenthood education seeks to remediate this recurring cycle with at-risk youth before they become parents. Eighty-two alternative school students, grades 7 through 12, were randomly assigned to either an experimental or control group. After the experimental group completed a 16-session parenthood education program, differences between the two groups were tested using two measures: the Self-Efficacy Scale and the Parent Effectiveness Measure. Two-way ANOVA analyses showed statistical significance between the primary caregivers in the experimental and control group on the social self-efficacy and parent effectiveness measures. Implications and suggestions for further research are discussed.

Keywords: parenthood education, pre-pregnancy prevention, at-risk youth, social self-efficacy, parental effectiveness

At-risk adolescents typically lack the resources and background to build a strong foundation for parenthood. Often these adolescents do not have appropriate models of parenting, which potentially account for higher rates of teen pregnancies, higher incidences of childhood abuse or neglect, lack of self-efficacy, and low socio-economic status (Bifulco et al., 2002; Coleman & Karraker, 1997; Donenberg, Wilson, Emerson, & Bryant, 2002; Herrenkohl, Herrenkohl, & Egolf, 2003; Griffin, 1998; Helge, 1991, 1990; Herrenkohl, Herrenkohl, Rupert, Egolf, & Lutz, 1995; Massey, 1998; National Campaign to Prevent Teen Pregnancy [NCPTP], 2002; Shumow & Lomax, 2002). Without some type of intervention, at-risk adolescents may be prone to developing the same unhealthy patterns they experienced in their own upbringing and continue the cycle of poor parenting. Minet (1985) suggests parental patterns are reproduced across generations. For example, studies have found that 40% of mothers who were abused or neglected as children maltreated their own children, another 30% provided borderline care (Cowen, 2001), and over 22% of adolescent females that were born to a teenage mother will become teen parents themselves (Terry & Manlove, 2000). In the absence of more effective options, cyclic dysfunction may ensue. Education programs may provide a catalyst to learn positive parenting techniques and skills from sources outside one's own upbringing (Reppucci, Britner, & Woolard, 1997) and to increase one's sense of self-efficacy (Bandura, Adams, Hardy, & Howells, 1980; Griffith, 2002; Leerkes & Crockenberg, 2002). A program that enhances student self-efficacy may lead to increased motivation and a transfer of efficacious beliefs to other domains in participants' lives (Bandura, 1982). This study examined the effect of a parenthood education program with at-risk alternative school adolescents on a measure of self-efficacy, parent effectiveness, and the parent-child relationship.

Cost to Society

Continuing the cycle of poor parenting comes with a great price tag to society. A host of societal problems—school failure, child abuse and neglect, substance abuse, assaultive behavior, intergenerational poverty, single mother births, welfare dependency, workforce underdevelopment, absent fathers and low self-efficacy—have all been shown to be closely associated with teen pregnancy (Herrenkohl et al., 2003; Massey, 1998; NCPTP, 2002). Financially, teen parenthood results in a considerable cost to local, state and national governments. The welfare costs for families started by a teen birth have been estimated at $25 billion in one year nationally (Herrenkohl, Herrenkohl, Egolf, & Russo, 1998),

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while almost 60% of the expenditures for another federal program, Aid to Families with Dependent Children (AFDC) go to single mothers who had their first child while a teenager (Dorrell, 1994). One cost benefit analysis suggests the government could increase spending on teen pregnancy prevention to eight times the current amount and still break even (Sawhill, 2001, 2007).

Although these figures are significant, the social-emotional burden is even more alarming. Without proper preparation to learn the skills needed for the challenges of childrearing, parents are highly likely to default to inappropriate coping mechanisms, such as violent behaviors. In the United States, 8,042 children are reported abused or neglected every day, more than 3.25 million annually; nearly four children die each day as a result of child abuse or neglect (Hopper, 2005; Massey, 1998). Education is an essential part of the foundation of our society; a violent or abusive environment undermines a student's ability to learn and the damage is not easily repaired (Prothrow-Stith & Quaday, 1995; Swick & Williams, 2006). Clearly, the ongoing, multifaceted cost to society is difficult to calculate.

Although decline in teen pregnancy and birth rates recently exists (Flanigan, 2001), the United States still has the highest rates of teen pregnancy, teen births, and teen abortion in the fully industrialized world. There are nearly half a million teen births annually; each hour nearly 100 teen girls become pregnant and 55 give birth (U.S. Department of Health & Human Services, 2002; Ventura, Mathews, & Hamilton, 2002). Four in ten young women become pregnant at least once before age 20 and nearly 40% of these are age 17 or younger (NCPTP, 2002). The NCPTP (2005) reports 35% of teen girls become pregnant at least once as a teen—850,000 annually. Moreover, more teens are sexually active earlier. In a recent study (see Pearson, Muller, & Frisco, 2006; Terry & Manlove, 2000), 8.3% of students report having sex before age 13, a 15% increase since 1997. There was a 3% increase in teen pregnancy rates between 2005 and 2006 (NCPTP, 2011). If current fertility rates remain constant, the number of pregnancies and births among teenagers will increase 26% by 2010 (NCPTP, 2002). Collectively, the effects of teenage parenting have become a national crisis. Research, as well as politicians and national, state, and local initiatives and campaigns have embraced some aspect of the teen pregnancy agenda. In his 1995 State of the Union address, former President Bill Clinton declared teen pregnancy the most serious social problem facing the country.

Adolescent pregnancy continues to be a cycle of dependency and poverty. According to the U.S. Department of Commerce children of unmarried teenage mothers experience long-term abject poverty four times as often as children from other families (U.S. Department of Commerce, 1990) and two-thirds of families begun by young unmarried mothers are poor (NCPTP, 2002). Recent research found that unmarried teen mothers had a 43% lower income-to-need ratio, were 2.8 times more likely to be poor and 1.4 times more likely to receive government welfare benefits than were non-teen mothers or married teen mothers (Bissell, 2000). The NCPTP (2005) reports that 52% of all mothers on welfare had their first child as a teenager, and teen mothers are twice as likely to become dependent on welfare than their counterparts— nearly 80% of unmarried teen mothers are on welfare (Dorrell,1994).

Unremitting poverty is not the only issue of teenage parenthood; education and employment are affected as well. Less than 4 of 10 teen mothers who have a child before age 18 ever complete high school (Hotz, McElroy, & Sanders, 1997, 2005), with school dropouts six times more likely to become unmarried parents than their graduated counterparts (Dorrell, 1994). Moreover, about one-fourth of teenage mothers have a second child within 24 months of the first birth, which can further impede their ability to finish school, obtain or maintain a job, or escape poverty (Kalmuss & Namerow, 1994; Raneri & Wiemann, 2007). Without a high school diploma, the economic outlook is bleak: according to the 2003 U.S. Census Bureau, the median income for college graduates increased 13% in the past 25 years, while median income for high school dropouts decreased 30%. Teen mothers are more likely to work at low-paying jobs, experience longer periods of unemployment, receive welfare benefits, experience single parenthood, and live in high poverty compared to mothers who do not have a child in their teen years (Bissell, 2000). Even if a teen parent finishes high school, earnings are nearly 20% less annually than that of those completing some college courses, and at least 75% less annually than those who complete a bachelor's degree—almost $1 million less in lifetime earnings (U.S. Census Bureau, 2003).

The Cycle Continues

If more children were born to parents who are ready and able to care for them, there would be a significant reduction in the social problems afflicting children—from school failure and crime to child abuse, neglect and poverty (NCPTP, 2002). The outcome for many children of teen parents is grim: children of teen mothers are 50% more likely to repeat a grade,

less likely to complete high school, and perform lower on standardized tests than children born to older parents (NCPTP, 2002). One in five children in the U.S. lives with a mother who has not completed high school; the chances of that child dropping out of school are two to three times higher than those of a child whose mother has graduated (Dorrell, 1994). The sons of teen mothers are 13% more likely to end up in prison and the daughters of teen mothers are 22% more likely to become teen mothers themselves (Terry & Manlove, 2000). An adolescent single parent is the best single predictor that a child will live in poverty (Griffin, 1998).

A 2002 study by Johnson, Cohen, Kasen, Smailes, and Brook found maladaptive or adverse parental behavior (classified as hostile, abusive, or neglectful) significantly associated with subsequent disorders experienced by offspring, including anxiety, depression, substance abuse, and disruptive disorders. Abused or neglected children tend to perform poorly in school, lack the social skills that lead to inclusion in conventional peer groups, exhibit low self-esteem and experience increased levels of depression (Smith, 1996). According to a study sponsored by the National Institute of Justice (NIJ), abuse or neglect in childhood increases the likelihood of arrest as a juvenile by 53% (by 77% for females) and violent crime by 38% ("April is Child Abuse Prevention Month," 2005). Another study found that disruptive behavior disorders in children are linked to negative parenting (Frick, Christian, & Wootton, 1999). As Prevatt (2003) concludes, these studies have consistently confirmed a direct correlation between parenting practices and developmental outcomes. The cycle is relentlessly repetitive.

When examining the childhood of teen parents, Herrenkohl et al. (1998) found that 96% of teen mothers and 97% of teen fathers had been abused or neglected as children, and a statistically significant number of teen parents were rated as lacking in self-confidence by their elementary school teacher. These adolescents exhibit a passive acceptance of their future and seem to believe nothing will change, despite their best efforts to the contrary (Griffin, 1998). This recurring cycle creates an overwhelming sense of hopelessness that can appear insurmountable to at-risk adolescents lacking in healthy supports and skills. Instead of reacting to the interminable products of this complex social problem, a proactive, preventive approach to intervention, which is both logical and cost-effective, may provide an enduring solution.

Parenthood Education Programs

Program rationale. In order to decrease the likelihood of teen pregnancy, increase self-efficacy, stop the cycle of childhood abuse, increase high school retention, improve the outlook of long-term employment, and increase parent effectiveness, a creative prevention program is necessary. One such approach is to integrate a proactive parenthood education program into the school curriculum to provide adolescents with focused educational intervention before they become parents. The public school systems are natural catchment areas, bringing together the majority of children and adolescents residing in a given community in a learning environment where didactic teaching is expected (Herz, Goldberg, & Reis, 1984). There is support for integrating programs that prepare "the next generation of parents" and recommendations from prior research have included adapting programs for inclusion in the school curriculum (Bissell, 2000; Cutting & Tammi, 1999; Dorrell, 1994; Griffith, 2002; Helge, 1989, 1991; Herz, Goldberg, & Reis, 1984; Jacobson, 2001; Rutgers, The State University, 1979; Stanberry & Stanberry, 1994; Stirtzinger et al., 2002).

Program description. A parenthood education program is comprised of a pre-service intervention through which adolescents are provided fundamental information regarding the role of "parent"—the skills, responsibilities, and time commitment required of a healthy functioning parent, appropriate parenting models, and positive, strength-focused parenting strategies. An effective parenthood education program repairs and reconstructs the lens through which at-risk adolescents see the parenting role, one that has typically been adversely impacted by their dysfunctional models. The adolescent is enabled to prepare more realistically for eventual parenting responsibilities and build a more effective relationship with their current parent/caregiver (Cutting & Tammi, 1999). Parenthood education aims to equip students with the skills necessary to make informed choices and a greater awareness of the responsibilities and implications of becoming a parent.

Prior programs. Relatively scant empirical literature exists on proactive parenthood education programs. A thorough review of the literature produced studies with three different types of programs. One study involving 7th and 8th grade students (ages 11–15) in two inner-city Chicago schools observed positive changes from pretest to posttest in the experimental group. The study measured the impact of a family life education program, for which the goals were twofold: reducing the risk of pregnancy by helping young teens develop a positive self-image, and promoting responsible sexual

and contraceptive decision making. Program participants exhibited "(a) improved knowledge about contraception, reproductive physiology, and adolescent pregnancy outcomes; (b) increased awareness of the existence of specific birth control methods; (c) among seventh graders, more conservative attitudes toward circumstances under which sexual intercourse was viewed as personally acceptable, and among eighth graders, a shift toward more liberal attitudes; and (d) a greater tendency to acknowledge mutual responsibility for contraception" (Herz, Goldberg, & Reis, 1984, p. 309).

A second parenthood education program was developed as part of *Save the Children*, Scotland's 3-year Positive Parenting Project in Angus, a rural school in North East Scotland. The participants were ages 13–14, labeled Year 2 level in Scotland. Goals were: increase the quality of life for the next generation of families; improve the way young people handle life within their own families; help develop young people's communication skills in all their relationships; and establish good parenting as the foundation for other aspects of personal and social education (i.e., drug awareness, environmental education, and community involvement). Although not an experimental study, the conclusion was that the program had a positive impact on students by helping them think more objectively about the parenting role and concurrent responsibilities of parenthood (Cutting & Tammi, 1999).

A third study examined the longitudinal effects of an Adolescent Development Program on participants in Trinidad, Spain, 10 years after participation. The 3-month program was designed to develop the social and academic skills of adolescents ages 16 to 19, and focused on self-understanding, parenting skills, overcoming everyday problems, and increasing motivation to better equip themselves with marketable skills. Qualitative findings, gathered through follow-up surveys, indicated participants benefited from the program in several ways: they became better parents, improved communication with their own parents, developed higher levels of self-esteem, and female participants postponed childbearing (Griffith, 2002). While these studies have been important in showing that parenthood education programs can be influential with adolescents, there is a gap in experimental research with the at-risk high school population in the U.S.

An alternative school population. This study was designed to expand the body of knowledge and address the identified gap in current literature by quantifying the results of a parenthood education program with one of the more needy populations—pre-pregnancy, pre-parenting alternative school students. Research is plentiful on parenting education programs geared toward teen parents, a necessary, albeit reactionary course of action. Alternately, this study implemented a parenthood education program with alternative school students prior to parenthood. Alternative school adolescents are plagued with countless obstacles—low self-efficacy, substance abuse, poverty, child abuse, school failure, employment barriers, teen pregnancy—as a result of recurring intergenerational cycles (Barr & Parrett, 2003; Payne, 2003). Without proactive intervention, the cycle is bound to continue indefinitely and outlook for improvement is dim. These challenges were addressed in this study by exploring the following research questions: Would a parenthood education program integrated into an alternative school curriculum produce student participants who (a) demonstrate higher self-efficacy, (b) believe they are more prepared to be effective parents, and (c) evidence increased empathy for their current parent/caregiver, thereby improving the student's appreciation for the parent-child relationship?

Methodology

Participants
The participants for this study were 82 students, grades 7th through 12th ($M = 9.93$, $SD = 1.44$), from an alternative school located in a rural community of a northwest state. Participants included 37 females and 45 males ranging from 13 to 20 years of age ($M = 15.73$, $SD = 1.66$). Sixty-five of the participants (79%) came from a home with a female primary caregiver, while 17 (21%) were from a family with a male primary caregiver. Additionally, 50 (61%) had a one-parent family, 27 (33%) had a two-parent family, and five (6%) were not living with a parent. The breakdown of the demographic characteristics by experimental and control group are displayed below.

Table 1

Demographic characteristics of student participants

Characteristic	Experimental Group *n* = 39	Control Group *n* = 43	Total *n* = 82
Gender			
Female	21	16	37
Male	18	27	45
Grade Level			
Seventh	0	3	3
Eighth	6	8	14
Ninth	7	6	13
Tenth	12	10	22
Eleventh	7	9	16
Twelfth	7	7	14
Primary Caregiver			
Mother (female)	30	35	65
Father (male)	9	8	17
Family Status			
Living with two parents	11	16	27
Living with one parent	26	24	50
Living with neither parent	2	3	5

Because the school is small (currently 100 students), the entire student population, except for pregnant or parenting teens, was utilized as a census sample. Therefore, no sampling procedures were enacted through the process. Four participants from the experimental group dropped out of the study. One male, grade 9, age 17, dropped out of school to get his GED; another male, grade 12, age 18, and the two female participants, both grade 12 and age 18, dropped out of school to seek full-time employment.

Instruments/Materials

Self-Efficacy Scale. The instrument used to measure self-efficacy was the Self-Efficacy Scale (Sherer et al., 1982). According to Bandura (1997), expectations of self-efficacy are the most powerful determinants of behavioral change because self-efficacy expectancies determine the initial decision to perform a behavior, the effort expended, and persistence in the face of adversity. According to Sherer, the primary author of the instrument, the goal in developing this instrument was to create a measure of self-efficacy that would not be tied to a specific situation or behavior. The purpose of this study was discussed with Sherer (personal communication, August 10, 2004), who agreed this instrument would be appropriate to measure a growth factor in the self-efficacy domain for this student population. The Self-Efficacy Scale is a 30-item measure assessing two self-efficacy constructs: general self-efficacy and social self-efficacy. The total scores for each subscale were utilized.

Parent Effectiveness Measure. Parent effectiveness, the second variable, was assessed with an adapted version of the Parenting Self-Agency Measure (Dumka et al., 1996). The 10-item instrument was measured on the same scale, but the items were modified to account for the fact that the student participants are not yet parents. The wording of items was changed to future tense to validate the change of context (e.g., "I feel sure of myself as a mother/father" was modified to

"I will feel sure of myself as a mother/father"). Dumka (personal communication, October 6, 2004), the primary author of this measure, agreed that the instrument would be equally valid when adapted as a prospective parenting assessment, even though it was originally developed for use with parents of young teens. Dumka et al. noted that hypothetically, increased parenting self-agency should be one outcome of any preventive or therapeutic parenting intervention.

Procedure

Student participants were randomly assigned to either the experimental or the control group, initially 43 in each group. In order to study the effect of parenthood education with only non-pregnant, non-parenting alternative school students, this study was delimited to participants who fit this criteria—students who were either pregnant or already a parent were not included in the initial randomization of students to experimental or control groups. The experimental group attended the parenthood education program two mornings each week, for eight weeks. The control group was offered the opportunity to attend the same parenthood education course after the post data collection. A survey of parent education research revealed a range in curricula length, with the mean program at 10.5 weeks of instruction (Bamba, 2001; Cline & Fay, 1990; Cutting & Tammi, 1999; Doetsch, 1990; Fay, Cline, & Fay, 2000; Herz, 1984; Stirtzinger et al., 2002).

The parenthood education program was designed as a pre-pregnancy prevention strategy to teach pro-social parenting skills, a realistic picture of child raising (including financial, time, and emotional demands), child development, goal setting, proactive family planning strategies, and included learning opportunities for the development of self-efficacy and empathy (with current parent/caregiver roles and responsibilities). The program is partially a derivative of an established parenting program, which was read and approved by Dr. Foster Cline, a renowned child psychiatrist and parenting educator/author (personal communication, November 2004). Based upon extensive experience and certification, the first author was selected as the instructor for the program. The teaching method consisted of lectures, small and large group discussions, daily journaling, instructional videos, role-playing, practical and relevant information dissemination, and question and answer periods.

Results

The program impact for the results of the two instruments described above was assessed using a between-subjects posttest design. The experimental group concluded the last program session by completing the four instruments while the control group participants simultaneously finished the instruments in their advisory classes. The classroom teachers adhered to the posttest protocol discussed by the first author prior to testing (test environment, order of instruments, student question guidelines, timeline, data collection). It should be noted that the experimental group was much larger (n=39) and the testing environment was considerably louder and less focused than control group settings, where the participants in each room ranged from only two to six students and the rooms were observed to be quiet and composed. The experimental group was reported to be "in a hurry to finish" and "distracted," with "excessive talking and chitchat" present in the room. It was expected that these factors might negatively influence the validity of the instrument results.

Table 2 summarizes the descriptive data—means and standard deviations of the scores—for each dependent variable with both the experimental and control group. The alpha level was set at .05 throughout the study, unless otherwise indicated.

Table 2

Means and Standard Deviations for Experimental and Control group on each measure

	Experimental group		Control group	
Dependent Measures	*M*	*SD*	*M*	*SD*
General Self-Efficacy (GSE)	62.97	7.65	58.86	13.14
Social Self-Efficacy (SSE)	22.44	4.82	20.91	5.83
Parent Effectiveness (PE)	5.16	1.10	5.5	.85

General Self-Efficacy (GSE). Two-way ANOVA analyses were conducted to evaluate the effects of a participant's group (experimental or control) and identified attributes (grade, age, gender, gender of primary caregiver and number of parents in the household) on general self-efficacy. Statistical significance was shown in the difference between the experimental and control group when averaged across the primary caregiver levels (male or female), F (1, 78) = 5.51, p < .05, partial η^2 = .07. No other main effect or any interaction effects were found to be significant on the GSE measure (see Table 3).

