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Exploring Social Sexual Scripts Related to Oral Sex: A Profile of College Student Perceptions

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Despite growing attention to the subject, a dearth of information exists regarding college students' perceptions and process of meaning-making related to the act of oral sex. Such perspectives and allied social sexual scripts can have considerable consequences on the sexuality and sexual health of older teens and college-aged populations. The present research serves to elucidate such perspectives and presents a profile of college students' degree of agreeing that oral sex is not sex. Over half (62.1%) of a sample of college students (N = 781) at a large southeastern university agreed that oral sex is not sex. Response rates across demographic groups are presented and factors that influence such perspectives are examined. Sexual script theory serves as the theoretical framework. Implications and limitations are explored.

Keywords: oral sex, social sexual scripts, college students, script theory, sexuality, sex counseling

Television talk show hosts, *The Washington Post* (Stepp, 2005) and *Science Daily* (University of California, San Francisco, 2005) have all had recent headlines related to oral sex in the older teen and college-aged populations. Because of these and other popular media sources, sex educators, parents and others have become more aware of oral sex engagement among college students and more concerned about the impacts of this engagement. Although society members are becoming concerned about this topic, limited information regarding college students' perceptions and process of meaning-making related to the act of oral sex is available in the literature. To develop sexuality education curriculum and resources targeted at young people engaging in oral sex, professionals must first identify those most likely to engage in oral sex, their process of meaning-making around this engagement and risks young people are exposed to as a function of their engagement in oral sex.

In an effort to provide insight into this population's process of meaning-making related to engagement in oral sex and initial information about characteristics of college students likely to engage in oral sex, this article presents the findings of a survey conducted at a large southeastern university. An initial profile of undergraduates who agreed with the statement "Oral Sex is Not Sex" is offered and findings are analyzed through the lens of social sexual script theory to explore the process of meaning-making related to the perceptions of participants regarding oral sex. We hope this information will assist sex educators, counselors, health professionals and parents in efforts to target individuals likely to engage in oral sex to minimize risks related to oral sex in the college student population. Thus, the purpose of this study was to provide a profile of undergraduates who agreed with the assertion that *oral sex is not sex* and to explore the links between participant responses and sexual scripts to illuminate fully how these participants perceived oral sex engagement. This profile is important because recent research suggests that young people perceive oral sex as safe, with few potential health risks (Halpern-Felsher, Cornell, Kropp, & Tschann, 2005). However, engaging in oral sex may expose individuals to the risk of viral and bacterial infections, including chlamydia, gonorrhea and herpes (Edwards & Carne, 1998a, 1998b). Consequently, it is critical that counselors fully understand the context and perceptions of college students in order to provide information to assist with healthy decision-making in developmentally-appropriate ways for these clients.

Theoretical Foundation

Sexual script theory situates perceptions of sexual interactions within the social context to explain how sexual identity and sexuality are shaped by social cultural messages (Frith & Kitzinger, 2001). Consequently, what is perceived to be "real" sex is defined by the society within which one exists, individual identity and socio-cultural normative sexual scripts. Sexual scripts vary across individuals, but often common elements exist within sexual scripts associated with particular cultural groups (Wiederman, 2005). As a social constructionist approach to exploring the development of sexuality, sexual script theory has been primarily used as a qualitative method of research (Simon & Gagnon, 2003). However, recent

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research has applied sexual script theory in quantitative research exploring the impact of exposure to sexually explicit material on young people (Stulhofer, Busko, & Landripet, 2010). For the study presented in this article, results were found using quantitative methods and then a qualitative exploration of themes that emerged from the quantitative data yielded links to sexual scripts postulated by sexual script theory.

Sexual Scripts and Heterocentric Standards

One sexual script prevalent in Western cultures, the *traditional sexual script* (Rostosky & Travis, 2000), serves to situate sexual intercourse between heterosexuals as *real sex*. This sexual script serves to disenfranchise sexual minorities by failing to recognize the full spectrum of sexual acts occurring between persons of any gender and the meanings attributed to these acts. Furthermore, not only is sex limited to heterosexual intercourse, but the concept fundamentally depends on male ejaculation since it is the male orgasm that denotes both the number of times a couple has sex and is the culmination (the climax) of sex (Frye, 1990). This phallocentric approach with regard to the concept of sex limits the power of women to be equal partners in a heterosexual relationship (Bhattacharyya, 2002). Consequently, these heterocentric standards for what qualifies as *sex* means that lesbians do not have *real* sex since lesbian sex does not involve penile penetration.

Within this sexual value system, vaginal-penile penetration/intercourse is at the apex of what constitutes sex, such that all other non-coital sexual practices/behaviors—such as oral sex—are considered *foreplay* and as a result have not been researched as fully and comprehensively as vaginal-penile penetration/intercourse. Much of sexual research has been situated within Western culture, resulting in the firm entrenchment of the *traditional sexual script* (Rostosky & Travis, 2000) within research methods and processes. This social entrenchment of heteronormative standards impacts the social sexual scripts college-aged individuals hold and apply in their sexual engagement (Bhattacharyya, 2002).

Peer groups have a strong influence on sexual behaviors, particularly among young adults. Peer group shifts in perceptions and values, when it comes to sex and sexual activity, will in turn impact sexual trends and patterns within peer groups. For college students, peer group perceptions powerfully impact individual perceptions and behaviors (Carter & McGoldrick, 1999). Prinstein, Meade, and Cohen (2003) discerned a positive relationship between young people's reports of oral sex engagement and peer popularity. This suggests that peer culture for college students supports oral sex practice.

Peer group perceptions are formed within the context of the larger society and events, media and social issues within the society. One such societal event relevant to this discussion is the Clinton-Lewinsky scandal. At the heart of the scandal is Clinton's famous utterance, "I did not have sexual relations with that woman, Miss Lewinsky" (Clinton, 1998). Whether his perception of oral sex as not real sex is due more to his personal perception based upon the *traditional sexual script* (Rostosky & Travis, 2000) or Clinton's cunning sense of self-preservation will never be known. What is known, however, is that his statement and the subsequent maelstrom of controversy that ensued solidly asserted the question: "Is oral sex really sex?" into the public domain for debate.

Prevalence of Oral Sex Engagement in Young Adult and College-Age Population

In 2002, as part of the National Survey of Family Growth, 10,208 people ages 15–19 were included in the overall sample, and, of these respondents, more than half of males (55%) and females (54%) reported engaging in oral sex (Mosher, Chandra, & Jones, 2005). Richters, de Visser, Rissel, & Smith (2006) analyzed data from the Australian Study of Health and Relationships from a representative sample of 19,307 Australians aged 16 to 59 and found that almost a third (32%) of the respondents reported that oral sex was included in their last sexual encounter. Similarly, in a study of 212 participants ranging in age from 15 to 17, Prinstein, Meade, and Cohen (2003) reported that a third of the males and half of the females had engaged in oral sex in the past year. These studies reveal that many of the college-aged population are engaging in oral sex.

Oral Sex Scripts and Pop Culture

As dialogue about oral sex entered contemporary popular culture, it also became mainstreamed into the young adult vernacular and embedded into the tapestry of social mores and norms. Sexual script theory (Gagnon & Simon, 1973)

emphasizes that social norms play a significant role in governing college students' processes of meaning-making regarding health information and subsequent health and sexual behaviors. This theory holds at its foundation the understanding that sexuality is borne from cultural norms and messages that define what is deemed *sex* and socially-appropriate responses in sexual situations and encounters (Frith & Kitzinger, 2001).

In considering the impact of culturally-laden sexual norms and social sexual messages, one may infer that as oral sex has entered contemporary discourse, the social norms emerging from this discourse have impacted college students' perceptions of and participation in oral sex. Understanding this process of social norm-belief-behavior interaction and possible consequences, including sexually transmitted infections (STIs), is critically important for sex educators, counselors and therapists working with the college-aged population, as these clients have intense levels of interactions with peers attuned to contemporary popular culture.

Young Adults and Sexually Transmitted Infections

Researchers also have found that young people are increasingly experiencing high rates of sexually transmitted infections (STIs) (Prinstein, Meade, & Cohen, 2003). According to the Centers for Disease Control and Prevention (2006), females who are 15–19 years of age reported the highest rates of all other demographic groups for chlamydia and gonorrhea. Of the 19 million STIs reported each year in the U.S., Weinstock, Berman, and Cates (2004) estimated that almost 50% occur in individuals who are 15–24 years of age. From these high rates of STIs in the young adult population, it can be inferred that more education around protection and safe sex engagement is necessary. Recent research has shown that young people also are concerned about the need for safety in sexual engagement and as such have turned to oral sex because they feel it presents fewer health risks (Halpern-Felsher, Cornell, Kropp, & Tschann, 2005). However, oral sex also presents risks of STIs. In a summary of research over more than 35 years regarding oral sex as a possible means of transmitting STIs, Edwards and Carne (1998a, 1998b) noted that oral sex may transmit viral and bacterial infections, including gonorrhea, chlamydia and herpes. Consequently, college students need to be educated about the risks of STI transmission through oral sex to minimize the harmful consequences.

The Need to Explore Perceptions of Oral Sex

In view of the various studies reporting the frequency and consequences of oral sex among young adults and college students, we emphasize the importance of educating this population about safe practices related to oral sex. A first step in this process is to assess the perceptions of this population in regard to oral sex. In short, though the research suggests that this population is engaging in oral sex (Prinstein, Meade, & Cohen, 2003), little is known about how they perceive the act and what meaning they attribute to the behavior in terms of their sense of self and sexual identity development. How do college students perceive oral sex? Do they perceive it to be *real* (i.e., intercourse) sex? How does it shape a young adult's sense of self? Do college students feel that by engaging in oral sex and other non-coital behaviors that they are practicing a form of abstinence, that they are maintaining their virginity? Finding the answers to these questions may assist sex educators, counselors and therapists in developing comprehensive sexuality education programs incorporating resource awareness, prevention and health-focused knowledge for this population (Bay-Cheng, 2003).

In an effort to begin to address these questions and process, this article presents the findings of a study exploring the perceptions and behaviors of college students regarding oral sex. The purpose of the research was to identify a profile of undergraduates who agree with the assertion *oral sex is not sex*. This profile can be used to identify college students who may be more likely to engage in oral sex, allowing clinicians and educators to plan and implement developmentally-appropriate measures in contexts most likely to reach this population. An exploration of the intersection of social norms, utilizing sexual script theory, with characteristics prevalent in the profile that emerged will be discussed, as well as the implications and limitations of the study.

Sexual Script Theory and Perceptions of Oral Sex

By exploring research focused on oral sex engagement, the college-aged population and prevalent social sexual scripts, one may make significant inferences regarding this population's perceptions of oral sex and process of meaning-making related to this sexual act. Again, it is important that the authors note that sexual scripts are based upon individual

experience and social engagement and as such are impacted by the intersecting identity characteristics of individuals. Sexual scripts are reflective of culture and thus some elements will be common to members of the identified cultural group to which the script refers (Geer & Broussard, 1990). However, personal identity is multi-faceted and individuals belong to many different cultural groups by the nature of their race, ethnicity, religion, social class, sexual identity, education status, etc. Consequently, there may be wide variation in sexual scripts across individuals, even within a specific cultural group or sub-group (Wiederman, 2005).

Remaining cognizant of the diversity of sexual scripts across cultural groups, the authors will lead an exploration of selected dominant sexual scripts that may impact college-aged individual's perceptions of and engagement in oral sex in the U.S. This exploration is not intended to be exhaustive; it is simply meant to serve as a foundation for understanding the potential of sexual scripts to impact these individuals' processes of meaning-making related to oral sex. Finally, the authors recognize that sex extends far beyond penile penetration of a vagina. Unfortunately, the majority of research findings gleaned from a comprehensive review of the professional literature promote heteronormative standards by focusing solely on sex as the act of sexual intercourse between individuals of different genders. Consequently, the discussion of current professional research is limited in scope, indicating the need for additional research exploring the full range of sexual activities and sexual scripts impacting young adults and the college student population of any gender and sexuality.

Perception One: Oral Sex is Safe

The current professional literature suggests that young adults and college students articulate diverse reasons for engagement in oral sex. A reason that emerges dominantly from multiple studies is the perception that oral sex is safe with minimal risk and consequence (Halpern-Felsher et al., 2005; Remez, 2000). In a study of ninth-graders in California, participants were unlikely to use barrier protection when engaging in oral sex (Halpern-Felsher et al., 2005), indicating that they felt the practice of oral sex carried minimal risk for STIs. Possibly contributing to adolescent and teen perceptions of oral sex as safe are the sex education programs to which this population is exposed. Data suggest that abstinence-only and faith-based sex education programs do little to educate young adults on the very real and possible dangers associated with oral sex—i.e., the spread of STIs (Lindau, Tetteh, Kasza, & Gilliam, 2008). This lack of information may lead to the perception that because risks related to oral sex are not talked about, it must be safe. Surveys find that most young adults are misinformed, in that they are taught that STI risks are only associated with vaginal-penile intercourse. In sum, we surmise that these sex education programs, shifts in societal perceptions of and sexual scripts related to oral sex, and the use of oral sex as a substitute for intercourse may have a strong effect on the perceptions of the college age population reflecting that oral sex is safe sex.

Perception Two: Oral Sex Mitigates Religiosity and Sex Guilt Tension

Studies have shown strong correlations between degree of religiosity and patterns of sexual behavior. Kinsey, Pomeroy and Martin (1948, 1953) were some of the first to show empirically that religious identification limits sexual behaviors among the unmarried. Schulz, Bohrnstedt, Borgatta, and Evans (1977) also found that religiosity had a significant inhibiting effect on sexual behavior for both men and women. A study conducted by Wulf, Prentice, Hansum, Ferrar, and Spilka (1984) examined the sexual attitudes and behaviors among evangelical Christian singles, and found overall a more conservative outlook in sexual beliefs compared to the cultural norms. Of this group, those that were intrinsically faithful—that is, the more intensely religious who had a strong identification with traditional Christian values—and were not involved in a relationship, displayed the most conservative sexual attitudes. Among the more devout and single, the strongest correlations were found with respect to premarital intercourse and oral sex, in that these individuals were least likely to have engaged in these two activities.

Numerous studies have shown strong relationships between religiosity and sex guilt (Langston, 1973; Mosher & Cross, 1971). Those with conventional religious beliefs are more likely to have sex guilt, which in turn inhibits sexual behavior (Sack, Keller & Hinkle, 1984). Individuals with sex guilt are more absolutist in their orientations to sex and are less sexually active, since transgressing these strict sexual parameters might elicit intense displeasure and an antagonistic relationship with their religious community. By perceiving oral sex as not *real* sex, young adults and college students may be able to mitigate the tension between religious beliefs and sex guilt. For instance, a meta-analysis of studies looking

at sexual attitudes and practices among young adults found that a majority believe oral sex to be less intimate compared to intercourse and that oral sex does not spoil virgin status (Remez, 2000). Many abstinence-only and faith based sex education programs now include a new push for virginity pledges, reinforcing the notion that vaginal intercourse is what is most at stake when it comes to preserving one's virgin status.

Perception Three: Oral Sex Requires Less Commitment

Studies examining sexual attitudes and practices have found that sexual experience seems to be associated with a more liberal orientation to sex. This more liberal orientation to sex has been linked with "hooking up," defined as having sex with someone one has just met (Richey, Knox, & Zusman, 2009). Paul, McManus, and Hayes (2000) examined the hookup culture within a college setting. They found that students high on impulsivity had a more noncommittal orientation with regard to relationships, displayed a high level of autonomy, and were much more likely to engage in both coital and non-coital hookups.

Social scripts are shared interpretations and have three functions: to define situations, name actors, and plot behaviors. For example, the social sexual script operative between two college students who are hooking up is to define the situation (a hookup, not a relationship where they will see each other tomorrow), name the actors (male and female college students out to meet someone for an evening of fun), and plot behaviors (go back to one's dorm room or apartment, *fool around*, and not see each other again.). This hookup process leads to lessened intimacy and expectations for commitment in sexual encounters. Related to oral sex, findings (Halpern-Felsher et al., 2005) show that among teens and the college-aged population, oral sex is used as a substitute for vaginal-penile intercourse and as such may take the place of vaginal-penile intercourse in heterosexual hookup events. This perception of oral sex as less intimate by the college-aged population stands in contrast to perceptions of older adults, particularly older women, who view oral sex as equally intimate (or more so) to vaginal sex (Remez, 2000).