Table 3

Two-Way Analysis of Variance for General Self-Efficacy by Primary Caregiver Gender

Source	df	F	η	p
Group (G)	1	5.51*	.07	.02
Primary caregiver gender (PC)	1	3.24	.04	.08
G*PC	1	2.14	.03	.15
Error	78	(113.86)		

Note. Values enclosed in parentheses represent mean square errors. *p < .05.

Social Self-Efficacy (SSE). The results for the two-way ANOVA on social self-efficacy indicated two statistically significant main effects. The primary caregiver factor, averaged across the grouping factor (experimental or control) was found to be significant at the alpha level .001, F (1, 78) = 11.24, p < .001, partial η^2 = .13 (see Table 4). The second main effect showing significance was the number of parents in the household (1, 2, or none), F (2, 76) = 3.51, p < .05, partial η^2 = .08 (see Table 5).

Table 4

Two-Way Analysis of Variance for Social Self-Efficacy by Primary Caregiver Gender

Source	df	F	η	p
Group (G)	1	2.47	.03	.12
Primary caregiver gender (PC)	1	11.24**	.13	.001
G*PC	1	.30	.004	.58
Error	78	(25.84)		

Note. Values enclosed in parentheses represent mean square errors. **p < .001.

Table 5

Two-Way Analysis of Variance for Social Self-Efficacy by Number of Parents in Household

Source	df	F	η	p
Group (G)	1	2.36	.03	.13
# Parents in Household (#P)	2	3.51*	.08	.04
G*#PC	2	1.11	.03	.34
Error	76	(27.05)		

Note. Values enclosed in parentheses represent mean square errors. *p < .05.

Parent Effectiveness (PE). The two-way ANOVA analyses were again conducted to evaluate the effects of a participant's group and attributes (grade, age, gender, gender of primary caregiver, and number of parents in the household) on a dependent measure, parent effectiveness. Statistically significant results were indicated in the grouping main effect (experimental or control), $F(1, 78) = 5.03$, $p < .05$, partial $\eta^2 = .06$, although in the opposite direction than originally hypothesized. The other main effect, parent effectiveness, and the interaction effect did not produce statistically significant results (see Table 6).

Table 6

Two-Way Analysis of Variance Parent Effectiveness by Primary Caregiver Gender

Source	df	*F*	η	*p*
Group (G)	1	5.03*	.06	.03
Primary caregiver gender (PC)	1	.41	.005	.53
G*PC	1	2.79	.04	.10
Error	78	(.94)		

Note. Values enclosed in parentheses represent mean square errors. *$p < .05$.

Discussion and Implications

The purpose of this study was to examine the effect of parenthood education on self-efficacy and parent effectiveness. Review of research studies corroborates that at-risk students are confronted with discouraging cyclic patterns including school failure, child abuse and neglect, substance abuse, poverty, out-of-wedlock births, welfare dependency, workforce underdevelopment, fatherless children and low self-efficacy (Herrenkohl et al., 2003; Massey, 1998; NCPTP, 2002). These intergenerational cycles of unconstructive parenting patterns will continue, absent new knowledge and more effective options. The current inquiry offered a proactive approach to teaching fundamental information through an integrated parenthood education program.

Using a two-way ANOVA, statistically significant results were obtained from four main effect analyses: (1) General Self-Efficacy measure (group by gender of primary caregiver); (2) Social Self-Efficacy measure (gender of primary caregiver); (3) Social Self-efficacy measure (group by number of parents in the household); and (4) Parent Effectiveness (group). Interestingly, the Parent Effectiveness measure actually produced results counter to the purported outcome.

The seemingly contradictory results from a comparison of overall means obtained on the Parent Effectiveness measure (the control group mean calculated higher than the experimental group) are a logical outcome when considering one of the goals of the parenthood education program—to increase student awareness of the financial, social-emotional and time demands of actual parenting. Once the experimental group became cognizant of the realistic depiction of parenting, it is probable they were evaluating themselves more accurately in the parental role, unlike the control group who idealistically, albeit erroneously, rated themselves as more "effective" parents based upon a limited, narrow definition of parenthood. These naïvely confident students, as Hess, Teti, and Hussey-Gardner (2004) contend, may feel highly secure at parenting tasks and believe they are a competent parent, but when they are working from a faulty knowledge base of what is developmentally appropriate, the self-analysis of parenting skills will not be a genuine reflection of ability. Hence, the experimental group's authentic assessment was lower because it was filtered through the newfound knowledge of what it actually takes to be a healthy functioning parent. Cutting and Tammi (1999) documented a significant impact on participants' perceptions of parenting after the parenthood education program in their Scotland study; students rated "Made me a lot more aware about what being a parent involves" higher than other survey choices. Similar to Griffith's 2002 study, which found that the intervention enhanced the participants' future parenting skills, these study results suggest a new awareness level of participants. Although contrary to the intention of this research, the outcome may be considered

positive because there is a possibility students are now more prepared for parenthood and may be more cautious and introspective about pregnancy and family planning. Consistent with the Trinidad Spain study's long-term follow up (Griffith), future studies should include subsequent analysis of pregnancy rates at various time intervals after program intervention to determine the program's childbearing effects and capacity to deter teen pregnancy.

These findings are consistent with Bandura's 1982 theory that a program which aims to enhance self-efficacy will lead to increased motivation and a transfer of efficacious beliefs to other domains in participants' lives. The intervention program provided a mechanism for student participants to gain new knowledge and attitudes from a source outside their own family construct and to increase their own sense of self-efficacy (Hess et al., 2004; Leerkes & Crockenberg, 2002; Reppucci, Britner, & Woolard, 1997). A supposition can be made that knowledge and new insight from the intervention program led to an increase of general self-efficacy for student participants, which subsequently translated into enhanced scores on the post-test measures. This would support Bandura's theory of efficacy transference. Integrating parenthood education into an alternative school curriculum affords at-risk students the opportunity for exposure to healthy parenting and family planning information that they would not otherwise receive. By participating in a parenthood education program designed as a pre-pregnancy prevention strategy, alternative school students receive instruction and guidance in prosocial parenting skills, realistic child raising (including financial, time, and emotional demands), child development, proactive family planning, goal setting, and the development of self-efficacy and empathy (with parent/caregiver's roles and responsibilities).

Limitations

The major limitation of this study was using the program with the entire experimental group (39 students) placed in one large instructional setting. Although logistically necessary for the school's academic and scheduling requirements, this arrangement was not theoretically sound from an alternative school educational pedagogy (Barr & Parrett, 2003). A group of 39 students is too many to monitor, focus toward lesson goals and objectives, and authentically involve in discussions and activities. It is likely that sustainability of program content for student participants was weak or even lost due to the size of the group. A smaller group would naturally prompt an increase in instructor-student interaction, group discussion participation, and greater retention of the information by student participants. Future programs or follow-up studies are recommended to be not more than 8–12 students per class session, which is consistent with group theory and at-risk curriculum recommendations (Corey, 1990; Becvar, Canfield, & Becvar, 1997).

The duration of the program—eight weeks, two times per week—can be a limitation. Although the length of the parenthood education program is consistent with best practices and the average for parent education programs (Bamba, 2001; Cline & Fay, 1990; Cutting & Tammi, 1999; Doetsch, 1990; Fay, Cline, & Fay, 2000; Herz, 1984; Stirtzinger et al., 2002), extending the program would allow for reiteration of material, increased process and reflection time, and retention of curriculum. Because the program content is unfamiliar to this population, a longer time span for program intervention would assist in assimilation and application for the students.

Generalizability of the study findings beyond this population is limited. Because the population consisted of only one alternative school in Northern Idaho, caution is advised in generalizing the results to other settings. In order to extend generalizability, future research should replicate the current study parameters in similar populations.

Recommendations for future studies include: (1) increased integration of the program across a full semester scheduled to meet at least one hour per week; (2) implementation of the program with group sizes which are theoretically sound for the at-risk adolescent population (between 8–12 students per group); (3) administration of posttests in at least two sessions versus all assessments completed in only one session; (4) the addition of a qualitative component to the posttest measures which would enhance understanding of the at-risk adolescent; and, (5) inclusion of a follow-up measure that would help analyze pregnancy rates at various time intervals after program intervention to determine the effect of the program in deterring teen pregnancy over time. These recommendations would serve to alleviate the current study's limitations, expound on its strengths, and produce a robust, credible parenthood education program effective with our at-risk alternative school adolescents.

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Changes in Occupations? A Commentary and Implications for Practice

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Fundamental changes occurring in the nature of work have led some authors to contest that established approaches to delivering career services may no longer be efficacious. This article challenges such notions and examines the idea of changing occupations and how these changes may influence the delivery of career services. While important changes have occurred, occupations remain a viable unit of analysis for the assessment and information resources used in delivering career services. The article concludes with clinical implications for career counselors and service providers.

Keywords: career services, occupations, assessment, career theory, technological innovations, clinical implications

While the efficacy of various educational and vocational guidance interventions has always been a matter of debate, concerns have been raised about the continued use of interventions developed in the past and based on possibly outdated concepts (e.g., occupation). An example of such a concern was raised most recently by Savickas et al. (2009).

We reviewed the literature on this topic and constructed a generalized assertion compiled from various sources:
> *The transition from the industrial age to the information age has been accompanied by unprecedented change. Virtually every aspect of modern life has been impacted by technology. Occupations have changed in fundamental ways as technology and globalization have reshaped the workplace. Occupations have become fluid and organizations are evolving rapidly, adapting their workforce to respond to a rapidly evolving marketplace.*

Although the wording of this concern changes from one talk or publication to another, the essential elements are often repeated in the media and mentioned in presentations at professional meetings. This assertion has been repeated so often that it has attained the status of fact. The only problem is that it is not true. An analysis of current labor market information indicates that the extent of change in occupations, while real and important, is not as pervasive as common knowledge would have us believe.

A second assertion follows from the one above:
> *Much of the current practice in educational and vocational guidance is the product of the industrial age. Old models of practice, based on ideas about occupations and work that have changed dramatically, need to change to reflect the demands of the information age.*

These assertions, although popular, are flawed for two reasons. First, the extent of change in occupations is not as great as commonly assumed. Second, even if substantive changes have occurred, we have no data showing that well designed and implemented career interventions created in the past are no longer effective (Brown et al., 2003).

This paper examines the idea of changing occupations and how these changes may have affected the delivery of career services. For the purposes of this paper, occupations are defined as "a group of similar positions found in different industries or professions" (Reardon, Lenz, Sampson, & Peterson, 2009, p. 7).

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Misperceptions of the Extent of Change in Occupations

The perception that unprecedented change has occurred in occupations is the result of a variety of factors, including: (a) the idea that the magnitude of change between the agricultural and the industrial age was less than the change between the industrial age to the information age, (b) inaccurate information in the public media about change in occupations, and (c) the failure to use career theory in analyzing occupational change.

Change Across the Agricultural, Industrial, and Information Ages

Technology changes over time have profoundly influenced the lives of individuals, organizations and governments. For example, the steam engine and electricity changed the nature of work from the agricultural age to the industrial age, and the computer has led to the current information age. Some consider the extent of change between the agricultural age and the industrial age as less than or equivalent to the extent of change between the industrial age and the *information age*. In a discussion of the information age, Watts (1999, p.1) noted, "Robert Reich has called it the 'second great crossing,' comparable to the move from the land to the factory."

While this assertion may be true in some respects, the magnitude of these changes is not equivalent in our opinion. First, there was a massive geographic displacement from rural to urban areas in the transition from the agricultural to the industrial age. While relocation of workers still occurs at the present time, it is not on the scale that it was a century ago. Individuals moving from manufacturing to service occupations are often able to obtain employment without physically relocating. Moreover, in many instances it is factories that are moving to locations where labor is cheap. Second, 100 years ago success as a farmer was dependent on having a wide variety of skills. For example, the farmer did the work because it was too expensive to hire someone else to repair machinery. When farmers moved to urban areas and began working in factories, the range of job skills needed declined substantially. Work was simplified and made routine in order to improve efficiency in the factory. While this was not true for all workers, it did create a clear demarcation in the nature of working between the agricultural age and the industrial age.

More recently, Friedman (2005) suggested that technology innovations and the global economy now make it possible for individuals to work more independently in a *flattened world*. The work is accomplished in real time without regard to distance or worker location. While new forms of business organizations and ways of working will lead to occupational changes in the information age, the most important difference today from the past may be simply the rate of change.

As aforementioned, we do not see the changes in occupations and work occurring between the industrial age and the information age as having been as dramatic as the changes between the agricultural age and the industrial age. While information technology has increased the speed of change and the increasing complexity of work tasks has required more collaboration among workers, we believe the amount of change in occupations in our contemporary world has been oversold.

In all three eras, there were and have been changes in gender roles and relationships, family life, lifestyles, financial income, the kinds of jobs available, ways of working, job training and the diverse characteristics of workers (e.g., ethnicity, disability, and the nature of occupational choices). But, there are still jobs in construction, business and social services, food production, manufacturing, transportation, education, and a host of other industries, and these jobs comprise the occupations that persist in the new age.

Public Media Information about Change in Occupations

The perception that occupations are undergoing substantive change has been exacerbated by inaccurate information about occupations presented in mass media. The fact that the demand for home health aids, accountants, receptionists and food service workers is growing at 5% is not particularly newsworthy. However, the fact that the demand for robotic technicians is increasing at 50% per year is newsworthy, especially when the story is accompanied by video of a robot performing simple household tasks while the homeowner watches from a corner of the room and comments on how nice it is to have a robot. A brief interview with the robotic technician, stating how exciting and rewarding their job is, reinforces the notion that robotics work is a good option for the future. However, reality presents a different picture.

The concept of big growth and fast growth occupations (Reardon et al., 2009) is relevant here. For example, projected employment growth for environmental engineers and accountants/auditors from 2002 to 2012 shows 18,000 for the former and 205,000 for the latter. But, when the percent of employment growth is examined for these two occupations, the rate for environmental engineers is 38% (fast growth) and accountants/auditors are 19% (big growth with 205,000 jobs projected). The distinction between big growth occupations and fast growth occupations is rarely mentioned in the media. The public, as well as educational and vocational guidance practitioners who have limited knowledge of labor market information, easily conclude that substantive changes in occupations are occurring when only percent change is examined. Indeed, occupations with the most openings are not new, different, or unique but familiar and common (Reardon et al., 2009).

Pikulinski (2004), an economist with the U.S. Department of Labor, reported that most new and emerging occupations are in firms with fewer than 100 employees. Even many of the fast growth occupations in the U.S. are in familiar areas of work. For example, 11 of the 20 fastest-growing occupations are in the fields of health services or the provision of social, personal, or mental health services (Reardon et al., 2009).

Using Career Theory to Understand Occupational Change

Occupational change can be examined from the standpoint of Holland's (1997) career theory and provides a familiar schema for counselors in examining occupational change. U.S. census data from 1960 to 2000 provides evidence about the extent of change in occupations relative to Holland codes. First, occupational titles included in the census have remained quite constant over time, which is an indication of stability in occupational schema. Second, the pattern of employment for men and women by Holland code (realistic, investigative, artistic, social, enterprising and conventional) has been relatively stable (Reardon, Bullock, & Meyer, 2007). Third, realistic jobs have held constant from 1960 to 2000 and employed the most people; however, the percentage of people working in the realistic area has been declining. Very few people work in the Artistic area (about 1–2%) and this has remained constant over five decades, but occupational employment in the enterprising area has been increasing slightly over the same period.

The application of a career theory developed over the past 40-plus years adds to our understanding of occupations and occupational change, and it should be a basic tool for career counselors. However, this is not often noted in much contemporary career literature forecasting the demise of work as we have known and understood it. We believe that Holland's (1997) matching model is supported by data and experience related to occupational employment and can inform career services.

Actual Changes in Occupations

It is obvious that some change has occurred in occupations. For example, we would suggest that most occupations have been impacted by information technology ranging from bar codes, cell phones, computers, the Internet, social media and more. However, other aspects of work have not changed. Essential work behaviors such as problem-solving, written and oral communication, interpersonal relationship skills, manual dexterity, and creativity have remained constant despite rapid changes in technology. Moreover, job vacancy notices are still posted announcing the availability of work, and job titles are used as a quick way to communicate information about the nature of the work. Internet job boards such as *CareerBuilder* and *Monster* list millions of positions daily, and these positions have job titles for specific employing organizations that can be generalized to occupational titles across fields of work.

Consider the following examples: In dentistry, technology has led to improved instruments, electronic databases are used to store patient records, and X-rays are now viewed and stored digitally. However, other aspects of work have not changed. Essential work behaviors such as assessment, diagnosis, treatment planning, communication with patients, manual dexterity, and selecting and managing staff remain essential to the success of a dentist. The essential work behaviors of a dentist have not changed in 100 years.

Carpenters are another example. Despite advances in materials and methods of home construction, carpenters are still employed in large numbers. Although the use of prefabricated building materials has reduced the need for some specialized craft skills, such as making crown molding, the essential work behaviors of problem-solving, eye-hand coordination, teamwork and planning have remained constant.

The number of individuals employed in various occupations increases and decreases with changes in the economy. This dynamic was as much a feature of the industrial age as it is in the information age. The loss of positions for the coopers who shaped wooden staves and assembled barrels occurred in the industrial age long before computers became commonplace. Web designers are often given as an example of the substantive change currently occurring in occupations. Forklift drivers were unknown in 1870, but were commonplace by 1950 during the industrial age. The pace of change in the information age is undoubtedly faster, but it is a mistake to confuse the rate of change in occupations with the extent of change. A relatively small number of occupations appear and disappear in the labor market each decade, but the characteristics of most occupations change only incrementally and these changes are often peripheral (as is the case with dentists).

Occupational credentialing provides additional evidence of the relative stability of occupations. Despite changes in work tasks, numerous occupations still require a license or certification to work independently. There is no evidence that the number of occupations requiring a credential has decreased. Certainly the knowledge and skills required for credentialed workers evolves over time. These changes are reflected in content modifications in licensure and certification exams, as well as changes in experience requirements required for credentialing. However, the core elements of credentialed occupations are stable enough to warrant continued certification.

The process of identifying and describing an occupation is the work of occupational analysts who use a variety of specialized tools and classification systems in their work. For example, analysts working with census data examine hundreds of thousands of jobs and employment situations reported by citizens in each census period. Researchers then categorize the detailed job information into occupational groups using the census occupational codes and more recently the *Standard Occupation Code* (SOC; U.S. Dept. of Labor, 2000) to classify occupations. SOC is the system now used with *O*NET*, the online, comprehensive listing of the most common occupations in the U.S. that employ the most persons.

Implications for Practice in Career Services

We believe the magnitude of change in occupations has been oversold in professional counseling literature and in the popular media. The transition to the information age has not had the substantive impact on occupations that is generally believed. Thomas Gutteridge and Raymond Palmer, a researcher and career counselor, respectively, suggested that it is jobs that are changing, not occupations (as cited in Patterson & Allen, 1996). They noted that it is a mistake to consider the occupational world as unstable or unpredictable because the vast majority of occupations change very little. The findings of Reardon, Bullock, and Meyer (2007) support their assertion. The career assessments and career information used in the provision of educational and vocational guidance services are based on occupations and not jobs, and practitioners should have confidence that this is a useful schema for career services.

While a few occupations will change more, most will change less. Labor market analysts have the expertise to maintain the validity of occupational data. We also have the technology required to maintain and quickly disseminate these data. However, without a public policy to provide adequate and stable funding for analysis and dissemination of occupational information, the opportunity to provide individuals with potentially helpful career information will be negatively impacted.

While important changes in work have occurred, occupations remain a viable unit of analysis for the assessment and information resources used in delivering career services. It is inappropriate to assume that current changes occurring in the nature of work are a sufficient justification for substantive change in the delivery of career services. Career interventions that are old are not out of date unless there is evidence that some other intervention is more effective. Changes in the delivery of career services should be based on evidence that changes are warranted and that other interventions are likely to be more effective. New ideas are not necessarily better and old ones are not necessarily worse. As Savickas et al. (2009, p. 240) stated, "…we must not lose sight of those valuable contributions of 20th century theories and techniques that remain relevant in this new era. As we go forward, we should manage the great inheritance of the last decades of the 20th century, while increasing its richness."