Perception Four: Oral Sex is Not Sex

The authors posit that each of the preceding sexual scripts is subsumed by an over-arching sexual script prevalent within the college-aged population: *oral sex is not sex*. By positioning oral sex as a less risky, less intimate sex practice that allows one to maintain his/her virginity with minimal religion-based sex guilt, the college-aged population may not identify oral sex as real sex. According to Remez (2000), peer culture socializes young adults to perceive oral sex as abstinence, allowing one to maintain and protect one's virginity. Many factors related to contemporary social sexual scripts for oral sex support the assertion that the college-aged population does not identify oral sex as sex, including beliefs that oral sex does not impact their virgin status, is thought to be less dangerous, is less likely to lead to deterioration in the student's reputation, and leads to less guilt than vaginal-penile penetration (Hollander, 2005).

All of the aforementioned sexual scripts contribute to the perceptions of college-aged individuals regarding oral sex. By raising awareness of the social sexual scripts, we hope to illuminate the process of meaning-making college-aged individuals attach to the act of oral sex. Further illumination of specific characteristics aligned with the over-arching social sexual script of *oral sex is not sex* will allow sex educators, counselors and others to target initiatives aimed at reducing risks related to oral sex in a more intentional, focused effort on individuals within the college-aged population who are most vulnerable to those risks.

Method

Sample

The data for this study were taken from a larger nonrandom sample of 781 undergraduates at a large southeastern university who answered a 100-item questionnaire (approved by the Institutional Review Board of the university) on "Sexual Attitudes and Behaviors of College Students." Respondents completed the questionnaire anonymously (the researcher was not in the room when the questionnaire was completed and no identifying information or codes allowed the researcher to know the identity of the respondents). Listwise deletion was used to address issues of missing data and two participants were excluded from statistical calculations due to missing data.

Measures

The measure used to collect data was a 100-item survey developed by Knox and Zussman (2007): *Sexual Attitudes and Behaviors of College Students*. The survey was developed based on a review of the professional literature related to sexuality among undergraduates. For the purpose of this research, demographic characteristics including gender, race, age and class level and the survey domains of sexual practices, religious identification and sexual values were included in the analysis. Within the domain of sexual practices were items asking participants to respond to whether they have given or received oral sex. Items surveying participants' perceptions of themselves as religious and their beliefs about the importance of marrying someone of their same religion were included in the domain of religious identification. The domain of sexual values included items asking participants to choose the sexual value of absolutism, relativism, or hedonism, that best described their sexual values, and items asking participants to indicate their willingness to have sex without love.

Data Analysis

Data analysis was conducted using SPSS 17.0. Pearson product moment correlations and non-parametric statistics including cross-classification and Chi Squares were calculated to assess relationships among demographic characteristics and the selected domains. Following the quantitative analysis, themes within the results were explored through the lens of sexual script theory.

Results

Analysis of the data revealed several relationships that may be related to the dominant social sexual scripts affecting teen and college-aged individual's engagement in oral sex. The majority of participants (62%) indicated their agreement with the statement that *oral sex is not sex*. In comparing the characteristics of those who agreed and disagreed, five statistically significant relationships emerged. Through statistical analysis of the responses, a profile of participants who asserted that *oral sex is not sex* emerged. Of the respondents, 76.4% were females and 25.4% were males. Racial background included 79.5% European American, 15.7% Blacks (respondent self-identified as African-American Black, African Black, or Caribbean Black), 1.9% Biracial, 1.7% Asian, and 1.3% Hispanic. The majority, (95%) of the sample identified as heterosexual, 2.9% identified as bisexual and 2% identified as homosexual. The mean age of the sample was 19 years-old.

Underclassmen-Freshmen & Sophomores

Freshmen and sophomores were the most likely to agree that oral sex does not take away one's virginity, with the majority of freshmen and sophomores indicating their agreement that engaging in oral sex does not constitute *having sex* (see Table 1). Juniors and seniors were less likely than underclassmen to agree that oral sex *is not* having sex. Hence, there was a general pattern that the lower the class rank of the student, the more likely the student to hold the belief that he or she could have oral sex and remain a virgin.

Table 1

Class Level & Perceptions of Oral Sex as Not Sex

		Class Level				$\chi 2$	df
		Freshman	Sophomore	Junior	Senior		
Having sex is having sexual intercourse, not having oral sex	Yes	65%	67.5%	56.6%	43.8%	16.977**	3
	No	35%	32.5%	43.4%	56.3%		

**$\rho = .001$

European American

Race was significantly related to perceptions of oral sex as not being sex (see Table 2). European American undergraduates were more likely than Blacks (respondent self-identified as African-American Black, African Black, or Caribbean Black) to agree that oral sex is not sex. In this study, the limited number of Asian and Latino participants renders the data of minimal use, however 61.5% of Asian participants (N=13) and 70% of Hispanic participants (N=10) indicated that they agreed that oral sex is not sex.

Table 2

Race & Perceptions of Oral Sex as Not Sex

		Race					χ2	df
		European American	Black	Asian	Hispanic	Biracial		
Having sex is having sexual intercourse, not having oral sex	Yes	65%	67.5%	56.6%	70.0%	60.0%	37.877**	6
	No	35%	32.5%	43.4%	30.0%	40.0%		

**ρ = .000

Self-Identified as Religious

Students who noted that they considered themselves to be religious by indicating that they agreed or strongly agreed with the statement, "I am a religious person," were more likely to agree that oral sex is not sex than students who reported that they were not religious at all (61.3% vs. 14.3%). Participant responses revealed an inverse relationship between self-identification as "a religious person" and having never "given oral sex to a partner," $r(4) = -.121$, $p = .001$, and having "never received oral sex," $r(4) = -.099$, $p = .006$. An inverse relationship between perceptions of the importance of marrying someone with the same religious identification as oneself and giving and receiving oral sex respectively also was noted, $r(4) = -.114$, $p = .001$ and $r(4) = -.129$, $p = .000$. Participants who identified as religious were thus more likely to agree that oral sex is not sex and also indicated that they have engaged in oral sex.

Sexual Value

Given the alternative sexual values of relativism ("the appropriateness of intercourse depends on the nature of the relationship"), absolutism ("no intercourse before marriage") and hedonism ("if it feels good, do it"), students who self-identified as hedonistic were more likely than those who viewed themselves as relativists and absolutists to agree that oral sex is not sex (65.8% vs. 62.9%, and 48.0%) ($p < .05$). Expressed another way, over 50% of absolutists compared to 34% of hedonists say the idea that one is still a virgin after having oral sex is not true. This 16% difference is striking. Participants who reported having engaged in sex without love also indicated they had engaged in both giving and receiving oral sex $r(2) = -.229$, $p = .000$, and $r(2) = -.206$, $p = .000$. These findings reflect that students who express more hedonistic perspectives are more likely to agree that oral sex is not sex and does not impact one's status as a virgin.

Safe Sex Practices

A significant inverse relationship existed between participants who reported requiring the use of a condom before intercourse and never having given oral sex ($r(4) = -.120$, $p = .001$), and never having received oral sex ($r(4) = -.092$, $p = .010$). These findings indicate that the participants from this study who engaged in oral sex also used protective methods when engaging in intercourse outside of oral sex.

Gender

Gender was not significantly related to participant perceptions of oral sex as not being *real* sex and sex only referring to sexual intercourse. Gender was, however, significantly related to having never given oral sex $\chi 2$ (1, $N = 781$) = 3.843, $\rho = .05$) and having never received oral sex $\chi 2$ (1, $N = 781$) = 4.016, =.045), with males indicating in greater levels than females that they have received oral sex, and also that they have never given oral sex. These findings indicate that the

gendered experiences of giving and/or receiving oral sex are important to explore, because it appears from the participant responses in this study that there may be gender differences in the likelihood of an individual giving or receiving oral sex.

Discussion

This research sought to gain information about college-aged individuals most likely to agree that oral sex is not sex and to share information about individuals within this population's perceptions about engagement in oral sex. The results allowed for the development of a demographic profile of participants who agreed that oral sex is not sex. In considering the results and demographic profile of participants who agreed that oral sex is not sex, relationships between sexual scripts and participant responses emerged.

The demographic profile which emerged indicated that participants most likely to agree that oral sex is not sex were underclassmen (freshmen and sophomores), European American and self-identified as religious. Inferences from the results were made through a parallel exploration of sexual scripts and the quantitative data from the studied domains and the demographic profile.

Oral Sex is Safe

The negative relationship that emerged between requiring the use of contraception before intercourse and engagement in oral sex may have many meanings. From the limited information provided through this analysis concerning safe sex practices and perceptions of oral sex, few inferences regarding the relationship between these issues can be made. Although the literature would suggest that college-aged students believe oral sex to be safe, this study did not provide enough information to definitively make this inference. However, the negative relationship between participants who required the use of contraception and previous experience with oral sex indicated that participants with previous experience giving and receiving oral sex were more likely to require the use of a condom before intercourse than were participants with no prior experience giving and receiving oral sex. From this finding, it could be inferred that participants who engage in oral sex are more likely to engage in safe sex practices, aligning congruently with the social sexual script posited in the professional literature of the perceptions that oral sex is safe. However, there could be many contributing factors to this relationship and further study is necessary to make clear inferences.

Oral Sex Potentially Mitigates Religiosity and Sex Guilt Tension

Supporting the sexual script that oral sex mitigates sex guilt because it is not real sex, the findings of this study discerned a strong relationship between religious identification and engagement in oral sex. Participants who reported strong self-identification as religious also reported having engaged in giving and receiving oral sex. Additionally, a significant relationship existed between participant responses to "I am a religious person" and "oral sex is not sex" $\chi 2$ (4, $N = 781$) = 10.310, $p = .036$). Other studies have shown that teens and young adults engage in oral sex because they view it as something that they do before they are ready to have sex (Remez, 2000). This of course implies that the only thing that counts as sex is vaginal-penile intercourse, and that this type of sexual activity breaks the threshold of virgin status.

These findings are not enough to conclude fully that oral sex is used to mitigate sex guilt-religiosity tension. However, the findings do suggest that college students who view themselves as religious also engage in oral sex, indicating that oral sex may be viewed as less likely to violate religious mores related to sexual engagement, since it is not viewed as real sex.

Oral Sex Requires Less Commitment

Perceptions of oral sex as less intimate and requiring less commitment may be better understood by exploring the class level, racial and sexual value components of the profile that emerged. Students at the beginning of their college careers, freshman and sophomores, were more likely to agree that oral sex is not sex. Developmentally, individuals at more advanced stages of one's college career, such as juniors and seniors, may be more likely to be searching for a life-partner for a more committed, intimate relationship than students at the beginning of the college experience. By engaging in sexual acts perceived by this population as not real sex, these participants are able to avoid more deeply committed relationships.

In terms of racial background and the perception of oral sex as requiring less commitment, previous researchers have revealed that European Americans are more likely to engage in oral sex. In a national sample, 81% of European American men, 66% of African American men, and 65% of Latino men reported ever having received fellatio (Mahay, Laumann, & Michaels, 2001). Of European American, Latino and African Americans receiving fellatio, 82%, 68%, and 55%, respectively, reported the experience as "appealing" (Mahay et al., 2001). In the same study, 75% of European American women, 56% of Latina women, and 34% of African American women reported ever having provided fellatio for a male partner. Of European American, Latina and African American women providing fellatio, 55%, 46% and 25%, respectively, regarded the experience as "appealing" (Mahay et al., 2001). Mahay's findings suggest that European Americans are more willing to engage in oral sex because they view it as less intimate, involved, or serious (Mahay et al., 2001). Like deep kissing or manual stimulation, they may perceive it as *not* sex. In contrast, African Americans may view oral sex as more "intimate, involved, and serious" and hence would be more likely to agree that oral sex is sex. The findings of this study support Mahay's findings with European Americans being statistically more likely than African Americans to agree that oral sex is not sex.

Indicated sexual values also were related to the sexual script of oral sex as requiring less commitment. Participants who self-identified as *hedonists* (65.8%), with an *if it feels good do it* approach to sex, also agreed with the assertion that oral sex is not sex and will allow one to maintain virgin status. Since persons who "hookup" and had sex without love are more likely to be hedonists, it also is not surprising that students who reported that they had experienced having sex without love were more likely to report having engaged in giving and receiving oral sex. These findings support Young's (1980) analysis of college students' behaviors and attitudes relative to oral-genital sexuality, which revealed that college students who engaged in oral sex, had experienced sexual intercourse and were sexually active, possessed more favorable attitudes toward oral-genital sexual engagement.

In conclusion, Chambers (2007) studied college students and found agreement with oral sex is not sex, that oral sex is less intimate than sexual intercourse, and that the interpersonal context for being most comfortable about engaging in oral sex is a committed relationship, not a married relationship. Similarly, in the current study, we found that more than 60 percent of the respondents (62.1%) agreed that oral sex is not sex. Specifically, 62.1% responded "yes" to the statement "Having sex is having sexual intercourse, not having oral sex." In contrast, 37.9% responded "no" to the statement.

Implications

Recognizing undergraduates who are more likely to agree with the assertion that *oral sex is not sex* will enable counselors and sex educators to provide targeted, specific education experiences to this population. This study revealed that undergraduates who were European American, religious, and underclassmen were more likely to agree that oral sex is not sex. However, although certain statistical differences existed among participants who believed that oral sex is not sex, over 60% of the total participant group in this study agreed that oral sex allows one to maintain one's virgin status because it is not sex. This indicates that we do need specific targeted sex education opportunities for those most likely to agree that oral sex is not sex, but we also need broad, far-reaching education opportunities for the rest of the college-age population. Furthermore, this study explored the impact of dominant social sexual scripts on college-aged students' perceptions of oral sex. By understanding the potential of social sexual scripts to ascribe meaning to an act of sexual engagement, sex educators and counselors will be better prepared to engage in discourse with young adults and college-aged individuals in a timely, developmentally-appropriate manner.

Limitations

The data for this study should be interpreted with caution. The data used in this study were pulled from a convenience sample of 781 undergraduates at one southeastern university. This sample cannot be considered representative of the total college-aged population in the U.S. However, it may provide some information from which larger, more representative studies can be developed.

A major limitation of this study is the lack of diversity within the sample. With small numbers of gay, lesbian and bisexual participants, it was impossible to discern the perceptions and likelihood for engagement in oral sex by this

demographic segment of the college-aged population. The literature would suggest that college students identifying as gay, lesbian or bisexual may have unique perceptions of oral sex and processes for making meaning of this experience (Feldmann & Middleman, 2002). Unfortunately, this study had limited participants identifying as gay, lesbian or bisexual and did not fully explore this population's experiences and perceptions. This is a major limitation of this research and should be addressed by additional research specifically exploring the perceptions and engagement of college-aged individuals who identify as gay, lesbian or bisexual in giving and receiving oral sex. Additionally, there were few individuals of Latino or Asian descent included in the sample, limiting the utility of the findings with these individuals.

Another significant limitation of the study was the lack of in-depth exploration about the gendered experience of giving and receiving oral sex. From the initial results, it was determined that a significant relationship existed between gender and giving and/or receiving oral sex. This is an important consideration to explore, particularly when considering the impact of social sexual scripts on the sexual engagement of young people. It is quite possible that males and females in the young adult and college-aged population have very different experiences with and perceptions of the process of engaging in oral sex. This is an area that needs further research and not including a thorough investigation of the impact of gender on the responses of participants was a limitation of this study.

References

Bay-Cheng, L. Y. (2003). The trouble of teen sex: The construction of adolescent sexuality through school-based sexuality education. *Sex Education, 3*, 61–74. doi:10.1080/1468181032000052162

Bhattacharyya, G. (2002). *Sexuality and society*. New York, NY: Routledge.