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Silent Suffering: Children with Selective Mutism

Lisa Camposano

Despite increasing awareness, the childhood disorder of selective mutism is under-researched and commonly misdiagnosed. The purpose of this article is to highlight current issues related to this disorder as well as describe various treatment approaches including behavioral, cognitive-behavioral, psychodynamic, family, and pharmacological interventions. Suggestions for counselors working with children with selective mutism and implications for future research are offered.

Keywords: selective mutism, childhood disorder, children, etiology, treatment approaches

Although early references occurred 125 years ago, very little has been written about selective mutism (Steinhausen, Wachter, Laimbock, & Metzke, 2006). This disorder remained relatively obscure until 2006 when Newsday published an article entitled "Behind a Wall of Silence" that described an eight year-old girl's struggle with speaking at school. Selective mutism appeared in the news again the following year when it was revealed that Seung-Hui Cho, the shooter in the Virginia Tech massacre, was diagnosed with selective mutism as an adolescent (Kearney & Vecchio, 2007). Despite media coverage and growing public awareness, little research is being dedicated to examining this unique condition.

The lack of quality research and general awareness of selective mutism are serious barriers to helping children who suffer from this disorder. Too often, these children are misdiagnosed or labeled as "just shy." Schwartz, Freedy, and Sheridan (2006) surveyed 27 parents having a total of 33 children with selective mutism. Their survey revealed that primary care physicians either misdiagnosed or never referred about 70% of these children. The authors explained: "Selective mutism has largely gone unnoticed by most physicians who are not familiar with the key signs and symptoms. Pediatricians commonly assume that the patient with selective mutism is simply exhibiting excessive shyness and reassure the parents that it is something the child will outgrow" (pp. 43–44). Within the same group of survey participants, an accurate diagnosis did not occur until an average of nearly a year after the parents expressed concerns to a medical doctor (Schwartz et al., 2006). Within school settings, labels such as autistic, language delayed, defiant, or learning disabled saddle such children with inappropriate or ineffective interventions. In many circumstances, parents simply wait for the child to "outgrow" this disorder, not realizing that the absence of proper treatment can lead to lifelong psychological problems (Shipon-Blum, 2007).

The purpose of this article is to increase awareness about selective mutism as well as provide an overview of current issues associated with this disorder. Major themes related to etiology and current trends in treatment will be addressed. The importance of early intervention and participation of family members and school personnel in the treatment process will be stressed. This article will conclude with suggestions for future research, the counseling profession, and counselor training.

Definition of Selective Mutism and Prevalence

Selective mutism is described as "persistent failure to speak in specific social situations (e.g., school, with playmates) where speaking is expected, despite speaking in other situations" (American Psychiatric Association, 2000, p. 125). Children with selective mutism often engage, interact, and communicate verbally within comfortable surroundings, such as at home or with trusted peers. These children are capable of speaking and understand their native language. However, when placed in structured social settings such as school, they are mute and socially withdrawn (American Psychiatric Association, 2000).

Social skills among children affected by selective mutism vary greatly (Amir, 2005). These children are usually unable to verbally communicate when approached by an adult, yet social interaction among peers can vary. Some

children interact easily with peers in and outside of the home. Other children interact with peers, but do not verbally communicate with them. A third group remains completely withdrawn in social settings (Amir, 2005). Aside from verbal communication, many children with selective mutism are inhibited in other ways as well (McHolm, Cunningham, & Vanier, 2005). Avoidance of eye contact, lack of smiling, tantrums, blushing, and fidgeting are common symptoms associated with selective mutism (Dummit et al., 1997; Kristensen, 2001; Shipon-Blum, 2007).

Recent studies suggest that selective mutism may occur in .7 to 2% of early elementary students, although many researchers agree that these prevalence rates may be underrepresented due to the lack of knowledge of the disorder (Cunningham, McHolm, & Boyle, 2006; Lescano, 2008; Schwartz et al., 2006; Sharkey, McNicholas, Barry, Begley, & Ahern, 2007). Most investigators report that selective mutism seems to occur more frequently among girls (Cohan, Chavira, & Stein, 2006; Dummit et al, 1997; Lescano, 2008; Mendlowitz & Monga, 2007; Sharkey et al., 2007; Steinhausen & Juzi, 1996). Symptoms of selective mutism are usually present by the age of three, but this disorder is frequently not identified until the child enters school where there is an increased expectation to speak within social settings (Cunningham, McHolm, & Boyle, 2006; Sharkey & McNicholas, 2008). Entrance into the school environment appears to be a salient and definitive landmark for children with selective mutism.

Etiology

There is little consensus regarding the etiology of selective mutism. Psychoanalysts have cited unresolved internal conflicts as the cause of selective mutism (Cohen et al., 2006). Family systems theorists argue that children with selective mutism are part of faulty family relationships (Anstendig, 1998). Kratochwill (1981) states that behavioral therapists "have perceived mute behavior as a function of antecedent and consequent environmental events that vary across situation, people, and time" (p. 137). Early theorists argued that trauma or major life events, such as abuse or the death of a loved one, trigger the onset of selective mutism (Dow, Sonies, Scheib, Moss, & Leonard, 1995). However, according to more recent studies, children who have experienced trauma are not more likely to develop selective mutism, and early childhood trauma is rarely associated with the development of the disorder (Gray et al., 2002; Steinhausen & Juzi, 1996). In fact, Dummit et al. (1997) found no evidence of trauma among their case study participants. Therefore, isolating a single cause or traumatic event does not appear to be helpful in identifying selective mutism, thereby confusing diagnostic attempts.

Current conceptualizations of selective mutism link the disorder to anxiety, namely social phobia (Cunningham et al., 2006; McHolm et al., 2005; Sharkey & McNicholas, 2008). This particular phobia prohibits children from interacting and communicating within social settings, such as school and birthday parties. McHolm et al. (2005) explain that just as a young child can develop a fear of spiders or heights, for example, children with selective mutism have developed a fear of talking that is further crippled by anxiety.

Research has shown that anxiety disorders generally run in families. With regard to selective mutism, parents of children who have selective mutism are likely to exhibit signs of moderate to severe anxiety (Kristensen & Torgersen, 2001; Schwartz, Freedy & Sheridan, 2006; Shipon-Blum, 2007). Kristensen and Torgerson (2001) regarded selective mutism as a "family phenomenon" after they examined personality traits of parents of children with selective mutism (p. 652). According to their study, parents of selectively mute children were significantly more likely to have a history of shyness or social anxiety as compared to a control group. In a survey conducted by Schwartz et al. (2006), 33% of the participants reported a family member with social anxiety disorder and 12.1% had a family member with selective mutism. Despite the information obtained from the aforementioned case studies, it remains unclear how genetic and environmental factors affect the development of selective mutism among young children.

There also is mixed evidence concerning the association between developmental delays and selective mutism. In a study of 100 children with selective mutism (Steinhausen & Juzi, 1996), 38% of participants had a history of language delays or disorders. In contrast, other studies report no evidence of developmental delays among the participants (Black & Uhde, 1995). Definitive research in this area is lacking, and the link between developmental factors and selective mutism remains unclear.

Although the exact cause of selective mutism is unknown, researchers generally agree that selective mutism does not fall under the realm of speech/language disorders, communication disorders, defiant behavior, or shyness. In a recent

article written by Kearney and Vecchio (2007), the researchers point out that "this disorder is not due to a communication disorder such as stuttering and it is not due to a lack of knowledge or comfort with language" because affected children speak well in certain situations (p. 917). A case study conducted by Schwartz et al. (2006) revealed that a very small percentage of children with this disorder have speech and/or language difficulties. Selective mutism is distinctly dissimilar from shyness due to the severity of anxiety and duration of symptoms. Shyness is not paralyzing like selective mutism and the vast majority of children who suffer from selective mutism do not fully overcome their anxiety without formal intervention (Stanley, n.d.). Finally, selective mutism has been described by some as oppositional; however this assumption implies that mutism is a conscious choice. This viewpoint is clearly disputed by recent research on this disorder (e.g., Cunningham et al., 2006; McHolm et al., 2005; Sharkey & McNicholas, 2008). Anxiety appears to be the most likely culprit at the core of this disorder. There is evidence that family history of anxiety often plays a role in the disorder while speech and language problems, along with willful opposition, do not seem to contribute to the development of selective mutism.

Approaches to Treatment

Because the etiology of selective mutism is unclear, there is much disagreement among researchers regarding effective treatment approaches. Additionally, scarce quality research has been dedicated to examining the effectiveness of individual treatment approaches and interventions. As Sharkey et al. (2007) notes: "Despite the very handicapping nature of this disorder and its negative impact on both short- and long-term functioning in children and adolescents, the evidence for effective treatments is sparse and predominantly in the form of single case reports or small series using a variety of techniques" (p. 539).

Although a systematic approach has not yet been developed, there are some common goals among varying treatment programs. An initial goal of treatment is to lower the child's anxiety and develop healthy coping mechanisms for dealing with anxiety (Shipon-Blum, 2007). Interventions aimed at achieving this goal include relaxation skills, meditation, and breathing techniques. Increasing self-esteem and confidence in social settings is another integral objective of most treatment programs. The last and most evident goal is to increase verbal communication in social settings. As the final stage in the treatment process, increasing verbal communication may take years as well as long-term therapeutic intervention depending on factors such as the duration of the mutism and severity of symptoms.

Psychodynamic Approach

Early treatment approaches for selective mutism were mainly derived from psychodynamic theories. Interventions and techniques from this realm of therapy seemed to be the best fit as selective mutism was historically viewed as a result of unresolved inner conflicts or traumatic events during early childhood years (Kratochwill, 1981). Psychodynamic theorists describe mutism as a defense mechanism which the child utilizes rather than expressing feelings directly towards a parent, most commonly the mother (Cline & Baldwin, 1994). Through this approach, the primary goal of the counselor is not to directly address the mutism, but rather understand its origin (Cohen et al., 2006). This is accomplished by carefully examining the child's early psychosexual stages of development as well as the mother-child relationship, then eventually addressing the fears directly with the child (Cline & Baldwin, 1994).

There exists a major pitfall in this type of therapeutic approach. Symptoms of this disorder are deeply rooted in anxiety; therefore, pressure to verbalize thoughts and feelings can overwhelm the child. While expression can be accomplished through nonverbal means such as art therapy, substantial conversation and uninhibited free association are extremely difficult to achieve. It is more likely that the child will become tense and *freeze up* when placed in the structured setting of the counselor's office and asked to communicate. Shipon-Blum (2007) explains that psychological approaches are effective only when "all pressure for verbalization is removed and emphasis is [placed] on helping the child relax and open up" (p. 6). When pressure to verbalize is reduced, anxiety decreases and therapeutic interventions can subsequently occur.

In 1963, Browne, Wilson, and Laybourne (as cited in Garcia, Freeman, Francis, Miller, & Leonard, 2004) examined the effectiveness of psychodynamic therapy for selective mutism and concluded that the treatment was costly and commonly yielded a poor outcome. Freeman, Garcia, Miller, Dow, and Leonard (2004) added that there are no major case studies or research to provide evidence that these approaches are successful. While psychotherapy is rarely utilized as a primary

mode of treatment for selective mutism today, psychodynamic projective interventions such as play, music, and art therapy are commonly utilized by counselors in conjunction with other treatment approaches. Research has shown that these projective, less verbal interventions have been effective to some degree (Shreeve, 1991; Tatem & DelCampo, 1995).

Play therapy can offer a safe environment in which the counseling relationship is established without placing pressure on the child to speak (Hultquist, 1995). While describing the benefits of using psychotherapy with anxious children, Terr (2008) claims that effective therapy for anxiety disorders such as selective mutism "won't truly begin until [the spirit of play] is established" (p. 101). Additionally, music therapy can assist children with selective mutism to express their thoughts or feelings via nonverbal means as well as reduce anxiety through musical expression. Amir (2005), the director of a music therapy program at an Israeli university, describes her two-year experience of working with a selectively mute child. She concluded that the therapy sessions encouraged "feelings of safety" and served as "a container and foundation where heavy feelings and emotions [could] be explored" (p. 75). Furthermore, Amir claims that a trained music therapist can interpret music created by the child in order to establish a bridge to the child's "inner world" (p. 76). Similar to music therapy, art therapy provides a mute child with a nonverbal way to articulate feelings and fears. Cline and Baldwin (1994) noted that art therapy provides a "springboard for verbal communication" (p. 80). While these interventions are not generally used as primary modes of treatment, play, music, and art therapy can improve self-esteem and provide the counselor with an opportunity to build rapport and create a safe, inviting environment for the child.

Behavioral Approach

Researchers from the behavioral perspective view selective mutism as a learned behavior developed as a coping mechanism for anxiety. Therefore, the purpose of treatment is to decrease anxiety and increase verbal communication in settings such as school (Cohan et al., 2006). This approach incorporates practice and reinforcement for speaking in subtle and non-threatening ways. Emphasis is placed on observable behavior rather than early childhood development (McHolm et al., 2005).

Behaviorists rely on various techniques, such as shaping, self-modeling, and contingency management, to increase verbal communication and lower anxiety. Shaping, sometimes referred to as a *ritual sound approach*, is the procedure in which the counselor reinforces mouth movements and sounds that resemble speech (Mendlowitz & Monga, 2007; Shipon-Blum, 2010). This strategy involves breaking down the target goal of verbal communication into smaller steps in order to minimize anxiety. The exact sequence will vary according to the child, but some steps may include mouthing words, making sounds, whispering, repeating a word the counselor has said, and eventually increasing volume of speech (Cline & Baldwin, 1994; Lescano, 2008).

Another commonly-used strategy to elicit speech is a two-part process known as self-modeling. Using an audio or video recorder, the child speaks and answers questions within a comfortable environment. The tape is then edited to portray the child speaking in settings such as school. The child listens to the tapes repeatedly, often in the company of family members or friends, in order to become accustomed to hearing him/herself speak in these settings (Blum, Kell, & Starr, 1998). A variation of this strategy may include family members who are recorded while asking questions such as those the child might hear in school (Cline & Baldwin, 1994). The child then practices giving oral answers. Case reports (e.g., Kehle & Owen, 1990; Pigott & Gonzales, 1987) have noted successful treatment outcomes after utilizing this strategy with selectively mute clients. This technique is frequently used in many behavioral and eclectic treatment approaches, but Blum, Kell, and Starr (1998) note that taping can increase anxiety and may not be suitable for all clients.

Contingency management refers to the use of positive reinforcement as encouragement for the child to practice verbalizations. As early as the 1930's, Skinner (1938, 1971, as cited in Neukrug, 2007, p. 101) showed that specific behaviors would be repeated if positive reinforcement were given as soon as the behavior occurred. Contingency management is often used in conjunction with systematic desensitization in which the counselor sets goals of increasing difficulty with corresponding rewards for each leveled task that is completed (Lescano, 2008). This hierarchy of tasks is created with a consideration of locations, activities, and people that affect the child's comfort level (McHolm et al., 2005). Similar to systematic desensitization, stimulus fading is commonly used to gradually increase the number of people in the room or classroom as the child practices verbalizations. Positive reinforcement often accompanies treatments involving stimulus fading.

While psychodynamic approaches were formally the treatment of choice by many counselors and researchers, behavioral interventions are currently included in most treatment programs for selective mutism. This type of treatment provides a step-by-step approach that can be easily modified to fit the changing needs of the child. Behavioral techniques, such as shaping and self-modeling, are rarely used in isolation so it is difficult to assess the effectiveness of any single strategy. As a complete entity, behavioral treatment has been carefully researched and numerous studies have shown efficacious outcomes of this type of treatment (e.g., Gray et al., 2002; Kehle & Owen, 1990; Lescano, 2008).

Cognitive-Behavioral Approach

While the success of behavioral interventions is rarely disputed, the behavioral approach to therapy does not place emphasis on an individual's anxious thoughts. Some researchers consider this a major flaw and stress the importance of restructuring thought processes. The cognitive-behavioral approach to treatment, or CBT, is a practical, action-based treatment program that incorporates many of the aforementioned behavioral techniques such as systematic desensitization and stimulus fading. However, CBT is different from behavioral approaches because it has an additional dimension that stresses anxiety management education (Chansky, 2004). Chansky (2004) explains that during CBT, both children and parents develop "a specific set of skills to address the thoughts, physiological responses, and behaviors associated with anxiety" (p. 47). Treatment also requires children to use problem-solving and employ self-talk (McHolm et al., 2005). The ultimate goal of CBT is to help children modify their behavior by assisting them in redirecting their anxious fears and worries in healthy ways (Shipon-Blum, 2007).

Cognitive-behavioral treatment includes several components in addition to behavioral techniques. An important aspect of CBT is assessment. Many early sessions are solely dedicated to identifying factors that contribute to the child's anxiety (Chansky, 2004). The information obtained in these interviews guides treatment and provides a foundation when planning therapeutic activities. Shipon-Blum (2002), for example, has developed a continuum for ongoing assessment that ranges from non-communicative to initiating verbal communication, with many stages of nonverbal and verbal communication in between. This continuum is used to assess a child's level of anxiety within different settings as well as to set and modify goals for treatment. Since levels of anxiety are likely to elevate during behavioral interventions, particularly systematic desensitization and stimulus fading, children are taught relaxation skills in order to manage anxiety before applying such techniques (Cohan et al., 2006). These skills may include breathing techniques, muscle relaxation, or story telling (Sharkey & McNicholas, 2008).

Once research linked selective mutism to anxiety, evidence-based CBT interventions that were previously used to treat other anxiety disorders in children and adolescents were commonly incorporated in the treatment of selective mutism (Mendlowitz & Monga, 2007). One of these interventions, cognitive restructuring, has been utilized to call attention to and minimize negative or anxiety-producing automatic thoughts (Chansky, 2004). In its conventional form, this type of intervention requires the client to share and express feelings to the counselor. This clearly presents an obstacle when working with children who are selectively mute and are not comfortable talking in certain situations, such as a counselor's office (McHolm et al., 2005). If a child can be expressive using nonverbal means, or if a child is comfortable enough to speak to the counselor, cognitive restructuring can assist a child in learning to cope by thinking realistically. It is important to mention that a child's cognitive development dictates how well this intervention may work. Therefore, this intervention may be most effective with older children having average to above-average intelligence and the ability to think flexibly and in abstract ways. Despite these limitations, cognitive restructuring is an important element in the treatment process for some children.

Cognitive-behavioral treatment has gained attention from researchers of this disorder. Recent case studies and reviews (e.g., Cohan et al., 2006; Mendlowitz & Monga, 2007; Schwartz et al., 2006; Woodcock, Milic, & Johnson, 2007) have demonstrated the success of CBT in treating children suffering from selective mutism. Additionally, the safe nature of this type of treatment along with its high success rates, make it popular. Perhaps its most significant drawback is the amount of time and patience required of the counselor. Mendlowitz and Monga (2007) estimated that children suffering from selective mutism require five to six times more CBT intervention sessions than children suffering from generalized anxiety or separation anxiety.

Pharmacological Approach

Sometimes a child's symptoms are so debilitating that fully engaging in a counseling treatment program seems challenging. In such cases, researchers may initially utilize pharmacological interventions to assist the child in overcoming anxiety associated with the disorder so that other treatments can subsequently occur. This type of intervention may include selective serotonin reuptake inhibitors (SSRIs) or monoamine oxidase inhibitors (MAOIs) (Kearney & Vecchio, 2007). While pharmacotherapy is not generally recommended as the primary treatment, the use of medication can often facilitate CBT or other interventions (Kumpulainen, 2002). Once anxiety levels have been reduced via medication, verbal communication may become less challenging for the child.

The effectiveness of pharmacological interventions is perhaps one of the most widely debated issues related to this disorder. Shipon-Blum (2007) deems a combination of behavioral techniques and medication the best approach to treating selective mutism, while Black and Uhde (1995) noted that the differences between pharmacologically treated and non-treated groups were mostly insignificant. Kumpulainen (2002) reported that pharmacological interventions could be helpful when treating selectively mute children, but also warns that medication should be used in conjunction with other therapy modalities only when they are not independently successful. It is important to note that the short- and long-term effects of pharmacotherapy remain unclear. While Kumpulainen (2002) reported that participants seldom reported any harmful effects of the medication, Kearney and Vecchio (2007) admit that there are no large-scale studies of pharmacotherapy for selective mutism.