Carter, B., & McGoldrick, M. (Eds.). (1999). *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed). Boston, MA: Allyn & Bacon.

Centers for Disease Control and Prevention, Division of Sexually Transmitted Diseases. (2006). *Trends in reportable sexually transmitted diseases in the United States, 2005*. Retrieved from http://www.cdc.gov/STD/STATS/trends2006.htm.

Chambers, W. C. (2007). Oral sex: Varied behaviors and perceptions in a college population. *Journal of Sex Research, 44*, 28–42. doi:10.1207/s15598519jsr4401_4

Clinton, W. J. (1998). *Response to the Lewinsky allegations*. Miller Center of Public Affairs, University of Virginia. Retrieved March 9, 2009 from http://millercenter.org/scripps/archive/speeches/detail/3930.

Edwards, S., & Carne, C. (1998a). Oral sex and the transmission of non-viral STIs. *Sexually Transmitted Infections, 74*, 95–100. doi:10.1136/sti.74.2.95

Edwards, S., & Carne, C. (1998b). Oral sex and the transmission of viral STIs. *Sexually Transmitted Infections, 74*, 6–10. doi:10.1136/sti.74.1.6

Feldmann, J., & Middleman, A. B. (2002, October). Adolescent sexuality and sexual behavior. *Current Opinion in Obstetrics & Gynecology, 14*(5), 489–493.

Frith, H., & Kitzinger, C. (2001). Reformulating sexual script theory: Developing a discursive psychology of sexual negotiation. *Theory and Psychology, 11*, 209–232. doi:10.1177/0959354301112004

Frye, M. (1990). Lesbian sex. In J. Allen (Ed.), *Lesbian philosophies and cultures* (pp. 305–315). New York, NY: State University of New York Press.

Gagnon, J. H., & Simon, W. (1973). *Sexual conduct: The social sources of human sexuality*. Chicago, IL: Aldine.

Geer, J. H., & Broussard, D. B. (1990). Scaling heterosexual behavior and arousal: Consistency and sex differences. *Journal of Personality and Social Psychology, 58*, 664–671. doi:10.1037/0022-3514.58.4.664

Halpern-Felsher, B. L., Cornell, J. L, Kropp, R. Y., & Tschann, J. M. (2005). Oral versus vaginal sex among adolescents: Perceptions, attitudes and behavior. *Pediatrics*, *115*, 845–851. doi:10.1542/peds.2004-2108

Hollander, D. (2005). Many young teenagers consider oral sex more acceptable and less risky than vaginal intercourse. *Perspectives on Sexual and Reproductive Health*, *37*(3), 155–157. doi:10.1111/j.1931-2393.2005.tb00051.x

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1953). *Sexual behavior in the human female*. Philadelphia, PA: Saunders.

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. Philadelphia, PA: Saunders.

Langston, R. D. (1973). Sex guilt and sex behavior in college students. *Journal of Personality Assessment*, *37*, 467–472.

Lindau, S. T., Tetteh, A. S., Kasza, K., & Gilliam, M. (2008). What schools teach our patients about sex: Content, quality

and influences on sex education. *Obstetrics & Gynecology, 111*(2) Part 1, 256–266.
Mahay, J., Laumann, E. O., & Michaels, S. (2001). Race, gender, and class in sexual scripts. In E. O. Laumann & R. T. Michael (Eds.), *Sex, love, and health in America: Private choices and public policies* (pp. 197–238). Chicago, IL: University of Chicago Press.
Mosher W. D., Chandra A., & Jones J. (2005). Sexual behavior and selected health measures: Men and women 15–44 years of age, United States, 2002. *Advance data from vital and health statistics; no 362*. Hyattsville, MD: National Center for Health Statistics.
Mosher, D. L., & Cross, H. J. (1971). Sex guilt and premarital sexual experiences of college students. *Journal of Consulting and Clinical Psychology*, *36,* 22–32. doi:10.1037/h0030454
Paul, E., McManus, B., & Hayes, A. (2000). "Hookups": Characteristics and correlates of college students' spontaneous and anonymous sexual experiences. *The Journal of Sex Research*, *37*, 76–88. doi:10.1080/00224490009552023
Prinstein, M. J., Meade, C. S., & Cohen, G. L. (2003). Adolescent oral sex, peer popularity, and perceptions of best friends' sexual behavior. *Journal of Pediatric Psychology, 28*, 243–249. doi:10.1093/jpepsy/jsg012
Remez, L. (2000). Oral sex among adolescents: Is it sex or is it abstinence? *Family Planning Perspectives*, *32*, 298–304. doi:10.2307/2648199
Richey, E., Knox, D., & Zusman, M. (2009). Sexual values of 783 undergraduates. *College Student Journal, 43*, 175–180.
Richters, J., de Visser, R., Rissel, C., & Smith, A. (2006). Sexual practices at last heterosexual encounter and occurrence of orgasm in a national survey. *Journal of Sex Research, 43*, 217–226. doi:10.1080/00224490609552320
Rostosky, S. S., & Travis, C. B. (2000). Menopause and sexuality: Ageism and sexism unite. In C. B. Travis & J. W. White (Eds.), *Sexuality, society, and feminism* (pp. 181–209). Washington, DC: American Psychological Association. doi:10.1037/10345-008
Sack, A., Keller, J., & Hinkle, D. E. (1984). Premarital sexual intercourse: A test of the effects of peer group, religiosity, and sexual guilt. *The Journal of Sex Research*, *20*, 168–185. doi:10.1080/00224498409551215
Schulz, B., Bohrnstedt, G. W., Borgatta, E. R., & Evans, R. R. (1977). Explaining premarital sexual intercourse among college students: A causal model. *Social Forces*, *56*, 148–165. doi:10.2307/2577418
Simon, W., & Gagnon, J. H. (2003). Sexual scripts: Origins, influences and changes. *Qualitative Sociology, 26*, 491–497. doi:10.1023/B:QUAS.0000005053.99846.e5
Stepp, L. S. (2005, September 16). Study: Half of all teens have had oral sex. *The Washington Post*, p. A07.
Stulhofer, A., Busko, V., & Landripet, I. (2010). Pornography, sexual socialization, and satisfaction among young men. *Archives of Sexual Behavior, 39*, 168–178. doi:10.1007/s10508-008-9387-0
University Of California, San Francisco (2005, April). Teens believe oral sex is safer, more acceptable to peers. *ScienceDaily*. Retrieved May 10, 2009, from http://www.sciencedaily.com/releases/2005/04/050411135016.htm.
Weinstock H., Berman S., & Cates W. (2004). Sexually transmitted diseases among American youth: Incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health*, *36*, 6–10. doi:10.1363/3600604
Wiederman, M. W. (2005). The gendered nature of sexual scripts. *The Family Journal*, *13*, 496–502. doi: 10.1177/1066480705278729
Wulf, J., D., Prentice, D., Hansum, D., Ferrar, A., & Spilka. B. (1984). Religiosity and sexual attitudes and behaviors among evangelical Christian singles. *Review of Religious Research*, *26*(2), 119–131. doi:10.2307/3511697
Young, M. (1980). Attitudes and behavior of college students relative to oral-genital sexuality. *Archives of Sexual Behavior, 9*, 61–67. doi:10.1007/BF01541401

Social Support and Career Thoughts in College Athletes and Non-Athletes

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The career decision-making process can be a daunting task during the college years for both athletes and non-athletes alike. Understanding factors that influence this process and ways to best support students as they are making career decisions is integral to counselors working with college students. Social support and career thoughts were examined in 118 college student-athletes and 154 non-athletes from a large public university in the southeastern United States. Social support was found to have a significant relationship with career thoughts. In addition, several significant differences were found between the study's subpopulations. Implications for practice and future directions for research are further explored.

Keywords: career decisions, college athletes, social support, career counseling, sociocultural context

Career planning is a process in a college student's life that can cause a considerable amount of stress, and social support can have a positive effect on this stress. In the sport psychology research, social support has been found to be an important factor in reducing the effects of stress in athletes' lives (Bianco & Eklund, 2001; Taylor & Ogilvie, 2001). Athletes not only experience stress related to academics and athletics, but also related to what they will do after college. Some are talented enough to play professionally, but many must face the reality of having a career outside of the realm of sports. As a result, career planning is an important process for college athletes because it prepares them for life after sports. Social support can be an important factor during this process by alleviating the stress associated with career planning.

In research examining the general college student population, career thoughts have been found to have an important effect on the career planning process (Peterson, Sampson, & Reardon, 1991; Peterson, Sampson, Reardon, & Lenz, 1996; Sampson, Peterson, Lenz, Reardon, & Saunders, 1996b; Sampson, Reardon, Peterson, & Lenz, 2009). If career thoughts are negative, the individual is unable to clearly evaluate self and occupational knowledge that is necessary to make a career decision. Decreasing negative thoughts is the first and most important step in the career decision-making process. In conclusion, it is important for those who are influential in college students' lives to know what types of social support have the strongest relationship with the thoughts related to a career after college.

Social Support

Social support refers to the "social interaction aimed at inducing positive outcomes" (Bianco & Eklund, 2001, p.85). The terms "provider" and "recipient" are often used when discussing social support. A provider is an individual who gives the social support, and a recipient is an individual who receives the social support. A theory that targets social support and recipient satisfaction is the person-environment fit theory (Brown, 2002). This theory posits that the interaction between the person and environment is both active and reactive. The person-environment fit model of satisfaction is a part of person-environment theory. It defines satisfaction as "a pleasant affective state that is produced by the degree of fit between a person's needs, personality characteristics, abilities, and the commensurate supplies provided by, and abilities requirements of, the environment" (Brown, Brady, Lent, Wolfert, & Hall, 1987, p. 338). Conversely, dissatisfaction is defined as "an unpleasant affective state resulting from a misfit between relevant person and environment characteristics" (Brown et al., 1987, p. 338).

In many cases, person-environment fit is considered subjective because it focuses on the perceptions of the person. Within the context of subjective person-environment fit, satisfaction with social support is defined as "a positive affective state resulting from one's appraisal or his or her social environment in terms of its success in meeting his or her interpersonal needs" (Brown et al., 1987, p. 338). Conversely, dissatisfaction with social support is defined as "an

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unpleasant affective state resulting from a perception that the interpersonal environment is failing to satisfy important interpersonal needs" (Brown et al., 1987, p. 338).

Using person-environment fit as a theoretical basis, Brown, Alpert, Lent, Hunt, and Brady (1988) defined five broad factors of social support: (a) acceptance and belonging, (b) appraisal and coping assistance, (c) behavioral and cognitive guidance, (d) tangible assistance and material aid, and (e) modeling. The first factor, *acceptance and belonging*, measures the degree to which the individual's needs for affiliation and esteem are met through the provision of love, acceptance, respect, belonging, and shared communication. The second factor, *appraisal and coping assistance*, relates to the degree to which the social environment provides the individual with emotional support, hope, and coping assistance through assurances that feelings are normal, positive reinterpretations of the situation and future, and information on coping skills during times of stress.

The third factor, *behavioral and cognitive guidance*, relates to the degree to which the social environment meets the individual's needs for direct and modeled feedback about appropriate behaviors and thoughts. The fourth factor, *tangible assistance and material aid*, pertains to the degree to which instrumental needs for money, goods, and services are met by the social environment. The fifth and final factor, *modeling*, refers to the information on how others feel, handle situations and think (Brown et al., 1988). It also measures the satisfaction with a model or example to follow. In conclusion, the person-environment fit theory provides a basis for the description of five types of social support. In order to fully understand the role of social support on the career planning process, it also is essential to understand the role of career thoughts in the process.

Career Thoughts

Career thoughts are defined as "outcomes of one's thinking about assumptions, attitudes, behaviors, beliefs, feelings, plans, and/or strategies related to career problem-solving and decision-making" (Sampson et al., 2009, p. 91). Cognitive therapy theoretical concepts specify that dysfunctional cognitions have a detrimental impact on behavior and emotions (Beck, 1976; Beck, Emery, & Greenberg, 1985; Beck, Rush, Shaw, & Emery, 1979). Cognitive information process (CIP) theory explains the role of cognitions in career decision-making. This theory is meant to enhance the link between theory and practice in the delivery of cost-effective career services for adolescents, college students and adults (Peterson et al., 1991; 1996; Sampson et al., 2009). Its goal is to help individuals make appropriate career choices and learn improved problem-solving and decision-making skills needed for future choices (Sampson et al., 2009).

There are a few definitions that need to be understood in order to fully comprehend and utilize CIP. *Problem* is synonymous with career problem and is defined as a "gap between an existing and a desired state of affairs" (Sampson et al., 2009, p. 4). The gap may be between an existing state (e.g., *knowing I need to make a choice*) and an ideal state (e.g., *knowing I made a good choice*). *Problem-solving* is a "series of thought processes in which information about a problem is used to arrive at a plan of action necessary to remove the gap between an existing and a desired state of affairs" (Sampson et al., 2009, p. 5). *Decision-making* includes "problem-solving, along with the cognitive and affective processes needed to develop a plan for implementing the solution and taking risks involved in following through to complete the plan" (Sampson et al., 2009, p. 6).

CIP theory assumes that effective career problem-solving and decision-making requires the effective processing of information in four domains: (1) self-knowledge, (2) occupational knowledge, (3) decision-making skills, and (4) executive processing (Sampson et al., 2009). Self-knowledge includes individuals' perceptions of their values, interests, skills, and employment preferences. Occupational knowledge includes knowledge of individual occupations and having a schema for how the world of work is organized. Decision-making skills are the generic information processing skills that individuals use to solve problems and make decisions. Executive processing includes meta-cognitions, which control the selection and sequencing of cognitive strategies used to solve a career problem through self-talk, self-awareness, and control and monitoring.

Social Support and Career Planning

There is limited research examining social support and career planning. Career planning is related to career thoughts by the appraisal or cognitive processing that occurs during career decision-making. Based on limited scientific findings,

social support has been found to have a positive and important effect on career planning. In a study on unemployed individuals, Blustein (1992) found that instrumental support in the form of constructive advice and resources help to better appraise career-related information and adapt to the novel circumstances. It also was found that social support can positively affect the recipient's experience and is an important determinant of career activities such as researching career options or seeking assistance from a career advisor.

Similar findings indicate that along with instrumental support, emotional social support which is characterized by empathy, caring, love, and trust from families is especially important during stressful transitions such as job loss (DeFrank & Ivancevich, 1986). Regarding students and career planning, Quimby and O'Brien (2004) found that perceptions of robust social support resulted in feelings of confidence both in managing the responsibilities associated with being a student and pursuing tasks related to advancing vocational development. Though it is evident that social support is an important factor in the career planning process, additional research examining this construct and its place in career development is needed.

Given the reviewed literature and current gap, the purpose of this study was to examine the relationships among satisfaction with five types of social support and negative career thoughts in collegiate athletes and non-athletes.

Method

Participants

Non-student-athletes and National Collegiate Athletic Association (NCAA) Division I student-athletes from the same university were recruited for this study. Complete data were obtained from 272 participants (154 non-athletes and 118 athletes). One hundred forty-six (53.7%) of the participants were male and 126 (46.3%) were female. The race/ethnicity breakdown was as follows: Caucasian (n = 162, 59.6%), African American (n = 74, 27.2%), Hispanic (n = 15, 5.5%), Asian American (n = 1, 0.4%), other (n = 12, 4.4%), and more than one apply (n = 8, 2.9%). Forty-three (15.8%) of the participants were freshman, 65 (23.9%) sophomores, 94 (34.6%) juniors and 70 (25.7%) seniors. Of the athletes, the varsity sport breakdown was as follows: baseball (n = 13, 11.0%), basketball (n = 14, 11.9%), football (n = 37, 31.4%), golf (n = 5, 4.2%), soccer (n = 7, 5.9%), softball (n = 8, 6.8%), swimming & diving (n = 8, 6.8%), tennis (n = 3, 2.5%), track & field (n = 18, 15.3%), and volleyball (n = 4, 3.4%). One (0.8%) athlete did not indicate involvement in a particular sport.