Family Counseling/Therapy

Family counseling or therapy is often a necessary component of an effective treatment plan for children with selective mutism. Meyers (1984) noted dysfunction within the families of children with selective mutism. Other studies have cited higher rates of marital conflict and divorce among families of children with selective mutism when compared to controls (Viana, Beidel, & Rabian, 2009). Researchers from the family systems perspective have hypothesized that a child's mutism serves a certain function within the family (Anstendig, 1998). Therefore, it may be beneficial for all members of the family to participate in counseling in order to resolve underlying family issues that may have maintained the mutism. In general, the goal of family intervention in relation to selective mutism is to identify faulty family relationships and communication patterns that may have contributed to the development of the child's anxiety. The counselor would subsequently aim to help family members remove conditions that are causing the child's anxiety and maintaining the mutism (Cohan et al., 2006).

While research concerning the effectiveness of family counseling is scarce, it is evident that the cooperation and participation of parents in the treatment has a positive impact on recovery (e.g., Kumpulainen, 2002; Mendlowitz & Monga, 2007; Sharkey et al., 2007). In fact, Sharkey and McNicholas (2008) deemed parental involvement as the "key ingredient in treatment success" (p. 544). Acceptance and understanding of the disorder is crucial, and parents should not place emphasis on the lack of verbal communication. Shipon-Blum (2007) emphasizes the importance of parent participation during the treatment process: "Praise should be given for the child's accomplishments and efforts, and support and acknowledgement should be given for their difficulties and frustrations" (p. 5). Treatment programs often require parents to modify their parenting styles as well as develop healthy coping skills for handling stress and fear. Anxiety management education is often integrated with treatment so that parents are equipped to model healthy coping abilities for their children (Mendlowitz & Monga, 2007).

Counselors also may encourage parents to consider the amount of attention that is given to the child's nonverbal behavior (Beidel & Turner, 1998). A child's lack of verbal responses can result in a sibling or parent consistently answering for the child or overcompensating by frequently calling attention to the child's strengths or talents. In a case study by Sharkey et al. (2008), researchers trained parents to ignore their child's mutism and reinforce verbal behaviors by consistently responding to these behaviors with empathy, enthusiasm, and warmth. Shifting attention to verbal behaviors rather than nonverbal behaviors provides positive reinforcement for such actions.

Multifaceted Approaches

Due to the complex nature of this disorder, there exists strong support for treatment programs for selective mutism to

be multifaceted, address anxiety in a variety of settings, and involve teachers, peers, parents, and other family members during the treatment process. Therefore, an eclectic approach is the most common treatment option currently used by counselors. Countless researchers have successfully combined psychodynamic, behavioral, cognitive-behavioral, pharmacological, and/or family counseling interventions. An example of a successful eclectic treatment approach was described by Wright, Cuccaro, Leonhardt, Kendall, and Anderson (1995) in a preschool-aged child. This treatment included behavioral interventions, play therapy, family therapy, and pharmacotherapy. Jackson, Allen, Boothe, Nava, and Coates (2005) also used a multifaceted approach consisting of shaping, systematic desensitization, play therapy, parent journaling, and relaxation training to successfully treat a six-year-old boy with selective mutism. While this type of treatment approach has consistently appeared to be effective in published case studies, more research is needed to reveal which components of these programs are essential.

Importance of Early Diagnosis and Intervention

Early, accurate diagnosis and intervention are crucial to overcoming selective mutism regardless of the type of treatment program. Research suggests that treatment for this disorder is most effective if it begins as soon as symptoms of the disorder become apparent, thus minimizing the amount of negative reinforcement for these behaviors (e.g., Schwartz et al., 2006; Stone & Kratochwill, 2002). Shipon-Blum (2007) explains: "The earlier a child is treated for selective mutism, the quicker the response to treatment and the better the overall prognosis. If a child remains mute for many years, his or her behavior can become a conditioned response where the child literally becomes accustomed to nonverbalization as a way of life" (p. 5).

Shipon-Blum (2007) warns that if selective mutism is left untreated, the academic, social, and emotional repercussions may include depression, social isolation, poor academic performance, self-medication with drugs and alcohol, and suicide. Furthermore, Chansky (2004) points out that untreated anxiety associated with selective mutism also can lead to adverse health effects including cardiac, immune, and respiratory problems. Thus, early intervention provides more opportunity for successful treatment and, in the long term, a healthier, more functional child.

Role of School Personnel in Treatment

School personnel, especially teachers, play crucial roles in the treatment of selective mutism. Because the symptoms of this disorder are more evident once the child begins school, teachers often become responsible for making a referral for diagnosis. Most school personnel do not have the expertise or experience to deal with this disorder single-handedly, but it is important that teachers recognize anxious tendencies among these children and solicit the help of a school psychologist or counselor in order to make prompt referrals. Once an accurate diagnosis is made, studies (e.g., Kumpulainen, 2002; Lescano, 2008; McHolm et al., 2005) have shown that the willingness of the teacher and other school personnel to collaborate with the parent(s) and counselor affects the outcome of the treatment program. A multidisciplinary team that includes the child's teacher, principal, school counselor, and/or school psychologist may collaborate with the parent and contribute observations and feedback to the counselor (Lescano, 2008; McHolm et al., 2005). Vecchio and Kearney (2007) indicated that this team approach may be helpful in treatment "because of the widespread nature of the child's [speech] avoidance" (p 41).

Teachers may assist in reinforcing behavioral treatment techniques as well. For example, a teacher may provide positive reinforcement for verbalizations in school or participate in a video recording which the child will use to practice formulating verbal responses to questions. The teacher also may help to minimize anxiety while the child is in school. Shipon-Blum (2003) emphasizes the importance of a caring classroom teacher who understands the behavioral characteristics of the disorder and allows the child to communicate by nonverbal means as long as necessary. A nurturing, comforting classroom environment and flexibility within the classroom setting and schedule also are important factors in a multifaceted treatment program (Shipon-Blum, 2003). Overall research, therefore, supports both an individual and systematic approach that includes school personnel for the treatment of selective mutism.

Summary and Commentary

As described in this article, selective mutism is a complex psychological disorder with an unknown origin. There is general agreement that selective mutism is characterized by a child's inability to speak in certain social settings despite

the ability to speak in other situations. Nonetheless, there is disagreement among researchers regarding the most efficient and definitive treatment approach. Treatment has included a variety of psychodynamic, behavioral, cognitive-behavioral, pharmacological, and family systems methods. It seems that these approaches are rarely used in isolation; rather treatment programs for selective mutism are usually multifaceted. The cooperation of parents and school personnel during treatment is crucial for positive outcomes, and early intervention can minimize the long-term psychological effects (Kumpulainen, 2002; Shipon-Blum, 2007).

Suggestions for Counselors

While the main purpose of this article is to raise awareness of this disorder and its varying treatment options, counselors who are treating children with selective mutism should prioritize goals during treatment. Less emphasis should be placed on the absence of verbal communication, especially during the initial stages of counseling. An immediate goal is to build rapport and a trusting counseling relationship with the child. Once rapport is established, anxiety reduction is a vital component of any treatment plan for selective mutism. Behavioral strategies, such as stimulus fading and systematic desensitization, that are implemented before healthy coping skills are established will likely increase a child's anxiety and delay further treatment. In addition, it is important that the counselor and parent(s) work together to build the child's self-esteem and confidence, especially in social settings. Once anxiety levels are lowered and a child's confidence is established, verbal communication interventions will likely follow.

Additionally, it is vital that counselors design multifaceted therapy programs when treating children with selective mutism. Due to the complex nature of this disorder, eclectic treatment addresses varying symptoms and psychological effects caused by selective mutism. A multidisciplinary team should be established to assist the child in treatment. As discussed earlier, school personnel play an important role on this treatment team since the child's mutism is likely to be most apparent at school. These professionals may aid the counselor by providing regular monitoring of progress and implementation of behavioral interventions.

Lastly, it is important that a counselor take into consideration the amount of time and patience required to implement a treatment program for selective mutism. A thorough and detailed assessment is first required to determine factors affecting the child's mutism. Jackson et al. (2005) recognized "an in-depth analysis of the client and his or her environment" as a precursor for treatment (p. 107). After the initial stages of treatment and assessment, it is anticipated that the counselor will spend a considerable amount of time working outside of the office (Vecchio & Kearney, 2007). The counselor may conduct observations at the child's school, meet with the child's teacher and school counselor, and interact with the child in various social settings in order to effectively monitor and adjust treatment goals and implement appropriate interventions. If the counselor is unwilling or unable to devote such a level of time and dedication, a referral to another counseling professional with knowledge of this disorder should be provided to the client.

Suggestions for Future Research

Selective mutism has gained considerable national and global attention, particularly due to several magazine and professional articles recently published about this disorder. As a result, awareness is increasing while quality research on this serious disorder is scarce. Evidence for effective treatment has been predominantly presented in the form of single-case studies using a variety of techniques. Within these studies, the duration of treatment and follow-up time is brief and the age range is narrow, usually addressing only the needs of younger elementary school children (Cohan et al., 2006). In order to better understand selective mutism and the treatment approaches that best minimize its associated symptoms, it is imperative that large-scale studies are conducted with a focus on the efficacy of isolated techniques.

Beare, Torgerson, and Creviston (2008) described interventions used to increase the verbal behavior of a 12-year-old boy with selective mutism. These researchers exclusively utilized positive reinforcement to successfully increase verbalizations in three different settings. This is the only known case study where a single intervention was isolated and its effectiveness examined. It is important to note that case studies have limitations, involve a limited number of participants, and often lack control groups, as did this study. Despite such limitations, this study provides a springboard for further research on isolated interventions and will hopefully precipitate large-scale research devoted to examining effective treatment interventions for selective mutism.

In addition, research should be specifically devoted to examining the impact selective mutism has on long-term social development. It is logical to expect some level of social maladjustment regarding development of social relationships with peers given that children with selective mutism have limited social interactions. This is supported by research that has linked anxiety disorders, specifically social phobias, with social withdrawal and other difficulties regarding sociability (Beidel, Morris, & Turner, 2004). Nonetheless, case studies (e.g., Cunningham et al, 2004; Kumpulainen, 1998; Pelligrini, Bartini, & Brooks, 1999) imply that children with selective mutism are not bullied or victimized more than children who do not have selective mutism. More research is needed in this area to determine the extent of social maladjustment among children with selective mutism. Additionally, research should be devoted to investigate long-term effects of this disorder after the mutism is overcome. For example, exploring the ability to form relationships during teenage and adult years may help clarify the impact of mutism on long-term social development.

While an increasing amount of literature on selective mutism has been published during the last fifteen years, studies involving school personnel are virtually nonexistent. Children with selective mutism spend several hours each day with school professionals who are often involved in treatment interventions. More importantly, school is frequently the setting in which these children have the highest level of anxiety and mutism. Research has shown that teachers' involvement in the treatment process is vital to positive treatment outcomes (e.g., Kumpulainen, 2002; Lescano, 2008), yet their role in the treatment process is rarely described in the research. There is an urgent need to carefully examine these children's behaviors and interactions in the classroom during treatment, as well as interventions performed by the teacher. Such information would be vital to determining the overall effectiveness of treatment programs, specifically within the school setting.

Suggestions for Counselor Training

In addition to the recommendations pertaining to research and the counseling profession, it is important that counselor education provide training for treating this disorder. It is imperative that counselors, especially school counselors or counselors working with children, be trained in identifying the signs and symptoms of selective mutism. This training should stress that selective mutism be treated as an anxiety disorder, and the difference between this disorder and shyness, autism, or speech/language disorders should be emphasized. Additionally, instruction on non-verbal assessment tools should be provided as this is an ongoing aspect of treatment. Finally, counselors should be trained to work cooperatively with school personnel and parents when treating children with anxiety-related disorders, including selective mutism, because empathetic and knowledgeable school personnel are assets to successful treatment programs.

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Counseling Older Adults in LGBT Communities

John E. Mabey

Consideration of older adult lesbian, gay, bisexual, and transgender (LGBT) persons in gerontological research is lacking, leaving professional counselors without a substantive bridge with which to connect resources with treatment planning when working with sexual minorities. Therefore, presented here is an overview of aging research related to older adult LGBT individuals. The importance of individuality among LGBT individuals and suggestions for professional counselors who work with both individuals and couples in these populations also are presented.

Keywords: LGBT, older adults, gerontology, aging research, individuality

Multidisciplinary in nature, *gerontology* encompasses the study of dynamic processes of aging as experienced on the social, psychological, and biological levels (Hooyman & Kiyak, 2008). Knowledge of gerontology therefore enables professional counselors to work more effectively with older clients by facilitating understanding of their worldview. Professional counselors thus are better able to contextualize how aging itself is not the pathology, but rather the context that influences other aspects of the client's life.

Due to advances in medical care and quality of life, the average lifespan in the U.S. is being prolonged and the percentage of those reaching old age is increasing dramatically (Dobrof, 2001). According to recent U.S. Census data (2008), the number of Americans aged 85 years and older will increase from 5.4 million in 2008 to 19 million by the year 2050. In addition, about 1 in 5 U.S. residents will be age 65 or older by 2030. It is not uncommon in professional literature and research to differentiate old age into categories, such as the *young old*, typically between 60 to 79, and the *old old*, typically 80 and above, to capture more accurate developmental data at different stages of the life cycle (Grossman, 2008; McFarland & Sanders, 2003; Quam, 1993; Quam, 2004; Quam & Whitford, 2007). Although relatively arbitrary, such categories do point to the fact that there are developmental differences even among older adults.

Older adult sexual minorities have been relatively ignored in gerontological research (Apuzzo, 2001; Cook-Daniels, 1997; Grossman, 2008; Kimmel, 1979; Orel, 2004; Quam, 2004). It is estimated that there are between 1 and 3 million individuals in the U.S. over age 65 who identify as lesbian, gay, bisexual, or transgender (LGBT) (Jackson, Johnson, & Roberts, 2008; McFarland & Sanders, 2003), and that number is expected to increase substantially in the next 15 years (Penn, 2004). Unfortunately, whether because of discriminatory bias against LGBT individuals or the invisibility of sexual identity within older adult populations in the larger society, most professional counselors find themselves lacking in general knowledge about this growing population and therefore ill-equipped to provide professional services for them.

Older adults, whether heterosexual or part of the LGBT community, confront many concerns about aging, including financial matters, health, companionship, independence (Quam & Whitford, 1992), loss, and residence concerns (MetLife, 2006). All older adults also face issues and stereotypes surrounding ageism (Wright & Canetto, 2009), including discriminatory attitudes and behaviors against older persons (Hooyman & Kiyak, 2008). However, ageism as experienced in LGBT communities has the additional impact of making a stigmatized group feel even more of a minority (Brown, Alley, Sarosy, Quarto, & Cook, 2001; Drumm, 2005; Jones, 2001; Jones & Pugh, 2005; Kimmel, Rose, Orel, & Greene, 2006; Meris, 2001) .

Additional concerns unique to older adult LGBT individuals include the ability to make legal decisions for each other as couples/partners, lack of support from family who might not recognize or respect their sexuality, and homophobic discrimination in healthcare and other services. Older adult LGBT persons often face unparalleled discrimination and harassment in residential care facilities (Johnson, Jackson, Arnette, & Koffman, 2005; Phillips & Marks, 2008). While elder abuse is recognized as a significant problem among older adults in general, unfortunately there is a deficiency of

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specific knowledge about abuse for older adult LGBT persons (Moore, 2000). Thus, in the vast majority of situations, mainstream services for older adults are not meeting the specific and unique needs of the older adult LGBT population (Slusher, Mayer, & Dunkle, 1996).

Older adult LGBT individuals have lived through distinctively oppressive social climates for sexual minorities compared to more recent generations. Their early developmental years were marked by a typically homophobic culture in which homosexuality was overtly and profoundly admonished, and included messages from national and local leaders that their sexuality was immoral, pathological, and often illegal. For example, the old old grew up in an era during which President Eisenhower ordered all homosexuals to be fired from government jobs and Senator McCarthy sought to 'expose' communists and homosexuals (Kimmel, 2002). Without a more organized movement in place in that era to combat the rampant homophobia and negative stereotyping, blatant fear and dislike of homosexuality was seen in nearly all political, educational, and religious institutions. Indeed, the general lack of support for LGBT individuals in religious institutions continues today, leaving many in the position of a forced choice between two fundamental components of their sense of self: spirituality and sexuality. "In turn, this conflict can manifest itself through internalized disorders, such as depression, or through externalized disorders, such as risky or suicidal behavior" (Mabey, 2007, p. 226). However, it is important for professional counselors to be aware of the distinction many older adult LGBT persons make between spirituality and religiosity; religious dogma against homosexuality does not prevent many LGBT individuals from maintaining a strong spiritual identity (Mabey, 2007; Orel, 2004).

The young old, though, became adults during a time of more relatively progressive changes in society. The Stonewall riots in Greenwich Village in 1969, in which gay and transgender individuals physically fought back against unjust police harassment, marked a milestone in what would eventually become the modern gay rights movement. In the mid-1970s, homosexuality was finally declassified as a mental disorder within both the American psychiatric and psychological professional communities (but only after decades of miseducating medical and mental health professionals about the pathologic nature of sexual minorities).

As professional counselors work with an aging LGBT population, it is important to consider this historically negative climate which shaped an individual's experiences with, and impressions of, her or his own sexual identity (Berger, 1982). For the older adult LGBT individual, consequently, there might exist a sense of internalized homophobia (D'Augelli, Grossman, Hershberger, & O'Connell, 2001; Heaphy, 2007; Porter, Russell, & Sullivan, 2004) that contributes to nonparticipation in LGBT-supportive services and associated diminished overall mental health. These individuals also are less likely to seek any general health services for fear of having to disclose their sexual orientation to a possibly homophobic provider (Brotman, Ryan, & Cormier, R., 2003; Grossman, D'Augelli, & Dragowski, 2007; Sussman-Skalka, 2001). For example, refer to Zodikoff (2006) for vignettes that highlight unique aspects of social work practice with a diverse and aging LGBT population.

Aging and Individuality

Professional counselors should recognize that an older adult LGBT individual does not belong to one homogenous group within the LGBT acronym. For example, a gay youth living in New York City at the time of the Stonewall Riots will have experienced the movement in vastly different ways than, say, a gay youth then living in the rural Midwest. Similarly, a transgender individual involved in the Stonewall Riots will have faced different experiences than a gay male in those same riots because of the greater concealment of transgender individuals. Cook-Daniels (1997) wrote, "Lesbian and Gay male elders have been called an 'invisible' population (Cruikshank, 1991). If they are invisible, then transgendered elders have been inconceivable" (p. 35).

Transgender older adults also face unique challenges apart from those who are lesbian, gay, or bisexual (Cook-Daniels, 2006). For example, health concerns for those transitioning from male to female (MTF) or female to male (FTM) are greater because surgeries become more complicated with age. However, there has been a significant increase in the number of those willing to face the risk of transitioning in later life because of vastly improved methods of electronic communication about options, new research, and medical procedures (Cook-Daniels, 2006).

Another challenge to older adult transgender individuals is that most older adults in society, including gay and lesbian older adults, have well-established social roles and relationships. Thus, MTF or FTM transitioning becomes more difficult

with age because of the need for changed manners of speech and gesticulations. Legal issues include additional unique challenges as a change in gender is often associated with changed governmental benefits. For example, a formerly heterosexual marriage might be seen as an illegal same-sex marriage after one spouse transitions, and then formerly anticipated benefits, such as Social Security, might be revoked.

As professional counselors work with the older adult transgender population, there are several important aspects about this community to be considered in treatment planning (Cook-Daniels, 2006). First, although transphobia in the medical community and healthcare facilities has not been adequately researched, it is well-documented (Donovan, 2001). Therefore, making effective referrals necessitates that the new service provider be familiar and comfortable with the transgender population. Professional counselors also should understand the roadmap for individuals who are transitioning, and in particular how they need to be declared mentally fit as well as diagnosed with Gender Identity Disorder before any treatment for transitioning may commence. Professional counselors also should understand that persons in MTF or FTM are often perceived to be, "…mentally ill until proven otherwise, and they are fearful and angry that—to a degree that is rivaled perhaps only by prisoners and the severely domestically abused—their life choices are under someone else's control" (Cook-Daniels, 2006, p. 25). To the extent that a transgender person holds this perspective, it might interfere with his or her level of comfort in seeking the services of a mental health professional at all.

Transgendered individuals also cannot control the coming-out process of their gender identity because visual or auditory cues may expose their status, and therefore they are left open to the opinions and reactions of others they encounter. Thus, it is important for professional counselors to assess their own comfort levels, and meeting transgender individuals or volunteering in an organization that serves this population is a great way to increase familiarity with and knowledge about this group. It also is important to recognize that transgendered individuals face financial constraints that are usually greater than those typically encountered by other gay, lesbian, or bisexual elders due to hormone medication or surgical procedures that are usually not covered by insurance. Therefore, as with other clients experiencing financial constraints, professional counselors might employ a sliding-fee scale depending on their client's stage of transition and/or individual circumstances.

Bisexual individuals also experience a sense of invisibility within the LGBT community. As another underrepresented group in professional research literature, the needs and experiences of bisexual older adults also are often misunderstood. Professional counselors likely will work with bisexual clients during their careers, and should approach treatment without the erroneous assumption that sexuality is necessarily dichotomous (Dworkin, 2006).

Ageism typically precludes recognizing the sexuality of older adults (Hooyman & Kiyak, 2008). However, it is an important element. Consider a professional counselor who meets an older adult client who is happily married to a member of the opposite sex. That counselor likely will not consider that the client may in fact be bisexual—but it may be the case. Indeed, coming out as bisexual during a heretofore heterosexual marriage is the point at which a professional counselor might most be needed as issues of intimacy and restructuring of familial dynamics are addressed.

There also is the myth of the impossibility of monogamous relationships for bisexual individuals that should be considered by professional counselors (Dworkin, 2006). Simply because a person has the capacity for attraction and/or commitment to both males and females does not mean that the individual is unfulfilled with a monogamous relationship or that polyamorous relationships are necessarily seen as negative.

Aging Research and Identity

Differences among individuals within the "LGBT" acronym highlight the necessity for a professional counselor to understand the complex nature of identity. Through a shared history, current activism, and support networks, individuals within the LGBT community have much in common with one another. However, they also have differences. In building rapport with an older adult client, a professional counselor should recognize these differences (beyond commonly understood stereotypes). For an older adult LGBT client, having a well-informed professional counselor is essential to relationship-building and establishing trust, i.e., a comfortable environment in which LGBT history can be addressed and acknowledged.

Comprised of persons of every nationality, socioeconomic status, gender, ability level, race and ethnicity, the older adult LGBT population cannot be grouped or treated as one cohesive category. Unfortunately, research about LGBT elders is still underrepresented in gerontological literature, and representative samples of populations within that body of research are even more limited (Berger & Kelly, 2001; Butler, 2006; Grossman, D'Augelli & Hershberger, 2000; Jackson, et al., 2008; Kimmel, 2002; Quam & Whitford, 1992). Indeed, because of a variety of factors, such as "closeted" older adults and the lack of organized LGBT communities in some areas, no economically feasible method is available to generate a random sample of older LGB(T) individuals (Grossman, et al., 2000). Professional counselors must also consider this limitation when reviewing research, and how a significant number of studies have been conducted with LGBT individuals with limited sample sizes (and who primarily were Caucasian, highly educated, affluent, self-identified, younger, male individuals living in urban areas) (Dworkin, 2006; Grossman, D'Augelli, & O'Connell, 2001; Hash, 2006; McFarland, & Sanders, 2003; Porter, et al., 2004). Within the professional research and literature on older adult LGBT individuals, there exists a substantial gap in representation of people of color, the old old, and those living in rural areas.

Professional counselors should inquire of each older adult LGBT client about level of identification with an LGBT identity or community. Indeed, a professional counselor may be better educated about LGBT history and circumstances than the client, and therefore may be able to facilitate the older adult LGBT client's identity development. Indeed, it is rare for an older adult LGBT individual to have had LGBT parents, and therefore they are not necessarily taught this cultural history or coping strategies for overcoming homophobia, biphobia, or transphobia in the traditional family setting. Regardless, the ability of a professional counselor to access such information during a session is an important skill for relationship-building and even for educating the client regarding homework or making referrals.

As professional counselors consider the impact of an LGBT identity for the older adult individual, it also is important to not view that identity as necessarily problematic (Berger, 1982). In fact, researchers point to the idea of "crisis competence," in which the coming-out process enables the individual to develop a competency for dealing with other crises in the lifespan, including difficulties associated with the adjustment to aging (Heaphy, 2007; Kimmel, 2002; McFarland & Sanders, 2003; MetLife, 2006; Morrow, 2001; Quam, 1993).

Additional Skills for Professional Counselors

Sometimes an older adult individual in the LGBT community has difficulty coping with the stressors of homophobia and coming-out, and professional counselors might witness psychological distress or unhealthy behaviors. Kimmel (2002) outlines suggestions that can be adapted by mental health professionals to enhance the development of crisis competency and combat maladaptive thoughts and behaviors with this population. The suggestions include to:
- Aid the client to discover any familial or peer support.
- Identify positive role models locally or nationally that embody characteristics to which the client would aspire.
- Practice the use of effective coping skills.
- Assist in managing the integration of their multiple identities to enhance their sense of self.

Because the number of older adult individuals in the U.S. is expected to increase dramatically in the next 20 to 50 years, the number of older adult LGBT individuals will continue to grow as well. Professional counselors, working with these often misunderstood populations, face the additional challenge of treating LGBT elders with limited research or experience. Quam, Knochel, Dziengel, and Whitford, (2008) offer practical suggestions for working with same-sex couples that are adapted for work with older adult LGBT individuals:
- Your older adult client may define "family" as close friends who have assumed the role of absent families of origin. These fictive kin must be treated with the same respect as other family members.
- Because of anti-LGBT attitudes, your older adult client's biological or adoptive family may not be providing elder care. This care might instead be provided by fictive kin or not at all.
- Your older adult client might also be a caregiver for another elderly individual, especially as fictive kin play an important role in LGBT communities and caregiving.
- Your older adult client may have biological or adoptive children.
- Be knowledgeable about legal protections such as a will, power of attorney and a health care directive, as there are limited benefits for same sex couples (being denied visitation rights in a hospital when their partner is injured or gravely ill is a possibility).
- Confidentiality is essential when working with an older adult LGBT individual, specifically because of realistic

fears about anti-LGBT attitudes in the medical field or treatment facilities. Therefore, disclosing your client's sexual orientation without permission, even to another LGBT individual, should be strictly avoided.
- Familiarize yourself with older adult LGBT services and communities. An example is SAGE (Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders), a comprehensive social service agency with chapters across the country (http://www.sageusa.org).

As professional counselors continue to balance a scholar-practitioner role, increased research and experience with LGBT older adults and their aging will promote and elevate the counseling profession. It also will serve to enrich the lives of millions of LGBT older adults and their supporters. Both historically and in contemporary times, the counseling profession thrives as a fertile ground for pioneering and ground-breaking research; LGBT aging represents a generally underexplored but vital new challenge. Indeed, the dynamic and diverse nature of older adult LGBT communities provides opportunity for expanding academic inquiry and new and innovative treatment modalities in the counseling profession.

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A Preliminary Exploration of Support Systems for Parents of Children with Special Needs

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Raising a child with special needs exacerbates the inherent challenges of parenting. Although the needs of children with special needs are addressed frequently in the literature, the needs of the parents of children with special needs are often neglected. In order to offer effective and useful services for parents of children with special needs, this article examines the types and nature of support services used by the parents of children with special needs and the effectiveness of those support services in reducing the parents' stress levels and/or increasing their coping skills. Seventy-four parents of special needs children were assessed and results revealed that low-cost services, particularly those that resulted in mutual support, were a significant priority among parents. The article concludes with a discussion of clinical implications and needed directions for future research.

Keywords: parenting, children, special needs, support services, counseling

Parenting involves much effort and countless responsibilities. Child rearing can be one of the most challenging tasks with which a person is confronted. Raising a child with special needs intensifies the challenge significantly. However, although the needs of children with special needs are addressed frequently in professional literature and in the media, the needs of parents of children with special needs are addressed far less often. In order to offer effective and useful services for parents of children with special needs, their experiences with common issues and concerns and how their needs can be met must be investigated and understood because such information is essential to enable parents to feel empowered in raising their children with special needs.

Parents of children with special needs often experience high levels of stress from both internal and external factors. For example, a study conducted by Heiman (2002) revealed that 84.4% of the participants who had children with various special needs experienced feelings including "depression, anger, shock, denial, fear, self-blame, guilt, sorrow, grief, confusion, despair, [and/or] hostility" at the time of their children's first diagnoses. Barnett, Kaplan-Estrin, and Fialka (2003) reported a study of parents of children who were mildly or moderately impaired that showed about half of the parents were still experiencing negative responses to their children's diagnoses two or more years after the initial diagnosis.

In addition, parents of children with special needs may suffer being stereotyped by others. For example, Goddard, Lehr, and Lapadat (2000) used focus groups to collect individual narratives from parents of children with special needs. They found that, more than the parents' guilt or the condition of the child, being perceived as a victim of a tragedy and the sole advocate for the child as well as a lack of understanding from others, including professionals, contributes to parental stress. Financial concern is another external factor which contributes to high stress levels in parents raising children with special needs. Looman, O'Conner-Von, Ferski, and Hildenbrand (2009) found that the severity of a child's special needs increased the odds of financial burden experienced by the family. Clearly, there are a variety of both internal and external stressors, and accompanying emotional reactions, with which parents of children with special needs are confronted. Therefore, providing services to reduce the stress and negative feelings to minimum levels would lead to better quality of life for the parents of children with special needs.

Given the relative lack of attention to the support service needs of parents raising children with special needs, the purpose of this study was to conduct an exploratory investigation of the types of services used by parents of children with special needs and the effectiveness of those services for reducing parents' stress levels and increasing their coping skills.

Four primary research questions were addressed in this study:

1. What are the types of services used by parents of children with special needs?
2. How effective are services in reducing stress levels of such parents?
3. How effective are services in increasing the coping skills of parents?
4. What are some of the needs of parents which may be met by counseling services?

Method

There were two major parts to this research. The first involved distribution of a survey to parents of children with special needs and the second involved an extensive interview with a representative parent of a child with special needs. In the first part of the study a survey was used to collect data for approximately one year. Potential respondents included parents and/or primary caregivers of preschool or school-age children with special needs who resided in a Midwestern state. No restriction was placed on the potential respondents based on the type or number of special needs their child had. Participants were recruited through contact with organizations for families of children with special needs (e.g., local associations for learning disabilities, pervasive developmental disabilities, and physical disabilities) and snowball sampling with assistance of professionals at local public schools who work with children with special needs and their parents. An online survey, the primary means of data collection, was created using a commercial website (www. surveymonkey.com), and potential respondents were directed to the survey webpage from either the websites of the organizations or by typing in the website address found on a distributed survey invitation flyer. A paper version of the survey was prepared for participants from a university clinic for speech and hearing.

The second part of the study involved an individual follow-up interview. Initially, the intent was to garner enough participants for a focus group activity. Unfortunately, however, of all the survey respondents, only one expressed interest in participating in a focus group. Therefore, this respondent was selected and interviewed in order to explore the stressors, challenges, and supports available for the parents in greater depth. The interview was audio-taped and transcribed by the investigator.

Results

There were a total of 74 respondents. Among the respondents, 70 (94.6%) completed the survey online and 4 (5.4%) completed the paper form of the survey. Selected survey items and the resultant data are shown in Table 1.

Table 1

Selected Survey Items and the Resultant Data

Survey Items	No. of Responses	% Responses
Items for all the respondents ($N = 74$)		
How would you rate your degree of stress on the following scale?		
In the last month?		
Very low	0	0.0
Low	8	10.8
Moderate	22	29.7
High	33	44.6
Very High	9	12.2
In the last year?		
Very low	0	0.0
Low	5	6.8
Moderate	23	31.1
High	24	32.4
Very High	21	28.4

Survey Items	No. of Responses	% Responses

What would be the ratio of each factor that might be contributing to your stress level?

Raising a child(ren) with special needs

About 1–25%	9	12.2
About 26–40%	15	20.3
About 41–60%	15	20.3
About 61–80%	23	31.1
About 81–100%	11	14.9

Financial concerns

About 1–25%	15	20.3
About 26–40%	20	27.0
About 41–60%	12	16.2
About 61–80%	7	9.5
About 81–100%	15	20.3

Have you sought professional services (i.e., therapies) in dealing with your stress of raising a child(ren) with special needs?

Yes	30	40.5
No	43	58.1

If you answered **No** *to the previous question, what was (were) your reason(s) for not seeking professional services (i.e., therapies)?* ($n = 43$)

Unable to afford the service	5	11.6
Schedule conflict	7	16.3
Did not know about any service available	7	16.3
Unable to find a service that seemed helpful for your needs	12	27.9

Counseling as a category of received service (n=30)

Type of service you have received:

Individual counseling	22	73.3
Couples counseling	3	10.0
Family counseling	7	23.3

How helpful was the service for dealing with your stress?

Very helpful	7	23.3
Somewhat helpful	12	40.0
Neutral	2	6.7
Somewhat unhelpful	2	6.7
Very unhelpful	3	10.0

Compared with your stress level before receiving service, how much has it changed after receiving service?

Not changed at all	2	6.7
Greatly reduced	12	40.0
Somewhat reduced	7	23.3
Unsure	2	6.7
Somewhat increased	2	6.7
Greatly increased	2	6.7

Survey Items	No. of Responses	% Responses

Compared with your outlook on raising your child(ren) with special needs before receiving service, how much has it changed after receiving service?

Not changed at all	3	10.0
Greatly more optimistic	12	40.0
Somewhat more optimistic	4	13.3
Unsure	6	20.0
Somewhat more pessimistic	1	3.3
Greatly pessimistic	0	0.0

Group as a category of received service (*n*=16)

Group counseling	2	12.5
Support group	14	87.5

How helpful was the service for dealing with your stress?

Very helpful	6	37.5
Somewhat helpful	8	50.0
Neutral	1	6.3
Somewhat unhelpful	0	0.0
Very unhelpful	1	6.3

Compared with your stress level before receiving service, how much has it changed after receiving service?

Not changed at all	0	0.0
Greatly reduced	10	62.5
Somewhat reduced	3	18.8
Unsure	1	6.3
Somewhat increased	2	12.5
Greatly increased	0	0.0

Compared with your outlook on raising your child(ren) with special needs before receiving service, how much has it changed after receiving service?

Not changed at all	1	6.3
Greatly more optimistic	8	50.0
Somewhat more optimistic	2	12.5
Unsure	3	18.8
Somewhat more pessimistic	1	6.3
Greatly more pessimistic	0	0.0

Items for the respondents who sought a professional service(s) in the past for dealing with their stress of raising their children with special needs (*n*=30)

What have you gained from receiving service(s)?

Peer support	8	26.7
Professional support	7	23.3
Network	10	33.3
Specific knowledge about the child(ren)'s disability(ies)	14	46.7
Specific skills for dealing with the child(ren)'s needs	13	43.3

Survey Items	No. of Responses	% Responses
What are some of the factors that you consider when choosing a service?		
Cost (including transportation and session fees)	20	66.7
Schedule/frequency	21	70.0
Format (e.g., individual vs. group vs. psychoeducational vs. counseling)	16	53.3
How likely are you to seek an additional service(s) in the future?		
Very likely	9	30.0
Likely	8	26.7
Unsure	6	20.0
Unlikely	1	3.3
Very unlikely	0	0.0
If you were to receive an additional service(s), what would be the most likely format/venue?		
Individual counseling	15	50.0
Couples counseling	4	13.3
Family counseling	8	26.7
Group counseling	1	3.3
Support group	13	43.3
Parenting training individual sessions	4	13.3
Parenting training group sessions	6	20.0
Individual psychoeducational sessions	0	0.0
Psychoeducational group sessions	3	10.0
Coping skills—individual sessions	5	16.7
Coping skills—group sessions	3	10.0
Stress management—individual sessions	8	26.7
Stress management—group sessions	4	13.3

Note. Some of the items allowed multiple answers by a single respondent. Percentage of respondents for each item was measured based on the number of respondents corresponding to specific items.

Some of the 74 respondents did not provide responses for all items. The respondent group included 67 females (90.5%) and 63 (85.1%) participants who identified themselves as Caucasian/White. Thirty-five respondents (47.3%) were between ages 31 and 40, and 58 (78.4%) were married. Fifty-nine of the respondents (79.7%) had one child with special needs and 31 (41.9 %) reported the child's disability as moderate.

In regard to stress levels, 33 respondents (44.6%) indicated that they had experienced a high degree of stress in the past month, and 45 (60.8%) indicated that they had experienced either a high or very high degree of stress in the past year. Twenty-three respondents (31.1%) indicated that raising their child with special needs contributed to about 61–80% of their total stress level, and 20 (27.0%) indicated that their financial concerns contributed to about 26–40% of their total stress level. In regard to help seeking, 45 (60.8%) indicated that they had never sought professional services (e.g., various possible therapies) to cope with the stress of raising a child with special needs. The most frequently cited ($n = 12$, 27.9%) reason for not seeking support services was that they were unable to find services that they perceived to be helpful for their needs.

Among the 30 respondents who had sought professional services, 22 (73.3%) indicated that they had sought individual counseling (which also was the most used type of service). The second most used type of service was support groups, in which 14 respondents (46.7%) indicated that they had joined or were current members of a support group. Among those who had received individual, couple, family, or any combination of counseling, 19 (73.1%) indicated that their stress levels were reduced to some or a great extent after receiving such service(s) and 16 (61.6%) responded that their outlook on raising their child with special needs became somewhat or greatly more optimistic.

Specifically, among the 16 (53.3%) who had received either group counseling, participated in support groups, or both, 13 (81.3%) indicated that their stress levels were somewhat or greatly reduced and 10 (62.5%) indicated that their outlook on raising their child) with special needs became somewhat or greatly more optimistic. Finally, 14 (46.7%) responded that they had gained specific knowledge about the child's disability from receiving the services and 13 (43.3%) responded that they had gained specific skills for coping with the child's needs.

Although the respondents in this latter subgroup had participated in a wide variety of support services, it appears that most were psychoeducational in nature. Seventeen respondents (56.7%) also reported that they were either likely or very likely to seek additional services in the future. The three most selected types of services that these respondents would most likely seek were individual counseling (*n*=15, 50.0%), support groups (*n*=13, 43.3%), and family counseling (*n*=8, 26.7%). Session schedule and frequency, cost (including transportation and session fees), and format of the service were all important factors considered in use of support services.

The second part of the study was an interview with the mother of a son with cerebral palsy in order to gather information about personal experiences, particularly those contributing to her level of stress. The interview was conducted at a house close to the hospital to which she periodically brought her son for treatment. At the time of the interview, Amy (a pseudonym), the mother, was 39 years old, and Michael (a pseudonym), her son, was two years old. Amy was Caucasian, between 31 and 40 years old, married, and had one child with special needs; therefore, she was "typical" of the majority of the respondents to the survey. Specific interview questions were not prepared in advance. Rather, Amy was asked to convey her most important and/or strongest experiences and emotions as a mother of a child with special needs.

A wide variety of issues were discussed during the interview, but the most pressing issue mentioned by Amy was the lack of available resources for parents of children with special needs. Amy related that large cities might have many resources available, "but especially not my little small town—the resources are so limited." She talked about how in attempting to acquire information and resources to aid in Michael's care, she had asked many different people. Importantly, she did considerable research on her own, primarily using the Internet. She felt that many, or perhaps most professionals did not know more than she did, regardless of their formal education and training. She gave the example of having told one of Michael's doctors about Euro-Pēds, a facility specializing in physical therapy for children with cerebral palsy and other neuromuscular disorders. The doctor did not know about this resource. Amy also related how shocked she was when a receptionist at a local mental health facility was not aware of a "respite" fund provided by the facility. She expressed that it was "disheartening that these people are supposed to guide me, and they just couldn't." Then she went on to describe a situation in which parents of children with special needs could not obtain the service they wanted because they did not use the technical term:

> I was told that there were even situations where people who aren't articulate would call and say, 'I need a babysitter.' And they say, 'We don't do babysitting services.' Click. Because they didn't say 'respite,' they were turned away…. It's their job to be in tune with, maybe there's something I'm not getting here. Let me figure out what's wrong with this person that's calling my mental health facility.

Amy was often disappointed in seeking resources and help, probably because of the lack of understanding and education among professionals.