All participants were recruited from a single large university located in the southeastern region of the United States. They were above 18 years of age, and participants comprised of a volunteer, convenient sample obtained by contacting athletic administrators and professors.

Instrumentation

Demographic Information Survey. The survey contained information about participants' college major, age, gender, race/ethnicity, and academic year.

Social Support Inventory-Subjective Satisfaction (SSI-SS). The SSI-SS (Brown et al., 1987) consisted of 39 self-report items assessing one's satisfaction with five types of social support: (a) acceptance and belonging, (b) appraisal and coping assistance, (c) behavioral and cognitive guidance, (d) tangible assistance and material aid, and (e) modeling. Participants responded to these items on a 7-point Likert-type scale ranging from 1 (*not at all satisfied*) to 7 (*very satisfied*) to indicate their satisfaction with the support they have received. A total score is obtained by summing all of the items. The overall score of the SSI-SS ranges from 39 to 273. The acceptance-belonging subscale score ranges from 9 to 63, and the appraisal-coping assistance subscale score ranges from 9 to 63. The behavioral-cognitive guidance subscale score ranges from 6 to 42. The tangible assistance-material aid subscale score ranges from 5 to 35, and the modeling subscale score ranges from 4 to 28. The total score and the scores of each of the five factors will be assessed in this study.

Alpha coefficients for the five factors are .93 for acceptance-belonging, .88 for appraisal-coping assistance, .81 for behavioral-cognitive guidance, .78 for tangible assistance-material aid, and .83 for modeling (Brown et al., 1987). The

overall alpha coefficient is .96. The SSI-SS has been normed on college-age and adult populations.

Career Thoughts Inventory (CTI). The CTI (Sampson, Peterson, Lenz, Reardon, & Saunders, 1996a) is a 48-item self-administered, objectively scored measure of dysfunctional thinking in career problem-solving and decision-making. Participants respond to items on a 4-point Likert-type scale ranging from 0 (*strongly disagree*) to 3 (*strongly agree*) to indicate how much they agree with the negative career statement given. The CTI scores consist of one total score as well as scores on three subscales. The CTI is a CIP-based assessment and intervention resource intended to assess the quality of career decisions made by adults and college and high school students. It measures the eight content dimensions of CIP theory that include: (1) self-knowledge, (2) occupational knowledge, (3) communication, (4) analysis, (5) synthesis, (6) valuing, (7) execution, and (8) executive processing (Peterson et al., 1991; 1996).

The CTI has been normed on high school, college, and adult populations (Sampson et al., 1996b). Reliability evidence for the CTI total score includes internal consistency alpha coefficients ranging from .93 to .97 and a test-retest coefficient of .77. The readability of the CTI was calculated to be at a 6.4 grade level.

Decision-making confusion (DMC) is one subscale on the CTI and it refers to the inability to initiate or sustain the decision-making process as a result of disabling emotions and/or a lack of understanding about the decision-making process itself. Commitment anxiety (CA) is another subscale on the CTI and it reflects the inability to make a commitment to a specific career choice, accompanied by generalized anxiety about the outcome of the decision-making process. This anxiety perpetuates indecision. External conflict (EC) is the final subscale and it reflects the inability to balance the importance of one's own self-perceptions with the importance of input from significant others, resulting in a reluctance to assume responsibility for decision-making.

Procedure

Athletic academic advisers and professors at a large southeastern university were contacted via e-mail using a script. The principal investigator met with the participants whenever they were available to be administered the battery of tests, during their tutoring sessions in the athletic academic support office or in their classes. During the meeting, the participants were oriented to the purpose of the study. They were asked to sign an informed consent form, and told that their participation in the study was completely voluntary and that they may drop out at any time. The researcher administered the questionnaires beginning with the Demographic Information Survey, then the Social Support Inventory, and finally the Career Thoughts Inventory. Tests were then collected and a randomly assigned number identified each battery of tests.

Results

Preliminary analyses were performed to obtain internal consistency coefficients of the measures and descriptive statistics. The alpha coefficients observed in this study for each Social Support Inventory-Subjective Satisfaction (SSI-SS) subscale and total score were: acceptance-belonging ($\alpha = .79$), appraisal-coping assistance ($\alpha = .83$), behavioral-cognitive guidance ($\alpha = .81$), tangible assistance-material aid ($\alpha = .70$), modeling ($\alpha = .74$), and total score ($\alpha = .90$). For the Career Thoughts Inventory (CTI) subscales and total score, the alpha coefficients observed were as follows: decision-making confusion ($\alpha = .86$), commitment anxiety ($\alpha = .85$), external conflict ($\alpha = .82$), and total score ($\alpha = .89$). The alpha coefficient values indicated adequate internal consistency.

Descriptive Statistics and Bivariate Correlations

Descriptive statistics for the SSI-SS subscales: acceptance-belonging, appraisal-coping assistance, behavioral-cognitive guidance, tangible assistance-material aid, and modeling; and CTI subscales: decision-making confusion, commitment anxiety, and external conflict are presented in Table 1. Overall, participants averaged a T-score within the average range for the majority of the subscales with the social support subscale of acceptance-belonging having the highest mean ($M = 65.67$, $SD = 9.13$).

Table 1

Descriptive Statistics for Instruments Used

	N	*M*	*SD*
Acceptance-belonging	272	65.67	9.13
Appraisal-coping assistance	272	53.81	7.36
Behavioral-cognitive guidance	272	54.38	7.60
Tangible assistance-material aid	272	50.56	8.15
Modeling	272	54.68	7.57
Decision-making confusion	272	48.55	10.77
Commitment anxiety	272	46.59	11.15
External conflict	272	53.61	13.00

The bivariate correlations among study variables are presented in Table 2. Without controlling for any variables, the social support types of acceptance-belonging and appraisal-coping assistance had the strongest relationships with decision-making confusion (r = -.37 and -.38, respectively). The bivariate correlations also indicated that all social support types had significant relationships with decision-making confusion, commitment anxiety, and external conflict. When all variables were controlled, there were no significant relationships between any of the five types of social support and career thoughts.

Table 2

Correlation Matrix for Predictor and Criterion Variables

	1	2	3	4	5	6	7	8
1. AB	1.00							
2. ACA	.77*	1.00						
3. BCG	.76*	.83*	1.00					
4. TAMA	.54*	.60*	.55*	1.00				
5. MOD	.62*	.68*	.63*	.48*	1.00			
6. DMC	-.37*	-.38*	-.35*	-.27*	-.31*	1.00		
7. CA	-.26*	-.27*	-.29*	-.23*	-.25*	.80*	1.00	
8. EC	-.27*	-.27*	-.25*	-.20*	-.24*	.71*	.69*	1.00

Note. AB = acceptance-belonging; ACA = appraisal-coping assistance; BCG = behavioral-cognitive guidance; TAMA = tangible assistance-material aid; MOD = modeling; DMC = decision-making confusion; CA = commitment anxiety; EC = external conflict.

*=*significant at p<.01*

Regression

Three hierarchical regression analyses were performed with the five predictor variables and three criterion variables. All regression models were significant. It is suggested that the variance shared among the predictors is what accounts for the significant models. None of the social support types were found to have significant unique relationships with any of the career thoughts variables.

Structural Equation Modeling

Conceptual models of the posited relationship between social support and career thoughts, as seen in Figure 1, were tested using SEM procedures. The model shows that the five social support types were used as indicators for a social support latent factor and the three subscales of the CTI were used as indicators for a negative career thoughts latent factor.

The distributional properties of the study variables in the model were examined to select the appropriate model estimator. No substantial problems were evident in either univariate skewness (M = -.39; range from -.83 to .29) or kurtosis (M = .23; range from -.36 to .90) in the eight variables used in the SEM analysis. Mild multivariate kurtosis was indicated with a Mardia's normalized estimate equating to 10.15. For the model, the model-reproduced and observed covariance matrices did not differ, $\chi^2 = 18.79$, $df = 19$, $p = .47$. Desirable CFI and IFI indexes (1.00 for both) were observed. The satisfactory distribution of the residuals was substantiated by the observed standardized RMSR (.02). Figure 1 presents the standardized path coefficients and residuals for the SEM.

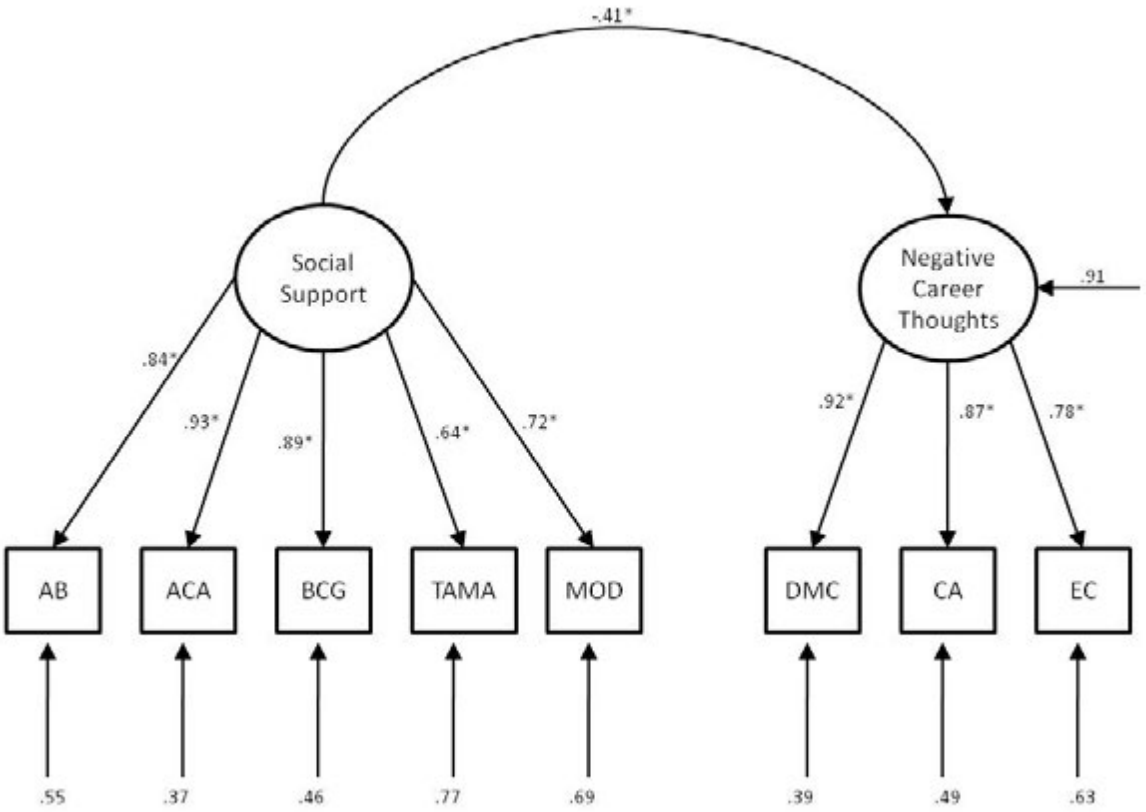

Figure 1. Negative career thoughts as a function of social support. A latent negative career thoughts variable based upon the Career Thoughts Inventory (CTI) serves as the criterion variable. All coefficients are standardized and significant (*$p < .05$). AB = acceptance-belonging; ACA = appraisal-coping assistance; BCG = behavioral-cognitive guidance; TAMA = tangible assistance-material aid; MOD = modeling; DMC = decision-making confusion; CA = commitment anxiety; EC = external conflict.

In the model, the social support latent variable accounted for 17% of the variance in the negative career thoughts latent variable. The social support latent variable accounted for the majority of the variance in the subscales of acceptance-belonging (R^2 = .70), appraisal-coping assistance (R^2 = .87), behavioral-cognitive guidance (R^2 = .79), tangible assistance-material aid (R^2 = .41), and modeling (R^2 = .52). The negative career thoughts latent variable accounted for the majority of the variance in the subscales of decision-making confusion (R^2 = .85), commitment anxiety (R^2 = .76), and external conflict (R^2 = .61). In summary, these analyses make it apparent that social support is associated with career thoughts as observed by the significant correlation between the latent variable of social support as measured by the SSI-SS and the latent variable of negative career thoughts as measured by the CTI.

Z-Score Analyses

Z-score analyses were performed to determine any significant differences between sample populations based on athletic status, gender, and academic class status in the relationship between social support and career thoughts. Regarding athletic status, a significant difference ($p < .01$) was found between athletes and non-athletes in the relationship between the social support type of appraisal-coping assistance and the career thoughts variable of commitment anxiety ($z = 1.95$), with that relationship being stronger in the non-athlete population. Also regarding athletic status, a significant difference ($p < .01$) was found between athletes and non-athletes in the relationship between the social support type of modeling and the career thoughts' variable commitment anxiety ($z = 2.02$), with that relationship also being stronger in the non-athlete population.

No significant differences were found between the male and female genders in the relationship between social support and career thoughts. Regarding academic class status, upperclassmen had a significantly stronger relationship ($p < .01$) between total social support and the social support types of appraisal-coping assistance and behavioral-cognitive guidance and the career thoughts' variable commitment anxiety ($z = 2.08$; 2.30; 2.15; respectively). In summary, several significant differences were found between sample populations.

Discussion

Results revealed that social support accounts for about 17% of the variance in career thoughts. This suggests that social support has a moderate relationship with career thoughts. These results also support the literature on the positive effect of social support on the career planning process (Blustein, 1992; DeFrank & Ivancevich, 1986; Quimby & O'Brien, 2004).

The person environment fit model (Dawis, 2002) provided an important framework in the present study as satisfaction with social support was found to have a moderate relationship with career thoughts. However, the strong relationships between the five types of social support made it difficult to examine the unique relationship of each to career thoughts. The results infer that the five types of social support identified by Brown et al. (1988) may not be independent.

The bivariate correlations indicated that all social support types had significant relationships with the career thoughts variables. When all variables were controlled, there were no significant relationships between any of the five types of social support and career thoughts. Instrumental support, as defined by Blustein (1992) and DeFrank and Ivancevich (1986), relates to Brown et al.'s (1988) social support types of behavioral-cognitive guidance and tangible assistance-material aid. The results of the present study show that both social support types had moderate relationships with career thoughts. Emotional support, as defined by DeFrank and Ivancevich (1986), relates to Brown et al.'s (1988) social support type of acceptance-belonging. This type of social support also was found to have a negative, moderate relationship with career thoughts. These results reinforce those found in Blustein (1992) and DeFrank and Ivancevich (1986) in that social support is an important component in the career planning process.

It was found that the sociocultural context in which the social support is provided has an effect on the perception of the social support by the recipient. The significant difference between the athlete and non-athlete and upperclassmen and underclassmen populations in the present study may be due to their different sociocultural contexts. The results of this study suggest that the appraisal-coping assistance and modeling social support types may be better provided to the non-student-athlete population who are experiencing anxiety related to the career decision-making process. In addition, the appraisal-coping assistance and behavioral-cognitive guidance social support types may be more influential in reducing

career decision-making anxiety if provided to upperclassmen.

The present study adds to the literature by studying the different types of social support that make up the social support construct. The study also adds to the literature by examining the relationship between social support and career thoughts, which has not been studied previously. In addition, the examination of the differences in the social support/career thoughts relationship between groups in the sample population (i.e., athlete/non-athlete, male/female, upperclassmen/underclassmen) adds an important dimension to the available literature.

Limitations

The main limitation of this study is with the convenience sampling because the extent to which the students were representative of the overall population of college students is unknown. The participants were not obtained by random sampling, but rather obtained because of availability. Therefore, it is difficult to know the extent to which the results of this study are generalizable beyond this sample.

Implications

The present study investigated the relationship between the five types of social support and the three constructs that comprise career thoughts. Although none of the types of social support were found to have a uniquely significant relationship with career thoughts, there was in fact a moderate relationship between the overall construct of social support and career thoughts.