Amy lamented that resources external to the family should not cause more stress because parents of children with special needs already are overwhelmed by feelings of guilt, helplessness and stress. She believed that Michael was not the cause of her issues, but rather that the actual problems were the by-products of his having a disability:

> It's not always directly related to the child, but all the side effects that how they affect you… A lot of it is just the overwhelming feeling that sometimes you wake up in the morning and say, 'I can't believe that he has so many problems.' And you feel sorry for him, and you feel stressed out about it.

Amy also felt guilty about not being able to spend as much time as she would have liked with her other two children; the demands of Michael's situation dominated all her plans. Amy had tried to be with her other children whenever she could, but still felt that she was not doing enough for them. Thus, she believed that Michael's disability affected not only her, but also everyone else in the family. Amy also felt tremendous pressure when talking to Michael's doctors:

> Michael's doctors say, 'We don't know if he can ever walk. But we don't know if he won't. It's gonna be up to you, Mom. It's gonna be, if he's got the potential to do it. You're the one that's gonna push him…'It's a lot of pressure and I don't think that these doctors meant to give me that unneeded pressure… But I work very hard to push Michael, you know, everyday. But it scares me. It scares me that, 'Am I pushing him enough? Am I pushing him too hard?'

Obviously Amy (and other parents of children with special needs like her) suffers from high levels of stress from both internal and external factors. To Amy, taking care of Michael was like "not knowing how to swim and you get thrown into a pool with another person who doesn't know how to swim." When Michael was born, Amy had to teach herself how to raise a child with special needs because "these children don't come with an instruction manual…or a book of resources." She believed that knowledge about Michael's disability would be particularly important in order for her to take care of him properly and effectively. She also was aware that the process of accepting her son's disability and learning how to take care of a child with special needs could be "a nightmare for some people," because "even someone with formal medical training struggles with these children." Amy related that she thought a support group to provide opportunities for the parents of children with special needs to discuss and share experiences and feelings would be beneficial. She also believed that inviting a professional such as a social worker to the group who could help the parents fill out paperwork for requesting funds and other assistance would be beneficial because many parents of children with special needs struggle with understanding and completing formal documents properly. At the end of the interview, Amy indicated that she felt like she was contributing at least in a small way to improving the lives of parents of children with special needs by participating in the research and that the interview was helpful in reducing her stress.

Discussion

This preliminary research was conducted to gather data, collect descriptive personal information, and, from the data, suggest future practices for gaining understanding of the unique needs of parents of children with special needs. Suggested in the results of this exploratory study, is that counseling services for parents of children with special needs are both warranted and needed. The format of such services likely should be group counseling because of lower cost and potential for mutual support among group members. Such group counseling sessions should be in part psychoeducational and in part intended to foster support to meet the goals of knowledge and skill acquisition for parenting children with special needs and sharing personal experiences with others. Individual and/or family counseling might be used as a follow-up service, especially for parents or families of children with special needs who appear to need intensive care. Finally, parents of children with special needs should be able to choose how they would like to interact, such as by phone, home visit, or face-to-face because they often struggle with finding child care for when they are away from home. Having support group meetings at each other's homes also can be an option so that parents can take turns watching children during meetings.

Limitations of this study included a small number of male participants. Whether more responses from fathers would have changed the results is only a matter of speculation. Thus, future research that includes significantly more input from fathers of children with special needs is needed. Also, to be noted is that some participants reported confusion about terms such as psychoeducation, which may have influenced their responses. Therefore, future research should identify specific services rather than the categories of services. Any online survey is limited to those who have access to the Internet and are comfortable using computers. Future studies can overcome this limitation to a great extent by incorporating multiple methods involving several types of data collection. Finally, the case interview was perhaps the most valuable part of the study in terms of revealing the reality and challenges faced by parents of children with special needs. Thus, qualitative, phenomenological research also would be beneficial, especially for understanding the unique and complex concerns of parents of children with special needs.

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Perceptions of Professional Counselors: Survey of College Student Views

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Numerous sources of information influence how individuals perceive professional counselors. The stressors associated with entering college, developmental differences, and factors associated with service fees may further impact how college students view mental health professionals and may ultimately influence when, for what issues, and with whom they seek support. Individual perceptions of professional counselors furthermore impress upon the overall identity of the counseling profession. Two hundred and sixty-one undergraduate students were surveyed regarding their perceptions of professional counselors' effectiveness and sources of information from which information was learned about counselors. Overall, counselors were viewed positively on the dimensions measured. The sources that most influenced perceptions were word of mouth, common knowledge, movies, school and education, friends, books, and television.

Keywords: professional counselors, perceptions, counselor effectiveness, professional identity, undergraduates

Perception is not reality, but perception is nonetheless a very cogent relative to how humans come to understand reality. Moreover, perception tends to drive behavior and decisions made by consumers. In the present context, we are interested in how college students come to perceive human service providers across a number of variables. The constructs explored are not novel, as this genre of research has been assessed in decades past (e.g., Murray, 1962; Strong, Hendel, & Bratton, 1971; Tallent & Reiss, 1959; West & Walsh, 1975). However, we believe the topic warrants refreshed attention, particularly with the professional licensure acquired among all human service professions: psychiatrists, psychologists, counselors, marriage and family therapists, social workers, and psychiatric nurses.

The media tends to exert a cogent effect on students' perceptions across multiple life domains, including human service professionals (Von Sydow, Weber, & Christian, 1998). Students also are affected by other information sources such as previous experiences with their high school (guidance) counselors, personal therapy, clergy, family doctors, parental influence, and input from peers (Tinsley, de St. Aubin, & Brown, 1982). Students' perceptions of human service providers also may be affected by various campaigns, typically receiving information-influence from multiple sources that actively attempt to shape their perceptions of mental health services' value and efficacy (Hanson, 1998).

Some human service professions have been more aggressive in how they advocate their service value to the public. Fall, Levitov, Jennings, and Eberts (2000) note that psychiatrists and psychologists generally have dwarfed counselors' efforts at advocacy. Counselors, as a profession, have struggled significantly with their own identity (Garrett & Eriksen, 1999; Eriksen & McAulife, 1999), which likely affects this phenomenon. That is, if one's identity is unclear to the respective professionals, then probably it will negatively affect its status among the laity (Gale & Austin, 2003). Psychology generally has lagged behind psychiatry in terms of the public's professional perceptions (Webb & Speer, 1985), although Zytowski et al. (1988) reported that people frequently confused the terms psychiatrist and psychologist relative to function. Counseling psychologists also often seem to be confused with professional counselors in the public's understanding (Hanna & Bemak, 1997; Lent, 1990).

Social work has existed as a vocation for over a hundred years. Kaufman & Raymond (1995) reported that the public's awareness of the profession's perception was somewhat negative in their survey sample. LeCroy and Stinson (2004) and Winston and Stinson (2004) likewise found individuals in their particular sample to be relatively knowledgeable regarding social workers' responsibilities, although reported attitudes were more positive than those reported by Kaufman and Raymond. This partly may be due to the fact that respondents reported more favorable perceptions of social workers as helping those needing avocation than they did for social workers as therapists. Sharpley, Rogers, and Evans (1984) suggest that marriage and family therapy, as a profession, is relatively cryptic to the general public. That is, people generally deduce what such human service personnel do, as indicated by the title, but do not have as much first-hand

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knowledge or experience with such professionals as they do with counselors, social workers, psychologists, and other professionals.

Ingham (1985) notes that a helping profession's overall image affects clinicians in that profession relative to their abilities in helping clients to utilize their services. This conclusion makes logical sense in that consumers' confidence in the care provided is subjective and highly influenced by psychological variables, such as idiographic perceptions. Attempts at educating the public regarding an apt understanding of what a human service profession has to offer has shown various levels of effectiveness (Pistole & Roberts, 2002). Nonetheless, Pistole (2001) also notes that the general public finds the distinctions among the various human service providers to be bewildering. In short, without periodic reminders, the public's image of various human service personnel may reconverge in a fog of misperception.

Since many individuals have never experienced the services of mental health clinicians, often their perceptions are based on reports or intuitively acquired opinions. For example, Trautt and Bloom (1982) report that fee structures affect perceptions of status and effectiveness provided by clinicians. The basic understanding, of course, is that the more expensive the treatment, the higher its perceived value and professional status. That, of course, can result in self-fulfilling prophesies—with people paying more money expecting more from therapy—and experiencing better success rates. We are unaware of any studies where clients were randomly assigned to professional therapists and (systematically) charged varying pay rates. Such a study, controlling for fee structures, might yield some valuable data to the present discussion regarding how the public perceives the value of respective human service professionals.

Beyond the public's general perceptions on this topic, however, we are particularly focused on students' perceptions. Hundreds of thousands of students annually utilize the services of university counseling centers, as well as private practice therapists and other human service agencies. With the added stress of academics, social pressures, being away from home for the first time, transitioning from teenage to adult responsibilities, dating, drinking alcohol, and other similar stressors, having apt utilization of psychotherapeutic services is paramount for college students. Turner and Quinn (1999) suggest that college students' perceptions differ from the population-in-general, and research data from one group may not accurately generalize to the other.

Notwithstanding obvious developmental differences between college students and more mature adults from the general population, counseling students may not pay (directly, out of pocket) for the services available to them. Campus counseling centers, for example, typically receive funding from tuition or generic student fees, rather than students paying direct dollars for the services. Additionally, most full-time students remain on their parents' medical insurance which also offsets financial costs involved in private practice expenses. In short, cost of services seems to be a significant variable for the general population (Farberman, 1997) that may not load with the same degree of importance vis-a-vis college students. Additionally, titles (such as "doctor") may not have as much bearing with the general public (Myers & Sweeney, 2004) as they do with college students who routinely use such nomenclature with professors and others on a daily basis. In short, while we accommodate research findings that compare the various mental health professionals as perceived by the general public (e.g., Murstein & Fontaine, 1993), we also treat the results with some degree of prudence and believe college students represent a distinct population worthy of particular focus and exploration.

Gelso, Brooks, and Karl (1975) conducted a study that was similar in some respects to our present one. They surveyed 187 students from a large eastern university with a sample of 103 females and 84 males. Subjects were asked to rate perceived characteristics of various human service professionals, including high school counselors, college counselors, advisers, counseling psychologists, clinical psychologists, and psychiatrists. They found that overall college students did not report significant differences relative to professionals' personal characteristics. However, they did report differences among the human service providers relative to their perceived competencies in treating various hypothetical presenting problems.

In the 30 years subsequent to this study, we are interested in how student perceptions have changed over time. Additionally, the Gelso, Brooks, and Karl (1975) study did not account for students' perceptions of social workers, marriage and family therapists, or psychiatric nurses. Given the present milieu, we are more interested in these professionals than the categories of school counselors or advisors. Additionally, we also chose to combine the categories of counseling and clinical psychologists into the generic grouping, "psychologist." The specific questions asked of

students also differed in our present study. However, the general tenor of the two studies is similar—and we believe the updating of knowledge in this area has significant importance for those working with college students in various capacities and milieus.

Warner and Bradley (1991) also conducted a study similar to the present one. Their participants included 60 men and 60 women who were undergraduate college students enrolled in a University of Montana introductory psychology course. They assessed student perceptions of master's-level counselors, clinical psychologists, and psychiatrists on multiple variables. Findings included students reporting their perceptions of counselors as possessing more caring-type qualities. Psychiatrists were seen as most able to address severe psychopathology and psychologists were viewed as more academics and researchers than as therapists.

Method

Participants
We surveyed 261 students from three sections of a general psychology course for this study. The course was selected, in part, because it is included in the university's general studies core curriculum. Consequently, it represented a relatively wide range of majors from the student body and included students from freshman through senior status. The sample was taken at a selective, private, comprehensive university located in the Midwest with a study body of approximately 3,000 students. It included 167 women and 92 men with ages ranging from 17 to 55. The students were mostly Caucasian with 9% identifying themselves as ethnic minorities representing 34 states.

Procedure
The instrument was first pilot tested (Goodwin, 2005) to a group of undergraduate students at a regional state university prior to utilizing it in the present research project. Modifications were made in clarifying ambiguous terminology, instructions, and time to complete. Due to practical considerations, the instrument was designed to be completed in about one-half of a normal class period. The survey was administered during a normal class period with students having the option to participate at will without reward or penalty for doing so. Two students chose not to complete the surveys for undisclosed reasons.

The survey queried students regarding their perceptions of human service professionals (HSP), taking about 20–25 minutes to complete. Anonymity was provided to all students regarding answers to all items. Questions were asked about the overall perceived effectiveness of various HSPs, for which types of problems they might recommend various HSPs, and overall perceptions about the various HSPs. Although obviously many types of HSPs exist, this particular survey focused on psychiatrists, psychologists, professional counselors, marriage & family therapists, social workers and psychiatric nurses. In order to control for order effects as potential threats to internal validity (Sarafino, 2005), the various HSPs were presented in random order each time they appeared throughout the survey. The amount of data collected from the survey was relatively substantial. However, given the practical number of journal pages that can be reasonably devoted to presenting the information, along with our desire to comprehensively address perceptions of counselors, the present article addresses only this particular segment of the data collection.

Results

We organized the survey's results in terms of the counseling services utilized, how effective students perceived counseling to be, for what types of problems or issues counselors are thought to be apt, how students came to view their perceptions of professional counselors, and qualities thought to characterize professional counselors. All percentages are rounded for clarity of reading and presentation, except where percentages fall below 1%.

Types of Services Utilized
At the end of the questionnaire, students were asked to confidentially self-disclose whether or not they had received services from a HSP. The question was placed at the end in order to have students already somewhat acclimated to HSPs and to have them somewhat more comfortable with the world of different types of HSPs. Of those answering the question, 28% of the participants indicated having received assistance from a HSP prior to completing the survey. The specific question asked whether or not students received prior professional assistance regarding personal, social, occupational or

mental health concerns. About 3% of all the participants chose not to answer this particular question. However, of the 28% only 1% indicated that they did not know the profession of their HSP, indicating that most of the respondents who previously had utilized HSP services were aware whether the professional they saw was a counselor, psychologist, social worker, etc. Relatively few (<20%) of the participants who had utilized HSP services indicated having seen a psychiatrist, psychiatric nurse, psychologist, marriage & family therapist, or social worker.

States possess a variety of titles by which professional counselors can or should be called (Freeman 2006). Consequently, rather than asking students simply to identify whether or not they had previously utilized the services of a "counselor," we specified some types of counselors they may have seen. These included professional counselor, pastoral counselor, addictions or chemical dependency counselor, rehabilitation counselor, clinical mental health counselor, professional clinical counselor, and school guidance counselor.

Of the 28% of students who indicated they had previously utilized HSP services, three particular types of counselors were more prominent than the others. Namely, 16% indicated having seen a school counselor, 11% saw a professional counselor, and 9% saw a pastoral counselor. Relatively few students indicated having seen a rehabilitation counselor (0.4%), an addictions counselor (0.8%), or a mental health/clinical counselor (3%).

Perceived Overall Effectiveness
Students were asked to indicate how effective they believed professional counselors are overall. The particular question was worded as follows: In general, what is your opinion about how overall effective professional counselors would be with helping a mental health consumer? The options provided, with descriptors in parenthesis, were 1 (Positive), 2 (Neutral), 3 (Negative), and 4 (Unsure or don't know). The intent of the question was to capture the gestalt of students' thinking regarding professional counselors, prior to probing more deeply vis-a-vis types of counselors and for which kinds of issues they might find effective interventions.

Only 3% of the participants indicated having no opinion regarding this question. Another 3% indicated viewing professional counselors negatively. A total of 28% of the participants indicated having neutral views regarding counselors' overall effectiveness. Sixty-six percent of the participants indicated having a positive view of professional counselors.

Types of Issues for Which Counselors Are Adept
Students were asked to identify for what types of issues they believed professional counselors would be particularly adept. They were provided with 12 different issues and asked to rate them as Yes (I would recommend a professional counselor for this situation), No (I would not recommend a professional counselor for this situation), or NS (Not sure, not familiar). Relatively few students skipped these questions or chose not to respond (range=0.8% to 3.4%). In other words, response rates were consistently high for these questions, obviously adding to the interpretation process. The same is true with students indicating that they were unsure or unfamiliar. Namely, on average 4% or so of students indicated being unsure for the situations presented (range=1.9 to 6.9). Results showed three clusters of participants' responses.

The first cluster had four prominent responses, exhibited by 80% or more of the respondents—they involved college issues, academic problems, depression, and career counseling. A total of 91% of the participants indicated believing a professional counselor would be effective for helping college students who report homesickness, roommate problems, and falling behind with class assignments. A similar number (88%) believed that a professional counselor would be effective with a depressed individual who reports feeling sad and empty most days, finds little pleasure in daily activities, has insomnia, and is unable to concentrate. Comparable responses (83%) were seen for professional counselors addressing a young person with adequate intellectual capacity, but a pattern of academic problems (e.g., failing grades and significant underachievement). Finally, 80% of participants indicated that a professional counselor would be effective for a person reporting job dissatisfaction and uncertainty about career choices.

The next cluster of responses involved issues of family dysfunction, substance abuse, and attention-deficit hyperactivity disorder (ADHD). Seventy-six percent of participants indicated feeling that professional counselors were effective for a family unit reporting communication problems, negative interactions, criticism, and withdrawal among family members. For cases when a person self-administers and abuses drugs that results in impairment of daily academic, occupational and social functioning, 73% of the respondents in our survey believed a professional counselor would be

effective. Sixty-seven percent of participants indicated that a professional counselor would be effective when a person with persistent patterns of inattention and hyperactivity-impulsivity that interferes with academic, occupational, and social function.

The final cluster of participants' responses involved issues of personality assessment, intelligence testing, psychotic symptoms, physical disabilities, and mental health evaluations. Just over half (53%) of the participants indicated that professional counselors were apt for working with a person who needs personality assessment. Forty-four percent said that a professional counselor would be effective for a person with psychiatric symptoms who experiences delusions, hallucinations, disorganized speech, and is frequently incapable of meeting ordinary demands of life. When asked if an unemployed individual with a physical disability seeking employment would be a target source for a professional counselor, 43% answered affirmatively. Only 40% of participants indicated that a professional counselor would be effective in helping a client who needs a comprehensive mental health evaluation. Fewer (37%) indicated that intelligence testing was germane for a professional counselor.

Table 1

Types of Issues for Which Counselors Are Adept

Types of Issue	Yes	Not Sure	No
A college student reporting homesickness, roommate problems, and falling behind with class assignments. (N = 257)	233 (91%)	7 (3%)	17 (7%)
A depressed individual, who reports feeling sad and empty most days, finds little pleasure in daily activities, has insomnia, and is unable to concentrate. (N = 254)	224 (88%)	3 (1%)	27 (11%)
A young person with adequate intellectual capacity, but a pattern of academic problems (e.g., failing grades and significant underachievement). (N = 260)	217 (83%)	8 (3%)	35 (14%)
A person reporting job dissatisfaction and uncertainty about career choice. (N = 259)	206 (80%)	16 (6%)	37 (14%)
A family unit reporting communication problems, negative interactions, criticism, and withdrawal among family members. (N = 253)	192 (76%)	5 (2%)	56 (22%)
A person who self-administers and abuses drugs that results in impairment of daily academic, occupational and social functioning. (N = 253)	185 (73%)	14 (6%)	54 (21%)
A person with persistent patterns of inattention and hyperactivity-impulsivity that interferes with academic, occupational and social functioning. (N = 255)	171 (67%)	11 (4%)	73 (29%)

Types of Issue	Yes	Not Sure	No
A person who needs personality assessment. (*N* = 254)	134 (53%)	12 (5%)	108 (43%)
A person with psychiatric symptoms who experiences delusions, hallucinations, disorganized speech, and is frequently incapable of meeting ordinary demands of life. (*N* = 254)	112 (44%)	12 (5%)	130 (51%)
An unemployed individual with physical disability seeking employment. (*N* = 255)	109 (43%)	12 (5%)	134 (53%)
A person who needs a comprehensive mental health evaluation. (*N* = 256)	102 (40%)	16 (6%)	138 (54%)
A person who needs intelligence testing. (*N* = 252)	92 (37%)	18 (7%)	142 (56%)

Sources of Perceptions about Counselors

Another line of inquiry addressed the identified sources by which students indicated they developed their perceptions about counselors. In other words, they told us about the factors that influenced them the most regarding how they came to think about professional counselors. The options from which to choose included books, common knowledge, friends or associates, HSPs, insurance company or carrier, Internet, magazines, physician or nurse, movies, newspapers, personal experience, school and education, and television. Only 2% of the participants declined to participate in this section of the survey or marked "none."

Instructions asked students to complete this section in two steps. First, they were to indicate (by checking a corresponding box) whether or not they learned about a professional counselor from the identified source. Students were told they could select multiple sources. In the second step, they were asked to rate whether the information about the HSP was 1 (positive), 2 (neutral) or 3 (negative). Only 2% of the students marked a box described as "other," indicating that the categories provided were relatively comprehensive. Results from this portion of the survey showed the data falling into three clusters. The two clusters representing extreme scores were of relatively equal size, while the third or middle was small (only two sources in the category).

The first cluster showed the following items as being relatively influential in how students came to understand the roles of professional counselors: common knowledge (84%), movies (63%), school and education (60%), friends (55%), books (49%) and television (44%). The middle cluster included personal experience (27%) and Internet (24%). The finding that 27% indicated personal experience to be influential is consistent with the demographic portion of the questionnaire where 28% of students said they had personal contact with a HSP prior to completing the survey. The third cluster comprised those sources that participants said were relatively non-influential in generating their perceptions of professional counselors. They included magazines (20%), physician or nurse (18%), newspaper (13%), HSPs (10%) and insurance companies (5%).

Results from the second step in the survey are more difficult to summarize. The data was more dispersed than the first step, although three clusters inductively emerged. Some items received few responses, as they were not selected very frequently in step one. The percentages listed do not add up to 100% for each item because the remaining percentage for each item is accounted by students who did not provide answers for that item. For example, if an item had 1% positive,

1% neutral, and 1% negative, then 97% of the participants simply left the question blank.

The first were items where students indicated that professional counselors were as viewed mostly positive. These included school and education (43% positive, 13% neutral and 3% negative), friends (38% positive, 10% neutral and 6% negative), books (30% positive, 17% neutral and 2% negative), personal experience (17% positive, 7% neutral and 3% negative), physicians (10% positive, 6% neutral and 2% negative), and HSPs (8% positive, 0.8% neutral and 0.8% negative). The second cluster comprised items that were rated as being mostly neutral and with relatively few positive indicators. These included: movies (14% positive, 28% neutral and 19% negative) and television (13% positive, 25% neutral and 6% negative). The third cluster showed a relative spread of responses, although there were few negatives in each category. They included: common knowledge (38% positive, 42% neutral and 3% negative), magazines (10% positive, 8% neutral 3% negative), Internet (10% positive, 12% neutral and 1% negative), newspapers (5% positive, 6% neutral and 3% negative), and insurance companies (0.8% positive, 2% neutral and 2% negative).

Perceived Counselor Qualities

The final portion of the questionnaire addressed how participants viewed various professional counselors' characteristics. Students were asked to identify statements that they believed to be true about professional counselors, based on their overall knowledge of them. Options included competent, can be in independent private practice, diagnose and treat mental and emotional disorders, doctoral degree required to practice, intelligent/smart, overpaid, prescribe medication and trustworthy. Consistently, only 1% of the participants chose not to respond to this portion of the survey, making interpretation for this section relatively straightforward. The findings fell neatly into two categories: characteristics counselors presumably possess and those they do not.

Characteristics that students believed professional counselors possess include being competent (81%), independent private practice (81%), trustworthy, (79%), and intelligent/smart (77%). Contrariwise, participants identified the following as not characterizing professional counselors, as indicated by the relatively low percentages of marked responses: doctorate required (30%), diagnose and treat mental disorders (22%), overpaid (16%) and prescribe medications (5%).

Discussion

Given the formation and advancement of the American Mental Health Counseling Association (AMCHA), the introduction of state licensure laws that specifically use mental health counselors as formal nomenclature (Freeman, 2006), and particular certifications that have been offered in clinical mental health counseling, we were somewhat surprised that only 3% of the students who had previously used HSP services identified doing so with clinical mental health counselors. Of course, they may have been confused with names, but to the degree that accurate reporting occurred, the numbers were relatively low compared to other types of counselors.

Obviously, school counselors are very important relative to how students perceive professional counselors. They accounted for the largest portion of users (16%). First impressions are not always necessarily lasting impressions. However, they are cogent and school counselors may set the tone for how these students, for the rest of their lives, perceive others using the word "counselor" in their professional titles. This sentiment was illustrated in qualitative research findings by Wantz, Firmin, Johnson, and Firmin (2006).

Three times as many students indicated having seen a pastoral counselor than a mental health counselor (9% and 3%, respectively). Obviously, we do not know if some students actually meant that they saw an ordained clergy person for personal issues, considering this person to be a pastoral counselor, since they received counseling from him/her and the person was clergy. However, assuming accurate reporting, it suggests that graduate training programs should consider giving additional attention to this domain of counseling. Although courses in pastoral counseling sometimes are seen in religiously-oriented universities (e.g., seminaries, Catholic or Christian colleges), the apparent popularity of their use by students, suggested by the present research, provides evidence that more widespread attention to pastoral counseling is warranted.

Students' overall perception of professional counselors as being effective is heartening. Particularly welcoming is that only 3% viewed counselors negatively. Social psychology research (Myers, 1994) has shown that a few negative, public incidences can have overshadowing effects on a group's overall positive characteristics. Fortunately for professional counselors, whatever data might feed negative overall impressions seems to be relatively dormant for students in the present sample.

A general continuum emerged vis-a-vis students' perceptions of what types of issues are most germane for professional counselors to address. Namely, high responses were provided for general, developmental life issues such as academic problems, depression and career counseling. Moderate responses were provided for problems where direct brain-behavior connections are involved such as ADHD or drug counseling. The lowest responses were provided for types of situations where assessment is warranted, such as personality or intellectual assessment and mental health evaluations. These findings are consistent with overall perceptions that students do not think of counselors in terms of being clinical mental health professionals, but rather as more generic, trained counselors. If the field wishes to advance itself toward the direction of diagnosis, assessment, and treating psychopathology, then data from the present survey would suggest that efforts should be redoubled.

Not all media sources appear to be equal in influencing students' perceptions of professional counselors. For example, newspapers (13%), magazines (20%), and the Internet (24%) were relatively inconsequential when compared to movies (63%), books (49%) and television (44%). Unfortunately for professional counseling organizations, the most potentially influential sources also happen to be the most expensive ones to target. Nonetheless, if organizations such as the American Counseling Association (ACA), American Mental Health Counselors Association (AMCHA), and the National Board for Certified Counselors (NBCC) are going to impact students' thinking, then they should target the most efficacious sources. It could be, of course, that the reason newspapers, magazines and the Internet were so relatively non-influential is that few inroads have been attempted in these domains. Advertising in university newspapers, posting and promoting user-friendly web sites, and generating informative articles in popular magazines simply may be an important need for professional counseling advocacy at this time.

In a separate study under development, using qualitative methodology, we are attempting to better flesh-out some of the details relating to these sources of impact on students' perceptions of professional counselors, particularly the concept of "common knowledge." Although not surveyed in this study, an influential source proved to be word-of-mouth in perception formations regarding counseling. That is, influences of school, friends, personal experience, physicians, and HSPs most likely have some type of personal connections tied to the medium. Evidently, there is some truth to the adage that word-of-mouth is the best means of advertising—assuming, of course, that the messages being relayed are positive.

In the perceived counselor qualities portion of the survey, it was somewhat disheartening that comparatively few (22%) students indicated they saw professional counselors as competent to diagnose and treat mental disorders. This finding was consistent with other data throughout the survey. Namely, students generally view counselors as professionals who address relatively normal, human development issues rather than psychopathology or more severe disorders requiring assessment, diagnosis and treatment. Again, if the counseling profession wishes to move in the latter direction, then findings from the present research suggest that there is some distance to go. Early acquired school counselor perceptions tended to initiate students' mindsets regarding what counselors do and they seem not to have moved far from those early perceptions.

In summary, we believe that the present study is a strong first step in a line of needed research regarding just how people come to understand counselors. The findings here do not dictate any action on behalf of professional counseling organizations. However, we believe that the findings indicate in which directions the winds of student perceptions are blowing—and that is data which should be considered when making policy decisions. If counselors are going to move to new, future levels of excellence in terms of public perception, then paying attention to this type of data and giving it due consideration is an important initial component.

Limitations and Future Research

All good research studies report limitations (Murnan & Price, 2004) and we indicate four of them here. First, while our sample had several strengths, including adequate size (Patten, 1998), high response rate (Stoop, 2004), and lack of

incentives/bribes for participation (Storms & Loosveldt, 2004), it was taken from a single locale. Some compensation exists, such as students coming from 34 states and the relatively broad cross-section of college majors represented. However, future research in this domain should assess students from a wider variety of institutions such as research universities, state universities, and liberal arts colleges—as well as from diverse locales in the country in order to enhance the study's external validity (Cohen & Wenner, 2006).

Second, our study had relatively low representation from minority students. This simply was an artifact of the university where the data was collected. Specifically, minorities comprised only 6% of the student body population. Further research should contain samples with larger representations of minority individuals. Additionally, replicating this present study with all minority students would provide an interesting comparison among many points of investigation.

Third, some of the items queried were selected a priori. While we believe them to be of interest and germane to our purposes, future research should broaden questionnaires to include questions that are derived empirically from the research literature. Also, organizations such as the Council for Accreditation of Counseling and Related Educational Programs should provide input vis-a-vis questions that directly would enhance their efforts in counselor education preparation. The same is true with potential input from NBCC and ACA as they market professional counselors to the general population as well as college students.

Fourth, in retrospect there are two particular changes we would have made to the survey instrument. One is that we would have added a Likert-scale to the first question, querying the perceived overall effectiveness of counselors. While we believe that rating professional counselors with three choices was useful—and we would keep the question—we also would recommend future researchers add a Likert-scale question that is anchored with descriptions, but to which numeric interval-scale values could be assessed. Second, looking back on our questionnaire, we would have asked how many students saw more than one HSP. That is, did they use more than one type of human service professional's services (e.g., they saw both a rehabilitation counselor and a school counselor). Accounting for multiple uses within the same clientele could provide potentially useful data.

Future research should take the present study and apply it to the population in general. That is, we produced what we believe to be fairly apt representations of perceptions among students—but they do not represent the population at large. Obviously, college students have unique features of adult development that are not necessarily shared by older adults (Foos & Clark, 2003). The very low reported influence that health insurance companies have on college students' perceptions is one of many examples of where student ideations and those of more middle-aged adults might differ.

And finally, qualitative research is needed in this area. A prime value of questionnaires, such as the present one, is that more voluminous amounts of data can be collected—providing breadth of understanding (Gall & Borg, 2003). Such research also tends to answer "how many" or "what" types of questions (Hittleman & Simon, 2003). Thicker descriptions are needed to help flesh-out some of the details on which survey research was only able to skim. Answers to some of the "why" and "how" questions that the present findings raise can best be answered with follow-up qualitative research methodology (Flick, 2002).

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nbcc

The Symbiotic Relationships of the Counseling Profession's Accrediting Body, American Counseling Association, Flagship Journal and National Certification Agency

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To inform and guide their practices, counselor educators would benefit from having a clearer picture of how the research literature and professional standards of the field correspond and contrast. To elucidate this relationship, researchers analyzed 538 Journal of Counseling and Development articles published from 1997–2006 for fit with the 2001 and 2009 eight core areas of Council for Accreditation of Counseling and Related Educational Programs (CACREP). The articles fell into three tiers delineated by year and based on the number of articles assigned to each core area. Human Growth and Development and Helping Relationships are the two core areas most frequently represented across the 10 year time span examined.

Keywords: professional standards, research literature, CACREP, NBCC, ACA, Human growth and development, helping relationships

There is an inherent symbiotic relationship that exists among related professional organizations. Within the counseling profession, there are a number of organizations or entities that coexist, support one another, encourage and challenge one another, disseminate information, and act as gatekeepers. These major counseling entities include the American Counseling Association (ACA), the National Board of Certified Counselors (NBCC), the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the *Journal of Counseling and Development* (*JCD*). These entities mutually influence each other by acting and reacting to needs, changes and research findings within the counseling profession.

Given the new CACREP 2009 standards, it is now time for counselor educators to review and possibly revamp their training programs to better reflect the current issues faced by those in the counseling field. Counselor educators will benefit from having a clearer picture of how our research literature and professional standards correspond and contrast to inform and guide our practices.

As the respective flagship journal and primary accrediting standards of the counseling field, the *JCD* and the CACREP standards are predominant guiding resources that reflect, communicate, and shape the values, interests, and work of counselor educators. As *JCD* is the journal for ACA, and as the National Counselor Examination is based on CACREP requirements, an obvious extension to include these entities occurs as well. These entities also influence each other. *JCD* and CACREP can be seen as leaders of an input loop in the counseling profession. *JCD*, as the flagship journal for the American Counseling Association (ACA), shapes counselors', stakeholders' and counselor educators' views of the counseling field. Continuing the loop, every seven years CACREP engages in a review of its standards for counseling programs. This review includes invitations for input from all counselors and stakeholders (Bobby & Kandor, 1995). As the revised standards are enacted in CACREP and CACREP-modeled programs, the standards influence the education and licensing of counselors, which then influences the work, research, writing, and submissions to *JCD* from the counseling field over time; *JCD* article topics, content, and methodology loop again to inform counseling practitioners, students, and educators.

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While the 2009 CACREP standards revisions are implemented into counseling programs, it seems an important time for counselor educators to reflect on and explore the profession's flagship journal articles in relation to future CACREP standards and to discuss future counseling literature that will shape and inform directions for counselor educators and the counseling field. Calls for a strong professional counselor identity (CACREP, 2009; Gale & Austin, 2003; Goodyear, 1984; Hansen, 2003) and professional unity from a recent ACA President (Canfield, 2007) would also seem to indicate the need to reflect on and gain perspective from the trends and foci of our professional literature. The current study provides an analysis and discussion of the fit of *JCD* articles from 1997–2006 with the eight core areas in both the 2001 and adopted 2009 CACREP standards. We selected this 10-year span because the research project began in late 2007 and 2006 represented the last complete year of *JCD* articles at that time. We hope such an analysis will help illuminate areas for potential change in counselor education programs.

Professional Organizations and Publications in Counseling

American Counseling Association

With its roots as far back as 1952, ACA is the world's largest association focused exclusively on representing professional counselors. As reflected on their website, "The ACA is dedicated to the growth and development of the counseling profession and those who are served" (ACA, 2010). Its mission is to enhance the quality of life in society and promote the development of professional counselors, advance the counseling profession, and use the profession and practice of counseling to promote respect for human dignity and diversity (ACA). ACA has 56 chartered branches in the U.S., Latin America and Europe and currently boasts 42,594 members. To communicate to its membership and inform the profession of contemporary issues and treatment modalities, ACA publishes an online website, numerous textbooks, Counseling Today (its monthly magazine) and *JCD* (its official journal).

Journal of Counseling and Development

In addition to being ACA's primary journal, *JCD* appears to have grown to a significant readership, and this is particularly interesting considering that at least two-thirds of ACA members receive *JCD* as their only ACA journal. According to ACA (personal communication, Rae Ann Sites, December 20, 2007), the *JCD* Winter 2008 issue had a total print run circulation of 43,500 journals. Approximately 1,000 of these subscribers are institutional subscribers (i.e., college/university libraries). Therefore, it seems logical to assume the majority of subscribers are individual ACA members.

Members also have the option to join one or more of 17 divisions within ACA and many of these divisions publish their own journals. As of December 20, 2007, the cumulative membership in these 17 divisions was 16,279. At most, division membership could represent 37% of ACA members, but it is important to note that some ACA members join multiple divisions, thus exaggerating the 37% figure. Following ACA's 1997 decision to allow ACA membership exclusive of a division membership and the 2004 decision to permit division separation from ACA, the American Mental Health Counseling Association (AMHCA) and American School Counseling Association (ASCA) announced independence from ACA and are no longer included in these 17 divisions. ACA data available from June 30, 2007, indicate 2,182 (approximately 5%) of ACA members who also were AMHCA members and 2,648 (approximately 6%) who also were ASCA members (personal communication, Jennifer Bauk, December 3, 2007). When compared to the total membership figures of these two professional counseling organizations (AMHCA, 5,860 [personal communication, Mark Hamilton, November 27, 2007]; ASCA, 23,021 [personal communication, Jennifer Bauk, December 3, 2007]), the percentage of AMHCA members who joined ACA was 37% and ASCA members 16%. From these data, it is apparent that *JCD* is circulated to a wide and diverse counselor audience. Therefore, we can assume that many graduates of our training programs will read only *JCD* as their professional journal to inform them of current issues and important research.

Council for Accreditation of Counseling and Related Educational Programs

CACREP has evolved to be a significant influence on the counseling field. A brief recap highlights CACREP's growing influence. Bobby and Kandor (1992) reported that 44 programs housed within 16 institutions were granted approval by CACREP's Board of Directors at the Council's first meeting in 1981. In 1992, 195 programs had gained accreditation (Bobby & Kandor); and in 2004, that number had risen to 434 (McGlothlin & Davis, 2004). Currently, CACREP has accredited 505 programs housed within 210 institutions across 48 states, the District of Columbia, and Canada. In addition,

117 programs are currently being considered for CACREP accreditation. This is evidence of CACREP becoming more wide spread and ingrained within the counseling profession (CACREP, 2007).

National Board for Certified Counselors

Developed in 1982, NBCC conducts a national certification program for professional counselors; it is one of two leading certification organizations for the counseling profession, the other being the Commission on Rehabilitation Counselor Certification (CRCC). Although initially created by ACA, NBCC operates as an independent body without direct connection to ACA. Currently, over 46,000 counselors hold the National Certified Counselor (NCC) credential (NBCC, n. d.). In 41 states (82%), NBCC's National Counselor Examination (NCE) is used as part of the licensure process.

The NCE contains eight content and five work behavior areas. The eight content areas mirror those in CACREP's core curriculum and include human growth and development, social and cultural foundations, helping relationships, group work, career and lifestyle development, appraisal, research and program evaluation, and professional orientation and ethics. The five work behavior areas include fundamentals of counseling, assessment and career, group, programmatic and clinical intervention, and professional practice (NBCC, n. d.). Given this consistent overlap in core components and the growing use of the NCE for state licensure requirements, it is apparent that NBCC, ACA, *JCD*, and CACREP are linked in their view of what effective counselors need to know.

Support for Professional Organizations in Counseling

CACREP, *JCD* and NBCC have been the focus of several empirical studies. Over the past 10 years, researchers have examined issues pertaining to CACREP standards including supervision (LaFountain & Baer, 1999), spirituality and religion (Burke, Hackney, Hudson, Maranti, Watts, & Epp, 1999), community counseling (Hershenson & Berger, 1999), and school counseling (Holcomb-McCoy, Bryan, & Rahill, 2002). Haight (1992) investigated the CACREP standards, focusing on the quality of the standards. In addition, researchers have explored CACREP standards' relevance to counselor preparation (Vacc, 1992) and their perceived benefit for practitioners (McGlothlin & Davis, 2004). Although some researchers have challenged the standards, most reviews and discussions related to CACREP have been favorable (Schmidt, 1999).

Vacc (1992) investigated counselor educator perceptions of the 1988 standards relevance to the preparation of counselors. He found that respondents judged each of the eight CACREP core areas as crucial or important to counselor preparation. Percentages of perceived importance ranged from 91% to 100%, with Social and Cultural Competence perceived as least relevant and Group Development, Dynamics, and Counseling Theories perceived as most relevant. Based on these findings, Vacc concluded that the data provided evidence to support the validity of the standards.

McGlothlin and Davis (2004) investigated perceived benefits of the CACREP standards. They surveyed counselors to determine perceptions of the benefits of the 2001 core curriculum standards. The core curriculum standards were perceived as being beneficial overall. Ranked in order of perceived benefit (highest to lowest) were: Helping Relationships, Human Growth and Development, Social and Cultural Diversity, Group Work, Professional Identity, Assessment, Career Development, and Research and Program Evaluation. Both studies established credibility for CACREP's eight core standards.