This study has important implications for practice. Coaches, athletic administrators, career counselors, mental health counselors, professors and other post-secondary administrators now have a better idea of what types of social support are deemed as having the greatest impact on how college students view their post-collegiate careers. Current literature only focuses on the overall social support construct and its positive effects, but the present study allows for the differentiation of the social support types, which provides additional information for practical purposes (Bianco & Eklund, 2001; Taylor & Ogilvie, 2001). Hopefully, this will increase the likelihood of college students actually receiving these types of social support based on their subgroup (i.e., athlete/non-athlete and upperclassmen/underclassmen). Also, college students now have the opportunity to be aware of what types of social support will lead to less negative career thinking.

Regarding implications for research, it is evident that additional research needs to be done to gain a better understanding of the relationship between social support and career thoughts in college students. This is the first study that has examined these two constructs and more research is necessary. More and better social support measures need to be introduced into the field that better examine social support and its different types. Also, this study supports the literature on the importance of career thoughts during the career planning process (Peterson et al., 1991, 1996; Sampson et al., 1996b, 2009). An improved foundation is now available for additional research on the cognitive aspects of career planning and how it relates to social entities.

Future Directions

The present study provides an important foundation for future research. Since it is the first study to examine social support and career thoughts directly, additional examinations of these constructs are necessary per the practical and research implications previously stated. Other variables such as career maturity, self-efficacy, motivation, and personality characteristics should be included in future research to try and account for the remaining variance in career thoughts. Also, the negative aspects of social support, such as peer or parental pressures, should be examined.

Since the present study only examines college students, other populations should be included in future research. In addition, it may be interesting to examine the differences between college students at private and public institutions. Other populations also can be researched, including adults on the verge of retirement or high school seniors trying to decide

what to do after graduation.

It may be important to study the phases of the career development process and if different types of social support affect the various phases differently. For example, participating in volunteer activities to boost one's resume is unlike job searching. In addition, performing qualitative research may add to the information provided from quantitative research.

It is important to note that the strong correlations between each type of social support may infer a poor measure of the different types of social support. A confirmatory factor analysis would be useful in determining if the Social Support Inventory is in fact an adequate measure of social support and its subtypes. There may be better inventories available that measure the different types of social support, and they should be used to determine any differences between social support measures. It is important to note the complexity of the social support construct and that other instruments should be identified that better measure the complex aspects of the construct. Overall, the current study provides an adequate foundation for future practice and research. The relationship between social support and career thoughts is important to understand in order to better help college students and possibly other populations prepare for whatever career transition they may face.

References

Beck, A. (1976). *Cognitive therapy and the emotional disorders.* New York, NY: International Universities Press.

Beck, A., Emery, G., & Greenberg, R. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York, NY: Guilford Press.

Beck, A., Rush, A., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression.* New York, NY: Guilford Press.

Bianco, T. (2001). Social support and the recovery from sport injury: Elite skiers share their experiences. *Research Quarterly for Exercise and Sport*, *72*, 376–388.

Bianco, T., & Eklund, R.C. (2001). Conceptual considerations for social support research in sport and exercise settings: The case of sport injury. *Journal of Sport & Exercise Psychology, 23*, 85–107.

Blustein, D. (1992). Applying current theory and research in career exploration to practice. *The Career Development Quarterly*, *41*, 174–184.

Brown, S., Brady, T., Lent, R., Wolfert, J., & Hall, S. (1987). Perceived social support among college students: Three studies of the psychometric characteristics and counseling uses of the social support inventory. *Journal of Counseling Psychology*, *34*, 337–354.

Brown, S., Alpert, D., Lent, R., Hunt, G., & Brady, T. (1988). Perceived social support among college students: Factor structure of the social support inventory. *Journal of Counseling Psychology*, *35*, 472–478.

Dawis, R. (2002). Person-environment-correspondence theory. In D. Brown & Associates (Eds.). *Career choice and development* (pp. 427–464). San Francisco, CA: Jossey-Bass.

DeFrank, R., & Ivancevich, J. (1986). Job loss: An individual level review and model. *Journal of Vocational Behavior*, *28*, 1–20.

Peterson, G., Sampson, J., Jr., & Reardon, R. (1991). *Career development and services: A cognitive approach.* Pacific Grove, CA: Brooks/Cole.

Peterson, G., Sampson, J., Jr., Reardon, R., & Lenz, J. (1996). Becoming career problem solvers and decision makers: A cognitive information processing approach. In D. Brown & L. Brooks (Eds.), *Career choice and development* (3rd. Ed.) (pp. 423–475). San Francisco, CA: Jossey-Bass.

Quimby, J., & O'Brien, K. (2004). Predictors of student and career decision-making self-efficacy among nontraditional college women. *The Career Development Quarterly*, *52*, 323–339.

Sampson, J., Jr., Peterson, G., Lenz, J., Reardon, R., & Saunders, D. (1996a). *Career thoughts inventory.* Odessa, FL: Psychological Assessment Resources.

Sampson, J., Jr., Peterson, G., Lenz, J., Reardon, R., & Saunders, D. (1996b). Negative thinking and career choice. In R. Feller & G. Walz (Eds.). *Optimizing life transitions in turbulent times: Exploring work, learning and careers* (pp. 323–330). Greensboro, NC: University of North Carolina at Greensboro, ERIC Clearinghouse on Counseling and

Student Services.
Sampson, J., Jr., Reardon, R., Peterson, G., & Lenz, J. (2009). *Career counseling and services: A cognitive information processing approach*. Pacific Grove, CA: Brooks/Cole.
Taylor, J., & Ogilvie, B. (2001). Career termination among athletes. In R. N. Singer, H. A. Hausenblas, & C. M. Janelle (Eds.), *Handbook of sport psychology* (2nd ed., pp. 672–691). New York, NY: Wiley.

The Ethical Frontier: Ethical Considerations for Frontier Counselors

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Counselors working in frontier communities may encounter unique challenges and experiences not regularly found in larger contexts. This paper explores the aspects of counseling significant to rural and frontier settings. It discusses the traditional attitudes of rural and frontier populations, the counselor's place in these communities, boundaries of competence, and ethical concerns that are significant to these areas of counseling, such as confidentiality. It also offers potential ways to address related ethical issues. The cultural milieu in small communities, subcultural self-identification, frontier attitudes and beliefs, and multiple relationships are explored.

Keywords: rural, ethics, frontier, multiple relationships, confidentiality, boundaries of competence

Working in small and rural communities presents counselors with challenges and experiences not necessarily or often encountered in larger population centers. The geographic constraints of the area itself, the culture and behavior of the client population, as well as the attitudes and skills of the counselor, can combine to create significant difficulties in providing ethically competent mental health care. Even the term *rural* is difficult to define when attempting to describe the 16% (Nusca, 2011) of the total U.S. population and the 20% (Trading Economics, 2011) of the Canadian population that live in "rural" settings. *Rural* in this usage is generally defined in regards to low population density, population size and distance from larger population centers. Although governmental agencies vary in their exact definition and identification of rural locations and populations in the United States, *urban* is generally defined as an area having more than 100 people per square mile, rural areas generally comprise open country and settlements with fewer than 2,500 residents and are defined as having between 99 and 6 people per square mile, and *frontier* is an area having less than 6 people per square mile (Bushy & Carty, 1994; Helbok, 2003). Much of Alaska, the central United States, and central Canada are primarily designated as frontier areas.

"Rural" and "frontier" become increasingly difficult to define when viewed through the perceptions of those living in these areas. Individual life experiences and interpretations blend with considerations of distance between families and communities, self-sufficiency, access to resources, and support to and from the community to create a style of living centered on individual capacity and self-reliance, as well as increased community interdependence (Brownlee, 1996; Erickson, 2001). Small and rural community living, however, does tend to have some similarities across geographic areas including scarce resources, higher poverty rates, lack of access to employment opportunities, lack of higher formal education, higher illiteracy rates, limited health services, limited insurance coverage, higher rates of disability, greater environmental hazards, increased overall age-adjusted mortality, and fewer mental health resources (Helbok, 2003; Murray & Keller, 1991; Roberts, Battaglia, & Epstein, 1999; Wagenfeld, 1988; Wilcoxon, 1989). In addition to the concerns associated with rural living, frontier areas have to contend with even fewer mental health care resources due to populations spread over a large geographic area, reduced numbers of mental health care providers, limited access to crisis services, mental health services and general medical care, inaccessibility to remote geographic areas, and the increased hardship of living in isolated locations (Bushy & Carty, 1994; Roberts et al., 1999).

Alaska is illustrative of the difficulties of providing for mental health care needs and access to experienced practitioners in rural and frontier communities. Alaska is the largest state (656,424 square miles) with the lowest population density in the United States with 1.2 persons per square mile. Much of that population is concentrated in two metropolitan statistical areas that account for approximately 66% of the state's total estimated population (U.S. Census Bureau, 2012). In 2007, it had the highest suicide rate in the nation, with 21.8 suicides per 100,000 residents as compared to 11.5 suicides per

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100,000 for the rest of the U.S. For Alaska Natives, the suicide rate jumps to 35.1 per 100,000 people (State of Alaska Bureau of Vital Statistics, n.d.).

In 2006, a report on the prevalence of mental health concerns estimated that 4.6 percent (21,754) of Alaskan adults in households had a serious mental illness and that 7.2% (12,725) of Alaskan youth had a serious emotional disturbance. The estimates for adults only include those with a diagnosable disorder that had persisted for over one year and was associated with a significant impairment (State of Alaska, Health & Social Services, n.d.). In 2007, approximately 11.3% of the population (about 53,000) of Alaskan adults (age 18 years or older) experienced serious psychological distress and 7.6% (about 36,000) had at least one major depressive episode (SAMHSA, 2009).

Community hospitals are important healthcare contact locations in rural and frontier areas. In 2011, Alaska community hospitals had only one community hospital bed for every 433 people. Outside the primary population areas of the state, this number increased to one bed for every 792 people. Only two psychiatric hospitals exist in Alaska and both of these are located in the municipality of Anchorage; outside of this area the state has no public psychiatric treatment options (U.S. Census Bureau, Health & Nutrition, 2012: U.S. Hospital Finder, 2011).

Small Communities

Small communities can be seen as each possessing their own cultural milieu with a shared context, set of perceptions and understandings and a view of "how we do things around here" (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010, p. 50). When rural and frontier issues are part of a small community, the communities' concerns magnify through the restrictions of geography and scarcity of resources and all of the previously noted ways that distinguish rural and frontier populations. Even so, rural and frontier communities have common threads with other small communities in their methods of subcultural self-identification. Each of them can be defined as much by external forces (such as geographic setting, population density, available natural and economic resources) as internal motivators (desire for small community interactions, dislike of big cities, desire for support from those with similar values and outlooks), but each also has a shared context that encourages successful adaptation *in that setting*, including an appreciation and support for the cultural norms and values endemic to each setting (Alegria et al., 2010). Therefore, the life context of the people who live in these communities, whether they are in a geographically isolated village in Alaska, a group of military families living in and around a military base, or an alternative lifestyle community living in a larger city, have much in common. Each of them is a part of a culture that shapes attitudes, behaviors and values as well as perceptions of what is accepted as "normal" in their community (Schank, Helbok, Haldeman, & Gallardo, 2010). This perception is frequently in contrast, or opposition, to the majority culture and is continually evolving through member interactions, reaction to the environment and perceived self-identity.

Rural and Frontier Attitudes and Behaviors

Self-reliance, which includes self-care behaviors, is a characteristic traditionally associated with rural residents. Historically, this reliance on self and kinship ties helped people to survive in remote, isolated, and difficult environments (Bushy & Carty, 1994) and created a hesitancy to seek services. Current potential mental health clients still tend to turn to familiar people, friends and family as a first level of support (Bushy & Carty, 1994; Helbok, 2003). These services are informal, heavily steeped in a shared history or culture, and frequently follow a tacit understanding of reciprocity among participants. This informal level of healthcare can be very beneficial in its promotion of healthy living and self-care behaviors, for example, in a family's care of a mentally ill family member or a community's support of a person with a disability or developmental issue. It also can be highly detrimental as it can hide that person's issue within the family or community and enable a person to take on or maintain a *sick role* or prevent a person from seeking or receiving mental health care that may improve their overall functioning (Bushy & Carty, 1994).

The second level of assistance includes community groups, church and religious groups, school services, community educational and outreach programs, and civic organizations. Group members (usually extended community members) often combine and/or contribute resources to provide assistance to individuals and families in need, particularly in times of emergency or crisis. This generally takes the form of volunteering time and services, and donating food, clothing, other non-monetary items, and financial contributions. It also can include taking in an individual or family who is lacking

housing or needs more comprehensive support (Bushy & Carty, 1994; Murray & Keller, 1991). The third level of support covers formal services such as community mental health and hospital/clinic services, medical doctors, governmental programs and services, and for-profit commercial service providers (Bushy & Carty, 1994). Financial remuneration is expected for the services provided and may potentially be based on a sliding scale or reduced fee schedule (Bushy & Carty, 1994; Murray & Keller, 1991).

That residents of rural and frontier areas tend to initially rely on the two informal levels of social support may in part be due to their self-reliant tendencies aggravated by geographic location and/or isolation, inability to access or qualify for services, inability to pay for services and lack of service providers. This also may be due to cultural traditions regarding the accepted traditional method of handling mental health issues (or if the concern is even acknowledged as a significant issue), a shared belief that outsiders are not to be trusted, resentment of outsiders coming to "rescue" them, and/or negative perceptions of the value of formal services in addressing the issue (Bushy & Carty, 1994; Erickson, 2001).

Acceptability of services by rural and frontier residents also is influenced by the behavior and approach of mental health professionals. A provider's attitude and training in relation to rural and frontier practice can be fundamental in relating to a specific environment and the people living there. If a service is offered with an understanding of the particular characteristics and needs of a population, and the provider has been accepted into the community, then the services may be viewed as a treatment option in the community structure. If, however, the provider has not been accepted as a trustable member of the community or exhibits attitudes and behaviors that are incongruent with local values, then locals needing assistance may not seek services, or may not accept services that are readily available and accessible (Bushy & Carty, 1994).

Rural and Frontier Mental Health Services

The U.S. Department of Health and Human Services' Health Professional Shortage Areas, which are determined by the availability of mental health service providers in relation to population numbers for a defined area (HRSA, 2011), illustrates the lack of qualified mental health services and providers for rural and frontier populations. This lack of qualified mental health professionals translates directly to reduced services for a given area as well as professional practice concerns for those that provide services.

In the face of such scarcity, frontier mental health providers frequently assume multiple roles in order to function in a variety of situations. Counselors may take on many duties past their primary role as clinician including case manager, crisis intervention specialist, advocate for client services, and community outreach worker, just to name a few. This multiplicity of duties provides better generalized coverage for client care, but can place the counselor in the ethically dangerous position of potentially breaching client confidentiality, operating outside professional training and competence, managing multiple dual relationships and conflicting professional roles, limited or no professional support, and increased potential for professional burnout (Roberts et al., 1999; Schank, 1998; Werth, Hastings, & Riding-Malon, 2010).

Ethical Issues in Rural and Frontier Mental Health Services

Counselors frequently face serious ethical dilemmas as service delivery in rural and frontier communities presents them with ethical challenges distinctive to those environments (McDermott, 2007). These ethical dilemmas and potential violations are no less common in rural and frontier areas than in urban locations but according to studies are more difficult to resolve (Bolin, Mechler, Holcomb, & Williams, 2008) due to geographic and social isolation, scarce resources, limited population numbers, and the cultural expectations that characterize those communities (Roberts et al., 1999; Scopelliti et al., 2004).

These ethical issues are not limited to populations that are primarily defined or identified by geographic restrictions or population density. They also are particularly relevant to small communities that are identified by demographic variables such as age, race, culture, sexual orientation, disability, or spiritual orientation. Although there are some needs that are specific to certain populations, the determination of appropriate ethical practice guidelines also should include the needs and cultural values of other small community groups (Schank et al., 2010; Schank & Skovholt, 1997).

The needs and considerations of rural and frontier communities frequently cause professional codes and guidelines to be in opposition to prevailing small community standards and expectations (Schank, 1998). To address these concerns, rural and frontier clinicians may find it necessary to adopt a view of professional boundaries and ethical guidelines that places more importance on community values and professional roles in the community than on rules of behavior as defined by professional organizations.

Urban ethical orientation in mental health services. This necessity on the part of mental health providers is intensified by the fact that mental health training and much of the ethics literature and professional ethics codes appear to favor urban-based mental health practices. This could potentially lead to erroneous assumptions when it comes to distinguishing between ethical and unethical practices in small community environments (Helbok, 2003; Roberts et al., 1999; Werth et al., 2010).

Most mental health clinicians are trained at universities and colleges located in urban and suburban areas. Their practical experience takes place in urban and suburban clinical training sites that have adequate resources and readily available personnel. Later in their practice, clinicians tend to work within areas that have relatively easy access to referral resources at multiple levels of intervention (hospitals, psychiatric treatment centers, partial treatment and day treatment centers), public transportation, various community support and centers, self-help groups, and peer support including ongoing supervision and professional mentoring (Helbok, 2003; Schank et al., 2010). This exposure to training in an urban/suburban environment may not adequately prepare those clinicians that go forward to work with small community and rural populations and creates the general consensus in the literature that an urban model of mental health training and service delivery is inadequate to meet the needs of rural and frontier communities. With this in mind, mental health service providers often feel that ethics codes and other literature are so urban-biased that they are not helpful in a rural or frontier context (Helbok, 2003; Murray & Keller, 1991; Roberts et al., 1999; Schank, 1998; Werth et al., 2010).

Current ethical codes do not adequately address ethical concerns in rural settings. It is important to understand that while there may be significant differences between the ethical considerations of urban, rural and frontier mental health practices, this does not mean that ethical codes have no applicability in rural and frontier clinical settings; to the contrary, potential ethical concerns should be closely monitored precisely *because* of the inherent ethical dangers that come with working as a clinician in such areas (Helbok, 2003). The fact that such situations *will* occur in rural and frontier clinical settings and *will* influence mental health services encourages the need to develop and expand the ethical codes and ethical decision-making processes (Schank et al., 2010) to include an understanding that rural and frontier mental healthcare decision-making is "colored and shaded by values, beliefs, emotions, competencies, and resources" (Cook & Hoas, 2008, p. 52). It is only by understanding and working with this *coloring and shading* that mental health providers can develop awareness and skills needed to work effectively in rural and frontier communities. To do this, rural and frontier clinicians must do more than simply adhere to standards or rote application of rules—they must understand why those rules exist, at what point those rules may be a detriment to the development of clinical relationships, and what may constitute a severe enough ethical issue in regards to both ethical codes and community values to warrant concern. Rural and frontier clinicians need to understand that "ethics should not be static but rather constantly examined and evolving in order to be the most beneficial to clients and counselors" (Schank, 1998, p. 272).

Confidentiality

The limitations in both human and material resources in frontier areas can cause many seemingly obvious and standard professional practices to take on significant ethical aspects and primary among these is confidentiality. With fewer mental health professionals in a given area, fewer support mechanisms and services, and geographically large and sparsely populated areas, confidentiality can be more difficult to ensure in rural and frontier practice; while on the other hand a strict adherence to confidentiality can negatively impact important collaborative relationships in smaller communities (Scopelliti et al., 2004).

The close confines and small populations of many frontier areas and towns lend themselves to personal business being known by many people in the community and each person potentially being aware of many others' behaviors (Helbok, 2003; Roberts et al., 1999). It is in this regard that confidentiality is difficult to control as the size of the community lends

itself to many people knowing who is seeking and/or getting treatment at any time. The members of the community tend to collectively know those who are having difficulties with mental health, personal or addiction concerns. The stigma of receiving mental health services, particularly when the potential client knows that the community is aware of their actions, can cause many to avoid needed professional assistance. This is only compounded when the office or support staffs of a mental health service are longtime members of the community and are familiar with the client, or may even be related to the client. Potential clients may be reluctant to engage in services where they may personally know others, such as group counseling or outpatient addictions settings (Helbok, 2003; Solomon, Hiesbergr, & Winer, 1981). Office and support staffs, themselves not having to meet the ethical requirements of professional licensure, may be more apt to share confidential client information between themselves, friends and family members. This sharing of information between community members is a concern on a professional level as the lack of professional referral sources may mean involving people, groups and organizations that may not share a counselor's view of confidentiality. These referral sources may include community, church, and volunteer organizations, and these organizations and their associated paraprofessionals may create confidentiality concerns for clients through the informal sharing of information which is common in small communities.

This sharing of confidential information across professional lines also is significant in the relations of the counselor to the broader array of professional services and agencies that may interact with their clientele. Law enforcement, medical, educational and social service professionals may expect the rural and frontier counselor to freely share information the counselor considers confidential to the client. Without an appropriate informed consent or release of information the counselor is obligated to not share any personal or treatment information, or to even tell if the client is receiving services. This ethical stance can be damaging to a counselor's professional practice as it can distance them from the local professional community, reduce future client referrals and strain relations with other health and service professionals (Helbok, 2003; Solomon et al., 1981; Stockman, 1990). Hargrove (1986) maintained that confidentiality must be preserved unless there is consent to release information, or if there is a clear and present danger. At the same time, the counselor needs to be responsive to community standards and attempt to work in the best interests of their client even when most rural clients assume that information will be shared without their consent (Elkin & Boyer, 1987; Helbok, 2003). In frontier settings, it may be difficult to balance ethical obligations with community expectations, but the counselor can be the best agent of change in these situations by taking steps to educate referral sources and local professional organizations on the importance of confidentiality in counseling services and how confidentiality can reduce the client's fear of being stigmatized. Counselors also should take steps beyond the development of a comprehensive informed consent to discuss with clients the professional requirements of confidentiality and promote clarity regarding what information will be shared and in what circumstances (Helbok, 2003).

Boundaries of Competence

A counselor's boundaries of competence are defined as the "education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (ACA Code of Ethics, C.2.a, 2005) that qualifies a counselor to work with a particular client, population, or mental health area. In rural or frontier areas the determination of professional boundaries of competence can be difficult to achieve (Helbok, 2003). As rural and frontier clinicians are called upon to serve a diverse range of client issues, they tend to work as generalists rather than specialists in order to provide the highest quality of service to the most clients within a given area (Werth et al., 2010). Within a small community they may be asked to address many issues including adjustment concerns, addictions, mental illness, trauma, crisis, marital issues, career development, developmental and learning issues, life-changing circumstances and/or end-of-life concerns. These concerns can surface in any of the situations that a frontier counselor may find themselves in including community outreach, educational training, professional consultation and individual or group counseling settings (Werth et al., 2010).

When such a situation arises it is the duty of the counselor to determine if the concerns of the potential client fall within or without their professional competence while also considering the availability of appropriate referrals and professional services that may be better suited to address this issue, the geographic availability of such referrals, if such exists, and the ability, resources and inclination of the client to access such services. The counselor may choose to deny a client services on the grounds of non-maleficence; namely, that by working outside their areas of experience they risk more potential harm to the client than they would by violating their boundaries of competence. On the other hand, the counselor may

choose to uphold the principle of beneficence in regards to client care with the opinion that a potentially inappropriate treatment would be less harmful than no treatment, or when there are no reasonably available referral options (Remley & Herlihy, 2009). Both of these options can be untenable when judging the value of a person's mental stability and ability to function against an ethical code that does not take into account the realities of small community life. In that regard, each of these options serves to highlight the position that determinations of boundaries of competence in frontier areas need to include an awareness of the needs of the community.

In areas where members of close-knit communities traditionally depend on each other in the face of adverse living conditions, and the problematic behavior of even a single person can disrupt a family and through that a community, it is imperative to be aware of the interdependence and needs of small communities. With this in mind, when a frontier counselor is faced with a client concern that they do not feel wholly qualified to treat, they may choose to work with the client knowing that referral services are too far removed or inaccessible and that professional action may be construed as a violation of competence on the part of the counselor, but also that working with the client may serve to maintain the client's best functioning in the community, thus supporting the continued well-being of the community itself (Werth et al., 2010). In contrast, a counselor could deny services to a client based on the counselor's perception of their own professional abilities in regards to a particular client concern. The counselor could then seek to augment the boundaries of competence through supervision, mentoring and continuing education, expanding understanding until more comfort working with a particular concern or population was achieved. This assumes, of course, that adequate supervision and continuing education opportunities are available and that the counselor is able to access these services. In this manner, the frontier counselor is in the same predicament as their clients with geographic location and distance determining availability of resources. While technologies (Internet, audio/visual conferencing, telephone) do create greater potential access to necessary resources, the reality of frontier life is that many areas do not have Internet or phone access, or have very limited access heavily dependent on weather conditions and other factors relating to location and available technical resources. While most licensing boards allow some continuing education units (CEU's) to be obtained through distance means (Zur, 2006) and some allow distance supervision for licensure (McAdams & Wyatt, 2010), the actuality of frontier counseling frequently makes it difficult to readily obtain licensure CEU's, timely mentoring, and collaborative resources when needed.

Multiple Relationships and Conflicting Professional Roles

"A dual relationship would be considered to exist when, in addition to the professional role and relationship, there exists a further meaningful relationship with clear role expectations and obligations, such as employer, friend, family member, or business partner" (Brownlee, 1996, p. 498). These dual and multiple relationships are the most pervasive ethical concern facing rural and frontier counselors and are the most complicated of all the ethical dilemmas encountered in daily professional practice (Helbok, 2003; McDermott, 2007; Scopelliti et al., 2004; Werth et al., 2010; Zur, 2006).

Perceived problems with multiple relationships in counseling. The relationships themselves are, of course, not the problem. The ethical concerns begin to arise when the boundaries of a therapeutic relationship become unclear through multiple relationships to the extent that the potential of client dependency, feelings of entitlement to special favors, and financial, emotional, or sexual exploitation can more readily occur (Nickel, 2004). That is why the traditional view of managing multiple relationships has been to avoid them (Ebert, 1997; Faulkner & Faulkner, 1997; Stockman, 1990) and in general, the ethical codes of mental health professional organizations have discouraged multiple relationships in an effort to avoid exploiting the trust and dependency of clients (Erickson, 2001).

In the American Counseling Association's (ACA, 2005) ethics code, for example, counselors are encouraged to avoid all non-professional interactions or relationships with "clients, former clients, their romantic partners, or their family members…except when the interaction is potentially beneficial to the client" (A.5.c). If there is a potential benefit for a current or former client the counselor:

> must document in case records, prior to the interaction (when feasible), the rationale for such an interaction, the potential benefit, and anticipated consequences for the client or former client and other individuals significantly involved with the client or former client. (A.5.d.)

This may be a reasonable course of action when the counselor has the justifiable belief that he or she can move around in an environment without the immediate concern of interacting with a current or former client (Schank & Skovholt,

1997). But when the constraints of geography, availability of mental health services, population density, and the distinct characteristics and expectations of frontier communities and their inhabitants are taken into account it is a much more sensible assumption on the part of the frontier counselor that non-professional contact with a client, former client, their romantic partners, or their family members is not only inevitable but imminent (Faulkner & Faulkner, 1997; Schank et al., 2010). It is this inevitable imminence that lies at the heart of the disparity between current ethical guidelines and practical mental health provision to rural and frontier populations.

While there are some clearly delineated ethical violations that apply across professions and work environments, such as sexual or romantic counselor-client relationships, the complexity of social values and human relationships makes it impossible to define clear directives for engaging in nonsexual multiple relationships, particularly for those who practice in rural and frontier communities (Faulkner & Faulkner, 1997; Nickel, 2004; Pope & Vetter, 1992). With these considerations in mind, the idea that all dual relationships are unethical "would seem to be unnecessarily restrictive and unrealistic in a rural context" (Brownlee, 1996, p. 500).

Place of multiple relationships in frontier counseling. Unfortunately for the frontier counselor, the very social structure of frontier life fosters multiple interdependent relationships between people as a way of adapting to the realities of living in remote and sometimes harsh and dangerous environments. The smaller and more remote a community is, the greater the interdependence between its members in regards to life necessities such as food, water and shelter, as well as other needs including health issues, education and companionship (Roberts et al., 1999). In frontier areas, the likelihood of multiple relationships between community members is even greater due to scant resources and professional services, reduced population density, and the fact that many of the community members will have family relations between them as well. As Roberts et al. (1999) stated, "in these naturally 'enmeshed' communities, there are few options for relationships other than overlapping ones" (p. 499). Multiple relationships between members are seen as normal and reflect expected and traditional cultural and social norms (Campbell & Gordon, 2003). They expect to interact with each other in significant social and personal endeavors so their social norms have more flexible and permeable boundaries (Nickel, 2004) than might be encountered in less interdependent and socially interwoven populations.

Utility of multiple relationships in frontier counseling. It is into this world of highly interconnected social and familial relationships that the frontier counselor strives to be accepted and trusted. Faced on the one side with the idea of the ethical *slippery slope*, where relatively minor ethical infractions tend to lead to more severe violations (Faulkner & Faulkner, 1997), and on the other with a populace that expects and in many cases demands social and interpersonal interactions, the frontier counselor must find ways to be embraced by the people that make up their communities (Schank & Skovholt, 2006). The most secure route to this acceptance is through involvement with the community as this promotes familiarity which may lessen suspicion and increase approachability (Campbell & Gordon, 2003), thereby fostering community approval and trust (Horst, 1989; Schank et al., 2010).

This approval may directly establish the counselor as a trusted resource regarding mental health concerns and allow the counselor to act as an advocate for the value of formal therapeutic services. It also may indirectly influence clinical effectiveness (Erickson, 2001; Scopelliti et al., 2004) as clients may mistrust a counselor who lives and operates outside of the community structure and isn't available on social or personal levels. As Nickel (2004) stated, "No matter how warm and caring they may be during therapy, rural mental health care providers cannot be effective if they hold themselves distant and aloof in other situations" (p. 19). On a personal level, this aloofness may not be advisable as the frontier counselor, and potentially his or her family, is living in the community and as such, personal survival may depend on interactions and relationships with community members. This inherent dual relationship works against the potential of avoiding multiple relationships as it is acceptance into the community that helps ensure communal and personal survival in many frontier and remote areas. However, the deeper a counselor is accepted into a community the greater the probability of developing non-sexual multiple relationships with clients and their families (Werth et al., 2010). This, consequently, could lead to professional ethical concerns for all of the reasons mentioned previously and potentially lead to gross ethical violations and/or impairment on the part of the counselor (Faulkner & Faulkner, 1997; Stockman, 1990). It should be noted, however, that not all multiple relationships *must* lead to ethical violations. While some rural clinicians establish and maintain strict professional boundaries, discouraging multiple relationships due to a belief that clinicians who work in rural environments must make personal sacrifices (Faulkner & Faulkner, 1997), others believe that multiple relationships may enhance a clinician's standing in the community (Schank et al., 2010) to the extent that chance meetings

outside of therapy and routine social interactions are protected by the counselor's investment in the community and the community's trust in the counselor (Faulkner & Faulkner, 1997).

This emotional investment of the counselor in the community can become a positive ethical force as "dual relationships and familiarity with patients…tend to decrease the probability of exploitation—not increase it—as the power differential in a more egalitarian relationship is reduced" (Scopelliti et al., 2004, p. 955). Due to the counselor's involvement in the community, the local clientele may choose the services of the frontier counselor *because* they may be seen as someone who would understand and have awareness of the client's concerns (Schank et al., 2010). Thus the regard the counselor has for the community's overall welfare can act as a monitor "warning that distancing through anonymity and neutrality is not only likely to be counter-therapeutic, but also to increase the likelihood of exploitation" (Scopelliti et al., 2004, p. 955). This of course assumes that the counselor is diligently aware of their relations with clients and community members because, as Reamer (2003) states, such relations "can be ethically appropriate and, in fact, therapeutically helpful as long as the clinical dynamics are handled skillfully" (p. 128). Conversely, lack of awareness can lead rural clinicians to consider that because multiple relationships *can* be expected they are free to engage in any type of relationship and excuse it as a natural result (Werth et al., 2010).