As noted earlier, NBCC provides the examination used for professional licensure in the U.S. (NBCC, n. d.). Support exists for NBCC due to its oversight of the NCE. Adams (2006) compared NBCC National Counselor Exam scores across CACREP and non-accredited programs. She found that graduates of CACREP-accredited programs scored significantly higher than those from non-accredited programs. Pistole and Roberts (2002) encourage licensure as a primary way to secure professional identity. Similarly, Calley and Hawley (2008) identified professional certification and licensure, along with membership in professional organizations such as ACA, as ways counselor educators help promote a professional counseling identity. Support for both NBCC and the NCE is evident and furthers counselor professional identity.

JCD publications can be seen as shaped by a number of forces and as evolving over time. For example, Weinrach (1987) argued that *JCD* had been fashioned by contributors' articles and editors' aims. Twelve years later Williams and Buboltz (1999) asserted that *JCD* publications were influenced by changes within society, evolving counselor and student needs, the

teaching aims of professors, and most importantly by the research and practical topics that are popular during a historical period.

The content analysis by Williams and Buboltz (1999) of volumes 67–74 most closely resembles the aims of the current study. Their article analysis covered a nine-year span and cross-classified articles into 11 categories (e.g., Counselor Selection, Training and Evaluation, Personal Development and Adjustment, Technology and Media, and Special Groups) and sub-grouped articles by editorship. The purpose of their study was to identify possible topic changes and trends over time and *JCD* editors. Overall ranking of topics pertinent to the 8 core areas identified by CACREP included Individual, Group Counseling, and Consultation ranked first, Special Groups third, Vocational Development and Adjustment/ Career Counseling seventh, and Technology and Media tenth.

In this study, ACA is assumed to be represented by its flagship journal, *JCD*, while NBCC is represented by CACREP, as the NCE is based on CACREP accreditation standards. To date, no study has analyzed *JCD* article content by CACREP core areas. In addition, no study could be found that focused on the similarities and differences between what is required for appropriate training and licensure of counselors and what is represented in the flagship journal of the counseling profession. Therefore, the purpose of the current study is to provide that analysis and discussion for the consideration of counselor educators and the counseling field.

Method

Procedure

Using first the 2001 standards and later the 2009 revisions, two researchers used a qualitative content analysis method to sort articles into the eight CACREP core areas. The eight CACREP core areas included Professional Orientation and Ethical Practice; Social and Cultural Diversity; Human Growth and Development; Career Development; Helping Relationships; Group Work; Assessment; and Research and Program Evaluation. Researchers independently analyzed content by sorting articles by CACREP core area. As per classic content analysis procedures described by Ryan and Bernard (2000), researchers assumed that the eight 2001 CACREP core curricular experience areas were the pre-defined codes of interest. Because of the time span from which articles were analyzed (i.e., 1997–2006), the researchers determined that both an analysis of the 2001 and 2009 standards was appropriate given that the 2001 standards were adopted during this time period and analysis of the 2009 standards would provide insight as to how previous articles would fit into the future standards.

First, researchers independently analyzed the *JCD* articles using the 2001 standards. After independent analysis, the two researchers compared findings, identified matching results and noted findings on which they differed. A list was established identifying the articles on which the two researchers disagreed. The same two researchers independently reanalyzed these articles and then met to compare findings again. No comparisons were made between the first and second attempts in order to maintain the independence of the second analysis. After this second attempt, the researchers obtained a cross-rater reliability of .93 for the 2001 data. Of the remaining articles for which coding differed, 20 differed in coding for CACREP core area. These articles were equally distributed throughout the 10 years of *JCD* being analyzed and were not representative of a single time period or editor. These remaining articles were coded by a third researcher, once again independent of the first two analyses. The three coders then reviewed each article together and, through consensus, determined the best placement for each.

After completing analysis using the 2001 CACREP standards, the two researchers addressed the data using the 2009 CACREP standards. The researchers noted that the eight core CACREP area titles remained constant between 2001 and 2009. However, differences between the 2001 and 2009 standards included changes within the eight core areas. Changes typically included additions of specific counseling related practices into core areas. Within the Professional Orientation and Ethical Practice core, additions were made related to crisis management and counselor self-care. Under Social Cultural Diversity, counselor self-awareness, social justice, and cultural skill development were added. In the Human Growth and Development core, additions included the effects of crises on individuals and theories of resiliency. The Career Development core remained relatively unchanged. Helping Relationships added crisis response and wellness orientation. Group Work and Assessment core areas remained substantively unchanged while Research and Program Evaluation incorporated evaluative measures and ethics related to research (CACREP, 2009). One overall change appeared to be that culturally inclusive language was more represented across most of the core areas. With these changes in mind, the two

researchers independently re-reviewed titles and abstracts of all articles for 2009 CACREP core area best fit.

Analysis

The total number of articles in the *JCD* 1997–2006 issues was 538, excluding minutes from ethics committees and calls for editorial board members. Researchers examined 479 out of the 538 possible articles. Fifty-nine articles (11%) were eliminated from coding including interviews of well-known counselors and reviews of other articles (typically found in the *Trends* section). These articles did not fit into the predetermined coding categories. In all cases, an attempt was made to select only one option per area. Coding was based on the core area which was most representative of describing the article. For the 2001 Standards, approximately 7% of the cases (35 of 479 articles), were impossible to fit into only one area, so two areas were selected for coding. Three additional articles needed two areas after being reanalyzed with the 2009 Standards. For example, some articles were equally about a client issue and how counselors could effectively address the issue. These articles were coded as representative of both the Human Growth and Development and Helping Relationships core areas. In the two cases that no CACREP core area was found to match the article, an 'Other' category was selected. This category was used only when both researchers found it impossible to connect the article to a CACREP area.

When analyzing *JCD* articles using the 2009 CACREP core areas, researchers identified 97 articles that required reanalysis. These 97 articles were fully analyzed again. Fifty-nine of the 97 articles remained unchanged from the original assigned coding. Three articles were changed from representing two core areas to just one core area. Six articles were changed from representing one core area to two core areas (included originally coded CACREP core area plus one additional CACREP core area). Twenty-nine articles were recoded to a new core area.

Results

Due to the fact that only 29 (6%) of the 479 articles differed across core areas coding from the 2001 to 2009 CACREP standards, and because the proportional ranks remain the same, researchers are providing the 2009 CACREP Standards results, as 2009 is the current standard. CACREP core area results are presented in Table 1. The core area with the most articles was Human Growth and Development, followed by Helping Relationships and Social and Cultural Diversity. Group Work, Research and Program Evaluation, and Career Development were the least represented core areas. Thirty-eight of the articles were coded in two core areas, and all of the core areas were represented at least twice in a two-coded article. Seventeen of the two-coded articles involved Social and Cultural Diversity, 15 involved Helping Relationships, and 14 involved Human Growth and Development.

Table 1

Results by CACREP Core Areas in 2009 Standards

CACREP Core Areas	Frequency	Percentage
Human Growth and Development	136	26.3%
Helping Relationships	121	23.4%
Social and Cultural Diversity	102	19.7%
Professional Orientation	69	13.3%
Assessment	29	5.6%
Career Development	28	5.4%
Research and Program Evaluation	21	4.1%
Group Work	9	1.7%
Other	2	1.0%

Note. Total exceeds 479 due to two coding selections for 38 articles.

Rankings of core areas by percentage of articles tended to be stable throughout the 10-year focus period of this study. Human Growth and Development and Helping Relationships had the top two highest percentages of articles in the 10-year average and maintained consistently high percentages across the years, having been the first or second largest article category each year, except one. Within our analysis, these core areas formed the highest tier. Social and Cultural Diversity and Professional Orientation had the third and fourth highest percentages of articles and were ranked third or fourth each year (except one year for Professional Orientation and two years for Social and Cultural Diversity, affected by a special issue focused on that topic in 1999). Within our analysis, these core areas formed the middle tier. Assessment, Career Development, Research and Program Evaluation, and Group Work consistently varied from fourth to eighth in article percentages and formed the lowest tier of the rankings. These core areas not only occupied the lowest tier, but the percentages of articles representing them were noticeably lower than those representing the four leading core areas.

Table 2

Results by CACREP Core Areas by Years 1997–2001 and 2002–2006

CACREP Area	1997	1998	1999	2000	2001
Years 1997–2001					
Human Growth and Development	13 (46.4%)	10 (21.3%)	8 (12.3%)	18 (34.6%)	15 (30.3%)
Helping Relationships	8 (28.6%)	13 (27.7%)	12 (18.5%)	6 (11%)	12 (24.0%)
Social and Cultural Diversity	2 (7.1%)	8 (17.0%)	30 (46.2%)	10 (19.2%)	6 (12.0%)
Professional Orientation	5 (17.9%)	8 (17.0%)	10 (15.4%)	9 (17.3%)	9 (16.0%)
Assessment	2 (7.1%)	3 (6.4%)	4 (6.2%)	7 (13.5%)	3 (6.0%)
Career Development	0	4 (8.5%)	4 (6.2%)	4 (7.7%)	2 (4.0%)
Research and Program Evaluation	2 (7.1%)	2 (4.3%)	0	1 (1.9%)	5 (10.0%)
Group Work	0	3 (6.4%)	1 (1.5%)	0	1 (2.0%)
Other	0	1 (2.1%)	1 (1.5%)	0	0
Total Articles per Year	28	47	65[a]	52	50

CACREP Area	2002	2003	2004	2005	2006
Years 2002–2006					
Human Growth and Development	11 (21.6%)	15 (32.1%)	18 (37.5%)	13 (27.1%)	15 (34.1%)
Helping Relationships	16 (31.4%)	12 (26.1%)	14 (29.2%)	13 (27.1%)	15 (34.1%)
Social and Cultural Diversity	7 (13.7%)	11 (23.9%)	5 (10.4%)	17 (35.4%)	6 (13.6%)
Professional Orientation	7 (13.7%)	5 (10.9%)	6 (12.5%)	7 (14.6%)	4 (9.1%)
Assessment	4 (7.8%)	0	4 (8.3%)	0	2 (4.5%)
Career Development	5 (9.8%)	6 (13.0%)	1 (2.1%)	1 (2.1%)	1 (2.3%)
Research and Program Evaluation	1 (2.0%)	1 (2.2%)	3 (6.3%)	4 (8.3%)	2 (4.5%)
Group Work	3 (5.9%)	1 (2.2%)	0	0	0
Other	0	0	0	0	0
Total Articles per Year	51	46	48	48	44

Note. Numbers may exceed total articles due to two coding selections for some articles.
a = includes special issue on personal stories related to multiculturalism.

Results by CACREP Core Areas across the ten year span are presented in Table 2. Over the 10-year period, most CACREP core areas are equivalently represented with minor fluctuations between years. Human Growth and Development and Helping Relationships are the two core areas most frequently represented and are reasonably consistent in percentage of articles representation from year to year across the 10 years. Human Growth and Development core area articles ranged in frequency from 8 to 19 across the years with a mean of 13.6 articles per year. Helping Relationships articles ranged from 6 to 16 with a mean of 12.1 articles published per year. Professional Orientation is the most consistent core area from year to year (range of 4 to 9 articles) with a moderate number (mean = 6.7) of articles published per year. Social and Cultural Diversity fluctuates substantially from year to year with a low of 2 articles published in 1997, a high of 30 articles in 1999 and a mean of 10.2 for all ten years. Assessment articles are relatively steady from year to year, yet low in number with a range from 0 to 7 articles each year and a mean of 2.9 articles per year. Research and Program Evaluation is similar to Assessment in low but steady frequency across the years with a range from 0 to 5 articles and a mean of 2.1 per year. Notably, Research and Program Evaluation articles increased slightly in the latter five years. Career Development is low in frequency, but less steady across the years with a range from 0 to 6 and mean of 2.8 articles per year. Notably, only 3 articles were published in this core area in the last three years of this study (i.e., 2004–2006), one article each year. Lastly, Group Work article frequency ranged from 0 to 3 and the lowest average frequency at .9 per year. In the last three years no articles were published in the Group Work core area.

Discussion

Having established the symbiotic relationship between four central counselor entities (i.e., CACREP, ACA, NBCC and *JCD*), the researchers focused their review on the overlap between the required CACREP training core and the topics represented in the counseling profession's flagship journal, *JCD*. We were primarily interested in relating the content of articles from 1997–2006 to the eight CACREP core areas. When we began our study, we made the assumption that *JCD* and CACREP served as informative tools for its members and that CACREP standards were an appropriate measure of adequate counselor training. *JCD* purports "to publish articles that inform practicing professional counselors with diverse populations in a variety of settings and that address issues related to counselor education and supervision, as represented by the membership of the American Counseling Association" (*JCD*, n.d.). Whereas many specialty journals highlight one specific aspect or one core area, *JCD* attempts to provide relevant information that cuts across all CACREP core areas. Additionally, CACREP reports being "dedicated to (1) encouraging and promoting the continuing development and improvement of preparation programs, and (2) preparing counseling and related professionals to provide service consistent with the ideal of optimal human development" (CACREP, n.d.). In the counseling flagship journal and accrediting body, a goal exists to prepare, train, and provide counselors with information necessary to good clinical practice. As stated earlier, *JCD* is the journal representing ACA, and NBCC bases the NCE on current CACREP standards.

The results highlight an overlap between the missions and goals of *JCD* and CACREP with a weighted emphasis in key CACREP core areas. Results in Table 1 indicate that almost 70% of the articles published during this time period fall under three CACREP areas: Human Growth and Development, Helping Relationships, and Social and Cultural Diversity. It seems sensible and fitting to us that *JCD* articles would emphasize these areas. Remley and Herlihy (2007) stated that one of the essential beliefs in the counseling profession is that problems individuals face in life are developmental in nature. *JCD*'s emphasis on Human Growth and Development aligns with CACREP's view that counseling helps clients work toward optimal human development. Additionally, the focus on Helping Relationships in *JCD* seems appropriate given the preponderance of research and literature across time that support relationship variables as most important in predicting outcome in counseling (e.g., Bergin & Lambert, 1978; Cochran & Cochran, 2006, Krumboltz, Becker-Haver, & Burnett, 1979; Lambert & Okiishi; 1997; Lubersky et al.,1986; Norcross, 2002; & Wampold, 2001). Finally, the 2009 CACREP standards support both a broad definition of Social and Cultural Diversity as a core area and the more specific recommendation of incorporating this concept into every course. This change relates to the current belief that cultural issues are not separate from other aspects of counseling, but rather integrated into all counseling activities.

Results indicated subtle yet notable shifts in the literature focus from those in previous research studies. For example, when Vacc (1992) investigated counselor educator perceptions of the CACREP standards relevance to the preparation of counselors, he found Social and Cultural Competence perceived as least relevant while results of the current study indicate Social and Cultural Diversity as in the middle tier of topic occurrence in *JCD* from 1996–2007. This seems to reflect the increased emphasis given to Social and Cultural Diversity within the counseling field in the last 20 years. Additionally, Vacc found Group Development and Dynamics was perceived as one of the core areas considered most relevant by

counselor educators. The current study indicates that *JCD* articles focused on Group Work ranked in the lowest tier of frequency of occurrence. This could indicate a shift in importance over time or incongruence between counselor educator perceived importance and the number of *JCD* articles published in core areas. Finally, whereas group counseling and vocational development were covered extensively in *JCD* in the mid-1980s and early 1990s (William & Buboltz, 1999), our findings demonstrated considerably less focus on these areas over the last 10 years. Clearly, some important shifts in the literature have occurred over the past 25 years.

We find it important to also note the match between the ranked frequencies of *JCD* articles within the CACREP core areas and the results of McGlothlin and Davis' (2004) study of the core areas perceived benefits. McGlothlin and Davis' survey results ranked counselors' perceptions of the importance of the core areas in nearly the exact rank of article frequency in *JCD* by core area. This suggests an overall match between publication patterns of *JCD* and the valuing of CACREP core areas among counselors.

Implications for Counselor Educators and Practitioners

It is clear that the articles published in *JCD* follow many of the trends suggested by CACREP as training requirements for counselors. If, however, as the earlier statistics suggest, *JCD* is the only professional journal received by the majority of ACA members, it is important for practitioners to recognize that they may not regularly be receiving as much ongoing information in these core areas compared to others, especially if they are only receiving *JCD*. Career development is viewed as a central factor in the lives of most people (Betz & Corning, 1993). For counselors working with children and adolescents, career development is influenced by a multitude of factors, including perceived barriers and supports (Kenny, Blustein, Chaves, Grossman, & Gallagher, 2003), family background (Eccles, Vida, & Barber, 2004), and self-efficacy beliefs (Pinquart, Juang, & Silbereisen, 2003). In adults, career-related concerns are linked with traumatic experiences (Strauser, Lustig, Cogdal, & Uruk, 2006), relationship problems (Risch, Riley, & Lawler, 2003), and overall stress (Pinquart et al.). Clearly, most counselors will encounter a need to discuss career-related issues with their clients, yet findings suggest that counselors may not receive a robust and ongoing supply of contemporary theoretical or research-based treatment approaches on this topic in *JCD*.

In addition, many counselors have the opportunity to facilitate groups as a part of their work. Vacc's (1992) finding that counselor educators perceived Group Development and Dynamics as one of the most relevant core areas to the preparation of counselors and McGlothlin and Davis' (2004) finding that Group Work ranked fourth in perceived benefit of the CACREP standards suggests that Group Work may be of importance to current working counselors, even though it is not well represented in *JCD*. Continuing education through professional journals can be a way to keep counselors-in-training, practicing counselors, supervisors and counselor educators abreast of new research and ideas regarding career and groups. Counselor educators, as well as clinical supervisors and counseling practitioners, would benefit by realizing that supplemental journals are needed to ensure adequate information on group dynamics is reaching their students and supervisee's or informing their counseling practice.

Research and Program Evaluation and Assessment also received less representation in *JCD*. Counselors-in-training often struggle with these subjects or report disliking the bland content of these courses (Stockton & Toth, 1997). In fact, Bauman (2004) surveyed school counselors and found only 49% agreed or strongly agreed that they felt prepared to critique research, and only 43% agreed or strongly agreed that they had the skills needed to complete a research project on their own. Currently, a call in the profession exists promoting practitioners to conduct research in the field (Kaffenberger, 2009; Niles, 2003; Whiston, 1996), but with these feelings about research and assessment, it is unlikely that many will do so. Practitioners need to look beyond *JCD* for professional development on becoming competent and self-assured researchers. Knowing that a single journal is not the best option for gaining research self-efficacy might push practitioners to seek help elsewhere, rather than simply continuing on without furthering their knowledge.

Counselor educators and students can benefit in general from the findings of this study. For example, when conducting literature reviews or submitting research manuscripts for review, results provide guidance as to which counseling-related topics are more frequently or less frequently addressed in *JCD*. Results help to inform counselor educators when to best use and recommend *JCD* as an initial resource or different journal when they or their students are investigating specific topics within CACREP core areas. Additionally, one could argue that results suggest a reason to join multiple professional counseling organizations such as ASCA or AMHCA, or join the smaller sub-interest groups (e.g., National Career

Development Association and Association of Specialists in Group Work) when first joining ACA or renewing their ACA membership. Overall, having more information available on major sources of training and continuing education can only assist practitioners and educators in their roles.

Implications for Future Research

Although this study provides an analysis of *JCD* articles over a 10-year period, with CACREP guidelines, additional research in this area is needed. Several ideas for future research foci are provided as preliminary courses of action. Researchers could help to identify students', counselor educators' and working counselors' perceptions as to the importance of some of the lesser represented areas, such as Career and Group. Additionally, perceptions from these same constituents on how *JCD*, ACA, NBCC, and/or CACREP shape their views of the counseling field seems to be worthy of investigation. More research focused on specific CACREP areas and articles from other journals (e.g., the types of articles that represent each CACREP area and the impact on continuing education and training of future counselors) would further illuminate the relationship between the accrediting body and the counseling journals in general. Regardless of the exact focus of future research, it is clear that there is a link between the counseling accrediting body and the flagship journal. Further research is needed into how *JCD* and other counseling journals, along with CACREP and NBCC, may have or will influence each other over time.

Conclusion

It is our hope that the findings of the present study will be included in the perpetual input loop linking ACA, NBCC, *JCD*, CACREP and the counseling profession. With CACREP's 2009 accreditation standards being implemented, we believe now is a good time for the counseling profession to re-examine the roles of the major counseling entities' relationships to each other. Continuing this discussion, especially focusing on CACREP and ACA, may help strengthen the unity of our profession and further cement our identity as professional counselors.

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