Considerations for Frontier Counselors

Certainly there are no easy answers to the ethical dilemmas that working in frontier areas presents. Limited by resources, bound by geography and distance, and confronted with issues that might seem tractable in more urbane environments, the awareness of a frontier counselor needs to be focused on many professional and ethical levels at any one time.

Define Clear Boundaries

Informed consent is paramount. Considering the potential for ethical violations in a frontier setting the counselor must clearly communicate to his or her clientele the parameters within which the counseling relationship can exist. This should include how the client wishes chance or social encounters with the counselor to be handled as well as how multiple relationships, to the extent that they can be pre-determined, should be addressed when they occur. In an environment where overlapping relationships are best viewed as a certainty the need for transparency in the client/counselor relationship is fundamental for a clinical relationship that can weather the ethical realities of frontier life.

The counselor also needs to consider his or her own professional boundaries and determine a level of comfort in regards to the potential ethical issues that shape frontier clinical practice. Clarifying one's own understanding of where boundaries of competence are can help the counselor determine when he or she is entering an area of uncertainty regarding providing services in which the counselor may not be fully conversant. In this regard the counselor also needs to come to terms with his or her own acceptable level of multiple relationships with clients. Understanding one's self-determined boundaries, be they ethical or personal, can help alert the counselor to behaviors that could lead to ethical violations.

Confidentiality. The counselor must communicate to the client the confidentiality issues that are common in frontier environments and establish an understanding of the counselor's ethical and legal obligations. Even when the client expects the counselor to share information about the client with other services or professionals in the area, it is the responsibility of the counselor to foster an understanding on the part of the client as to the extent and obligation of counselor/client confidentiality. As with other aspects of counseling, the frontier counselor should also be prepared to define their professional boundary of confidentiality when dealing with other professional services or agencies in the area. To the extent that they are able, it is a counselor's duty to protect their client's confidentiality, even in the face of a cultural value that shares information as part of communal survival.

Professional Awareness

The journey from analyzing ethical case studies in training situations to personal involvement in potential ethical violations can be very short for the new frontier counselor (Schank & Skovholt, 2006). Counselors new to the frontier

perspective need to find qualified supervision to help them establish their understanding of ethical decision-making in ethically challenging environments. This may include investigating state licensure regulations on distance supervision (via phone, Internet, etc.) to expand the supervision and mentorship possibilities. The counselor, new or experienced, should also strive to find supervision and peer-consultation that has experience in rural and frontier communities to better support an informed awareness of the necessities and realities of frontier life.

"Acts of everyday living are self-disclosures" (Schank et al., 2010, p. 503) and the frontier counselor needs to be aware of their behavior on professional, social, and personal levels. As so much of frontier counseling is inter-relational, this self-attention is significant as it can help foster an awareness of the ethical aspects of many facets of frontier counseling practices and alert the counselor to potential ethical concerns in the making. When concerns are identified it is then incumbent on the counselor to determine the nature and extent of the issue and take action when necessary. The nature of that action is dependent on the role the counselor has created for themselves in the community, the needs of the client and the community and the potential actions that can be taken within cultural and ethical guidelines.

Cultural Awareness

With their own traditions and attitudes, frontier communities are very much their own small community cultures with self-determined ways of behaving and interrelating. For the frontier counselor to be accepted into the community it is necessary for the counselor to understand the values the community is built upon and work to honor and foster those values through professional practices. While many of the cultural behaviors of a frontier community may seem at odds with professional counseling ethical practices, a merging of the two is possible with vigilance and understanding. It is not for the counselor to enter a frontier community and require that they follow a professional ethic designed on a divergent cultural model by a dissimilar people; rather, it is for the counselor to appreciate that an ethical code is based on accepted cultural and behavior ideals and that it is the counselor's obligation to serve those ideals within the boundaries of accepted professional codes of ethics. Understanding the community needs and values in terms of desired ideals and expected behaviors will help the counselor to better become a part of and serve the community as an involved and invested member.

Future Investigation Directions for Frontier Ethics

As the work of rural and frontier counselors impacts a significant percentage of the U.S. population and that population experiences a higher lack of mental health provisions than urban clients, it is in our best interest to better understand the needs and practices of rural and frontier counselors so that we can then provide better services to rural and frontier communities. Primarily, research needs to explore the practices of small community, rural, and frontier counselors, which should include case studies of how clinicians approach and handle clinical issues. This investigation into counselor practices needs to focus on the ethical decision-making processes that counselors employ when managing the ethical concerns that are prevalent in these communities. It also needs to analyze the products of these processes in light of the professional counseling code of ethics to better determine at what level, if at all, rural and frontier counselors are experiencing ethical crossings or violations in their professional practices. Next, we need to gain an understanding of the extent to which counselor educators recognize and understand small community settings and their effect on counseling in such areas. This would include the training that may exist in counselor education regarding the preparation of counselors to work with small community, rural, and frontier populations and should include counseling program curriculum, professional development courses and continuing education opportunities. Understanding what counselors are being taught in relation to these populations will help to determine if their training is adequate and appropriate to the needs of these communities.

Conclusion

This paper seeks to illustrate the point that the ambiguity that makes a code of ethics a flexible set of guidelines of professional behavior also creates difficulties when the situations they caution against are an inherent part of the social fabric of the world that the counselor works within, particularly that of a rural or frontier community. It is clear that many ethical issues cannot be avoided when working with frontier communities and must be integrated into professional practice with due consideration. Counselors in these areas need to be conscientious in examining their relationships with

clients and community members. This examination should lead to clear communication with clients on potential ethical issues and help define the roles and boundaries of the client and the counselor. It also requires the counselor to remain vigilant against potential boundary violations and to take action whenever an issue arises (Helbok, 2003; Kitchner, 1988; Remley & Herlihy, 2009).

References

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: Taking diversity, culture and context seriously. *Administration & Policy in Mental Health & Mental Health Services Research*, *37*, 48–60. doi:10.1007/s10488-010-0283-2

American Counseling Association. (2005). *Code of ethics*. Alexandria, VA: Author.

Bolin, J. N., Mechler, K., Holcomb, J., & Williams, J. (2008). An alternative strategy for resolving ethical dilemmas in rural healthcare. *American Journal of Bioethics*, *8*(4), 63–65. doi:10.1080/15265160802147231

Brownlee, K. (1996). Ethics in community mental health care: The ethics of non-sexual dual relationships: A dilemma for the rural mental health profession. *Community Mental Health Journal*, *32*, 497–503.

Bushy, A., & Carty, L. (1994). Rural practice? Considerations for counsellors with clients who live there. *Guidance & Counseling*, *9*, 16–24.

Campbell, C. D., & Gordon, M. C. (2003). Acknowledge the inevitable: Understanding multiple relationships in rural practice. *Professional Psychology: Research & Practice*, *34*, 430–434.

Cook, A. F., & Hoas, H. (2008). Ethics and rural healthcare: What really happens? What might help? *American Journal of Bioethics*, *8*, 52–56. doi:10.1080/15265160802166009

Ebert, B. W. (1997). Dual-relationship prohibitions: A concept whose time never should have come. *Applied & Preventive Psychology, 6*, 137–156.

Elkin, B., & Boyer, P. A. (1987). Practice skills and personal characteristics that facilitate practitioner retention in rural mental health settings. *Journal of Rural Community Psychology*, *8*, 30–39.

Erickson, S. H. (2001). Multiple relationships in rural counseling. *Family Journal*, *9*, 302–304.

Faulkner, K. K., & Faulkner, T. A. (1997). Managing multiple relationships in rural communities: Neutrality and boundary violations. *Clinical Psychology: Science and Practice*, *4*, 225–234.

Hargrove, D. S. (1986). Ethical issues in rural mental health practice. *Professional Psychology: Research and Practice*, *17*, 20–23. doi:10.1037/0735-7028.17.1.20

Helbok, C. M. (2003). The practice of psychology in rural communities: Potential ethical dilemmas. *Ethics & Behavior*, *13*, 367–384.

Horst, E. A. (1989). Dual relationships between psychologists and clients in rural and urban areas. *Journal of Rural Community Psychology*, *10*, 15–24.

Kitchner, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling & Development, 67*, 217–221.

McAdams, C. R., III, & Wyatt, K. L. (2010). The regulation of technology-assisted distance counseling and supervision in the United States: An analysis of current extent, trends, and implications. *Counselor Education & Supervision, 49*, 179–192.

McDermott, D. (2007). *Rural psychologists' responses to multiple-role relationship ethical dilemmas and their perceptions of job burnout* (Doctoral dissertation). Available from ProQuest Psychology Journals database. (Publication No. AAT 3274819)

Murray, J. D., & Keller, P. A. (1991). Psychology and rural America: Current status and future directions. *American Psychologist*, *46*, 220–231.

Nickel, M. (2004). Professional boundaries: The dilemma of dual & multiple relationships in rural clinical practice. *Counseling & Clinical Psychology Journal*, *1*, 17–22.

Nusca, A., (July, 2011). *Rural U.S. population lowest in history, demographers say*. Retrieved from http://www.smartplanet.com/blog/smart-takes/rural-us-population-lowest-in-history-demographers-say/17982

Pope, K. S., & Vetter, V. A. (1992). Ethical dilemmas encountered by members of the American Psychological

Association. *American Psychologist*, *47*, 397–411.
Reamer, F. G. (2003). Boundary issues in social work: Managing dual relationships. *Social Work, 48*, 121–133.
Remley, T., & Herlihy, B. (2009). *Ethical, legal, and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.
Roberts, L. W., Battaglia, J., & Epstein, R. S. (1999). Frontier ethics: Mental health care needs and ethical dilemmas in rural communities. *Psychiatric Services*, *50*, 497–503.
Schank, J. A. (1998). Ethical issues in rural counselling practice. *Canadian Journal of Counselling*, *32*, 270–283.
Schank, J. A., Helbok, C. M., Haldeman, D. C., & Gallardo, M. E. (2010). Challenges and benefits of ethical small-community practice. *Professional Psychology, Research & Practice*, *41*, 502–510. doi:10.1037/a0021689
Schank, J. A., & Skovholt, T. M. (1997). Dual-relationship dilemmas of rural and small-community psychologists. *Professional Psychology: Research & Practice, 28*, 44–49.
Schank, J. A., & Skovholt, T. M. (2006). *Ethical practice in small communities*. Washington, DC: American Psychological Association.
Scopelliti, J., Judd, F., Grigg, M., Hodgins, G., Fraser, C., Hulbert, C., . . . Wood, A. (2004). Dual relationships in mental health practice: issues for clinicians in rural settings. *Australian & New Zealand Journal of Psychiatry, 38*, 953–959. doi:10.1111/j.1440-1614.2004.01486.x
Solomon, G., Hiesbergr, J., & Winer, J. L. (1981). Confidentiality issues in rural community mental health. *Journal of Rural Community Psychology, 2*, 17–37.
State of Alaska, Bureau of Vital Statistics. (n.d.). Retrieved from http://hss.state.ak.us/dph/bvs/
State of Alaska, Health & Social Services. (n.d.). Retrieved from http://hss.state.ak.us/dph/healthplanning/movingforward/intro.htm
Stockman, A. F. (1990). Dual relationships in rural mental health practice: An ethical dilemma. *Journal of Rural Community Psychology, 2*, 31–45.
Trading Economics. (2011). *Rural population (% of total population) in Canada*. Retrieved from http://www.tradingeconomics.com/canada/rural-population-percent-of-total-population-wb-data.html
U.S. Census Bureau. (2012). *The 2012 statistical abstract*. Retrieved from www.census.gov/compendia/statab/cats/population.html
U.S. Census Bureau, Health & Nutrition: Health Care Resources. (2012). Retrieved from http://www.census.gov/compendia/statab/cats/health_nutrition/health_care_resources.html
U.S. Department of Health and Human Services, Health Resources and Services Administration. (2011). Retrieved from http://bhpr.hrsa.gov/shortage/
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). Retrieved from http://www.oas.samhsa.gov/2k7State/Alaska.htm
U.S. Hospital Finder. (2011). Retrieved from http://www.ushospitalfinder.com/hospitals-in/Alaska
Wagenfeld, M. O. (1988). Rural mental health and community psychology in the post community mental health era: An overview and introduction to the special issue. *Journal of Rural Community Psychology, 9*, 5–11.
Werth, J. L., Jr., Hastings, S. L., & Riding-Malon, R. (2010). Ethical challenges of practicing in rural areas. *Journal of Clinical Psychology, 66*, 537–548.
Wilcoxon, S. A. (1989). Leadership behavior and therapist burnout: A study of rural agency settings. *Journal of Rural Community Psychology, 10*, 3–14.
Zur, O. (2006). Therapeutic boundaries and dual relationships in rural practice: Ethical, clinical and standard of care considerations. *Journal of Rural Community Psychology, E9*(1).

Sources by Which Students Perceive Professional Counselors' Effectiveness

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Using qualitative research methods, interviews were conducted with college students regarding the sources they used in generating perceptions of professional counselors. Respondents believed that information sources such as word of mouth, media sources and personal experiences were responsible for their understandings of professional counselors. The findings have applications for leaders in professional counseling organizations. Common knowledge characteristics, public perceptions, counselor identity and advocacy are discussed.

Keywords: perceptions, professional counselors, information sources, counselor identity, advocacy

Perceptions do not equal reality. However, perceptions eventually can lead to what reality becomes in time. All professions possess public perception. When someone refers to doctors, lawyers, dentists, and other specialized occupational groups, images are created in our minds. These percepts possess varying degrees of reality, of course, but the effects of such images are cogent nonetheless. Of particular interest to the present study is the perception of human service personnel, including professional counselors.

As a whole, the human service profession has landed itself on the positive side of the public's opinion spectrum (Nunnally & Kittross, 1958). McGuire and Borowy's (1979) research showed a continuum of perceptions held by the lay public regarding a wide range of professionals who worked with mental illness. Those occupying the fields of nursing, physicians, counseling psychologists, social workers, psychiatric nurses, psychiatrists, and clinical psychologists received the highest rankings.

Undergraduate students' opinions regarding effectiveness of various human service providers for helping mental health consumers were reported by Tse, Wantz, and Firmin (2010) and Wantz and Firmin (2011). Participants in these studies rated human service providers' effectiveness more positive than negative. Professional counselors and psychologists were rated more effective with providing mental health services than other human service providers.

Richardson and Handal (1995) found the general public viewed psychotherapy as a reasonably effective means of treatment for between 25 and 50% of all cases. Most people also recognized that services of *less traditional* human service providers, such as marriage and family therapists, also could be used effectively in relation to particular disorders. Psychiatrists and psychologists, however, were perceived as having higher levels of competence when addressing mental health issues (Schindler, Berren, Hannah, Beigel, & Santiago, 1987). Educational attainment (Dotson-Blake, Know, & Holman, 2010), chronological maturity (Erikson, 1963; Oliver, Reed, & Smith, 1998), and psychosocial development (Tinsley, Hinson, Holt, & Tinsley, 1990) have been reported to be positively correlated with perceived benefits of counseling.

Murstein and Fontaine (1993) found familiarity of the general public to be greater concerning physicians, clergypersons, and psychiatrists than it was in their knowledge of psychotherapists and psychologists. Consequently, of the two, psychologists were the source the general public was most likely to use when recommending a human service

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provider. Also reported, the most common reasons for which clients sought mental health professionals were mild depression, marital problems, and child-rearing issues. A generation ago, Gelso, Brooks, and Karl (1975) reported mental health consumers' overall preferences to be for counseling psychologists and psychiatrists.

Sharpley (1986) purported a tendency for mental health consumers to separate human service professionals into two categories, each entailing distinct perspectives. First, private practice and fee-for-service providers, psychologists and psychiatrists being the most prominent, were viewed as those who were most competent in treating mental illnesses. Second, public-utility and non-fee-demanding professionals, of which social workers and counselors prominently emerged, were perceived as being more practical and apt in providing service to the average person when addressing emotional problems.

Among the various human service professionals, counselors are of particular interest to the present study. Sharpley, Bond, and Agnew (2004) indicated that the public views counselors' roles to be primarily listening, supporting, and helping to solve problems. While 79% said counselors were needed, and the same number indicated a willingness to pay for services provided, survey respondents personally were likely to consult a counselor concerning only 13–20% of the problems they faced. Participants also reported benefits of counseling to include having an impartial person to listen and help clarify, as well as having a facilitator for problem-solving, and meeting in a safe, confidential environment.

Fall, Levitov, Jennings, and Eberts (2000) described the public's expressed general confidence in professional counselors' abilities to treat "less serious" cases, but less confidence when treating cases which were perceived to be at higher levels of seriousness (e.g., psychopathology). These findings are congruent with those found by Fall, Levitov, Anderson, and Clay (2005) specifically studying the perceptions of the African-American population. In both studies, the participants expressed significantly greater levels of confidence in the abilities of psychiatrists when addressing severe issues, such as psychotic depression or post-traumatic stress disorder. Findings further showed that doctoral-level counselors were perceived similarly to clinical psychologists, while both studies showed that in every case professional counselors with doctorates were preferred over those with only master's-level education. Wantz, Firmin, Johnson, and Firmin (2006) reported on university student perceptions of high school counselors. This qualitative study found college students reported high school counselors as having similar empathic and desire to help skills as licensed professional counselors.

Dixon, Vrochopoulos, and Burton (1997) reported the underrepresentation of counseling psychologists in introductory psychology textbooks, showing counseling to have significantly fewer references than clinical, school, and industrial psychologists. Likewise, Firmin, Johnson, and Winkler's (2005) research showed almost no references to professional counselors in general psychology texts. Consequently, we conclude that while the public generally possesses positive perceptions of professional counselors, their presence is kept somewhat cryptic by the gatekeepers. College-educated students depend on introductory psychology texts to frame for them professional domains and functions among human service professionals.

As counselors have achieved professional status through licensure over the last two decades, identity confusion has been demonstrated by the practitioners within the field (King, 2006). Inevitably, this perplexity has trickled down to the minds of mental health practice consumers regarding distinctions and roles of professional counselors. Consequently, while the public generally likes the construct of who they think of as counselors, they also are unsure of these professionals' roles (Butterfield, 1989).

Decades ago, Dahlem (1969) called for the vital need to research the general publics' perception of counselors' images and role perceptions, compared to counselors' self-perceptions. He stressed the importance of clarifying consumers' understandings and perceptions in relation to the success of the providers. Gelso and McKenzie (1973) followed up, studying ways in which students were informed of counselors' available assistance. Students receiving only written information about hypothetical problems appropriate for counseling were less likely to experience changes of perceptions. This suggested that the most effective way to impact students' impressions concerning counselors would be the presentation of written and oral information.

Narrowing the scope, the present study updates this important research inquiry. Specifically, our interests were to explore how college students, as potential consumers of mental health services, came to their understandings of counselors' professional competence. That is, how effective do students perceive professional counselors to be? Obviously, since such perceptions are tied to students' ultimate use of counselors' services, the answers to the research question have significant implications for personnel working in college counseling settings.

Method

In accomplishing the study's aim of assessing how college students generate their perceptions of professional counselors, we considered a number of potential research designs. While quantitative methods such as surveys would provide us with a relative breadth of understanding in this area (Patten, 1998) and this would be valuable, we believed such an approach would not be as apt as a qualitative design. Generally, quantitative approaches answer "what" or "how many" types of questions (Sarafino, 2005). However, we were more interested in knowing answers to "how" and "why" types of questions. These, by and large, are best answered via qualitative designs (Atkinson, Coffey, & Delamont, 2003).

At the outset, we are explicit regarding our decision in using an atheoretical approach to the qualitative method. Significant and heated debate presently exists in qualitative circles regarding whether one should or should not use theory—and if so, what that role should be. Originally Glaser and Strauss (1967) advocated that atheoretic, inductive approaches were the only means of generating a grounded theory. Later, Strauss and Corbin (2008) purported that theory was legitimate and useable for some qualitative research designs. Glaser (1992), however, vehemently opposed this departure from the classical approach indicating that researchers must exercise disciplined restraint in holding back theory when generating or interpreting results.

Obviously, we are not going to abate the controversy in this article, but we do wish to be explicit in reporting our commitment to classical grounded theory. That is, philosophically we believe that phenomenological studies such as the present one should be conducted inductively—holding theory at bay. While we understand the implications and even potential limitations of this approach, we believe it to be most apt, nonetheless.

A sample of 26 students was drawn from a general psychology course (16 females and 10 males). The institution was a selective, private comprehensive university located in the Midwest. Departing from traditional criterion or purposeful sampling most often used with qualitative research (Seidman, 2006), we used random sampling for this study because we wished to enhance the external validity of our findings as much as feasible. That is, the trade-off of expanded generalizability was believed to be worth the expense of potentially less rich descriptions through specifically selected students. Since the general psychology course was part of the liberal arts core curriculum at the institution, our sample reflected a relatively wide cross-section of majors, included students who were freshmen through seniors, and participants' ages ranged from 18 to 22 years of age. Interviews were tape recorded and later transcribed for analysis. In writing the present article, we used respondent pseudonyms for reading clarity.

We utilized a semi-structure method in conducting the in-depth interviews. We used staple constructs for generating questions, but also allowed students to deviate in their replies, enabling them to tell their own stories and share perceptions inductively. Following Firmin (2006a), two waves of interviews were conducted. That is, all participants were interviewed twice—with transcription and coding occurring in between the interviews. This allowed for constant comparison of the data and dialogue among the researchers for generating potential codes.

When analyzing the interviews, we used an open (Maxwell, 2005) coding, inductive process (Marshall, 1999). Since we located no studies published on this topic, axial coding was not practical and open coding was more consistent with the study's exploratory aim. Frequent meetings among the article's authors occurred and this process facilitated coding, providing verifications for consistency of analysis. When generating potential codes, we read through the transcripts, utilizing constant comparison methods (Bogdan & Biklen, 2007). This involved continuously comparing the transcripts to one another, looking for any repeating words, phrases, or constructs that were common among the participants. In order to keep the data manageable, some similar categories were collapsed into major categories. NVIVO qualitative research software also was used to help analyze data. This program helps to manage relatively large amounts of transcript

documentation as well as aid in the generation of reliable themes across multiple participant data sets. This technology enhanced human capability, and it did not replace the role of subjective judgments required to conduct intuitive work (Lewins & Siver, 2007). Following Gay, Mills, and Airasian (2009), the process of transitioning from codes to themes involved asking key questions, conducting organizational review, visually displaying the findings, and concept mapping.

The research team's dialogue regarding potential thematic outcomes enhanced the study's internal validity. Naturally, one researcher can appropriately analyze data and provide apt findings. Nonetheless, the assurance of valid findings often is enhanced when multiple qualitative researchers participate in the analysis process (Ryan & Bernard, 2003). We included in this article only those themes on which the entire research team concurred. The study's internal validity also was strengthened through generating a data trail (Daytner, 2006). This involved generating direct connections between each reported theme in our transcripts through identifying specific paragraphs within the interview conversations. Data trails can be useful to those who wish to check the validity of our reported findings or who hope to someday replicate or advance our present study (Firmin, 2006b).

Third, member checks (Merriam, 2002) were applied with various research participants. This is a qualitative research technique whereby we shared our findings with research subjects, garnering their feedback regarding how reported results aptly reflected their reported perceptions during the interview process. Each of the individuals with whom we checked commonly agreed with our reported results. Fourth, we strengthened the study's internal validity by including participation from an independent researcher with renowned expertise in qualitative methodology (Flick, 2006). This expert appraised the steps at each stage of the study, the legitimacy of our process, assessed our data audit, and provided analysis regarding linking the transcripts data with the results. Fifth, saturation (Silverman, 2006) occurred when analyzing the transcript data. Specifically, after approximately 24 interviews, our participants generally shared similar sentiments, with few fresh insights added as subsequent interviews were added to the sample. In the qualitative tradition of experts such as Guest, Bunce, and Johnson (2006) and Neuman (2006), we believe our sample size was both ample and appropriate for the context of this specific study.

In summary, internal validity is a critical component in delineating appropriate qualitative research (Cope, 2004). Weightier confidence may be placed in the reported themes, that they adequately represent the general sentiments of the research participants when particular, deliberate steps are taken. Both in the study's design and its implementation, we believe this project demonstrates rigor by established qualitative research standards (DeWet & Erasmus, 2005) and an apt grounded theory of the data collected (Lundberg & Young, 2005).

Results

Upon examination of the interviews, several themes emerged from the coded transcripts. Primarily, respondents discussed their awareness of sources such as the media, word of mouth, and personal experience in the development of opinions regarding professional counselors. Further, respondents discussed characteristics of a "common knowledge" upon which consumers draw in their utilization or hesitancy of seeking counseling services. Finally, responses delineated the perceived effects of this common knowledge on the reputation of counseling.

Three Sources

Repeatedly, respondents spoke of three main sources on which they depended in generating their opinions of professional counselors' effectiveness. Respondents particularly mentioned the contribution of media sources such as radio, newspapers, television, and movies, along with the more personal and implicative sources of word of mouth and personal experience. Considered holistically, this amalgamated into a nebulous resource of *common knowledge*. One respondent defined common knowledge as "general sources," implying the prevalent accessibility of this information.

Consistent with the sample's generational factors, responses repeatedly indicated the role of the media in their concept formation of who professional counselors are and what they do. Janet explained that "common knowledge would probably be just things they've heard on TV or seen on TV," revealing the expectation of what a professional counseling session should theoretically cover and how a session should appear. Media also sharply influenced perceptions of what a

counselor and client should look like (i.e., personal dress and hygiene) and even where these services are located (e.g., in a swanky hospital wing or in urban city slums). Pete specifically mentioned the impact Hollywood had on the formation of his own perceptions, indicating no coincidence in the congruity of college students' expectations with media depictions.

Fortunately, respondents spoke with a voice of relative discernment, aware of the possible slants injected into information relayed by the media. Injecting a sense of humor, Jason admitted: "I know I was watching TV the other day, I think it was *Growing Pains*, or something like that, and they were talking about it [counseling] so that's how I know." Not credulous to the media portrayal, he continued: "Like they have no problems in life, everything's going smooth for them . . . people that have no problems and are like happy all the time . . . that's not true." While not all respondents explicitly expressed this intuition, they generally did note the connotations associated with counseling by the media. For example, Coleen noticed the subliminal messages as she watched movies or television shows: "It's usually like TV and movies just have different characters in them and it usually seems like a negative type thing. . . I think that they make it seem like it's [counseling] a weird place to go and it's not a fun thing." Clearly, the media is not a bias-free information source, but requires active examination on the part of the viewer.

Numerous respondents mentioned the place that word of mouth had in the formation of their perceptions about counselors. Where personal experience waned and media fell short of credibility, respondents turned to testimonies of people they know who were counseled first-hand and held credence. When asked to describe sources of common knowledge regarding her perceptions of counselors, Barb offered: "I think a lot of people would be, maybe from people they know, who have been to one, who are one [professional counselor]." Respondents feel that no matter the strength of the connection, be it from a friend-of-a-friend or from the mouth of a professional counselor, hearing of others' encounters considerably influences perception formation. Making judgments on topics with which respondents are personally unfamiliar (i.e., no personal experience in counseling) is alleviated when backed by the testimony of personal references.

Dan mentioned the input of "the whole movies and TV and media" in passing, but pointed to word of mouth as the primary information hub about how he developed his percepts regarding counselors. His assertion that word of mouth is the primary means rests on another assumption, "I'm sure probably the majority of the people don't go to counseling," highlighting that where personal experience lacks, the information network through word of mouth becomes prominent in concept formations. Dan concluded: "I think that in general it's the word of mouth because you always know someone who's been through something or doing something and has had to go to counseling." Respondents believed that personal encounters with counselors by their friends were a rarity, and in a sense a commodity, taking what they heard at face value. As such, their collections of personal testimonies were typically sparse. Johanna considered word of mouth to be the prominent common knowledge source when thinking about counselors, as she stated: "I haven't really read up on them or anything, but just based on what people have said, that's where I've gotten my perspective from." Even more, Johanna looked to her immediate context: "For me it would be more of adults, like parents, parents' friends, stuff like that." Speaking from the periphery, students gain perspective based on other's comments.

When accessible, respondents relied on personal experience and interactions of acquaintances as their main contributors to their knowledge base about professional counselors. No matter how insignificant the interaction, respondents preferred personal encounters or those of close friends, more so than media or other sources, in their concept formations. For example, Emma drew on memories from elementary school: "Just like experiences in elementary school where counselors came around and talked like 'don't do drugs and things like that." Respondents readily admitted their recollections may be somewhat "fuzzy," but nonetheless preferred these to more broad sources.

The context of "home" was imperative for perception formation about counselors among respondents in our sample. Specifically, respondents heavily relied on past experiences to formulate opinions about new concepts or in discussing unfamiliar territory. Carla offered this insight: "I suppose it could be something that has come from their background or their family life." Familial beliefs are known to possess cogent influences in multiple life domains such as politics, religion, prejudice, etc. In the present context, our students suggested that generational influences play a moderating role in perceptions of professional counseling.

As the majority of respondents could not draw from personal experience, the testimony of friends often was their closest connection to professional counselors. Stephanie mentioned that common knowledge was a salient influence in how she came to think of counselors. Later, she elaborated this could be from talking with "friends that went to go see a counselor" and who could fill in the gaps of her understanding. Randy affirmed the power generated when he will "hear other people's experiences." Obviously, respondents in our sample could not judge the relative quality of their friends' experiences or the degree of truth represented by their friends' accounts. But hearing what their friends told them left indelible impressions, nonetheless.

Common Knowledge Characteristics

Upon examination of their information sources, respondents reflected on the characteristics of their sources. Specifically, respondents mentioned that their knowledge about unfamiliar topics such as professional counselors may have little-to-no factual basis or may be unreliable. Mandy shared that respondents evaluate counselors by "just what they think they know. It might not necessarily come off of anything." Respondents often were aware of this vulnerable reasoning, but when asked to offer their opinions, they drew on the ambiguous *common knowledge* anyhow. Linda stated her perception that this concept was "possibly general statistics or people's assumptions about professional counselors, not necessarily what's true." In consideration of the often inaccurate portrayal of counselors through movies, magazines, and additional sources of media, these assumptions may differ widely from reality. Kevin offered this reasoning about how common knowledge affects perceptions about counselors: "People . . . think they know stuff about stuff, and really don't. . . . So that's why the majority of people don't even know much about counselors and stuff like that. They hear one thing, and generalize it about everybody." The tendency to generalize can be potently beneficial, depending on the accuracy of the source, of course. This principle has important ramifications for the development of counseling as a potential profession.

A second characteristic of common knowledge in our study is an inability of participants to recall the sources from which the information comes. Clearly, when making decisions such as choosing counseling services, knowing potential sources behind the motivation for utilizing them are important. Lori mentioned that students often rely on "things from a long time ago that they may not remember specifically" in order to evaluate the positive or negative effects of seeking professional counseling services. Similar to Rob's tendency to generalize, our subjects' distant recollections were said to be formative in their perceptions, however accurate they may or may not be. Steve elucidated that this source of common knowledge may be far removed from the true source: "Like second and third hand information about people who have gone to counselors, again television and movies, the joke from the Sunday newspaper, you know." Perceptions for these students are formulated from a conglomeration of sources, credible or not, evidently even from the comics section of the Sunday newspaper.

While respondents relied heavily on word of mouth, Jordan did speak of the possible flaws in this resource: "I guess from other people talking to them about it. You can't just know, obviously, but obviously they don't remember where they've heard it from." While acquaintances and peers may be eager to share their opinions, our subjects evidently often were unable to support their opinions with factual sources. Cathy concurred in stating that common knowledge of counselors is generated by "probably a little bit of what they fill in, what they assume." Not only are their potential sources emitting their own assumptions, but the respondents fall prey to the same tendency in order to compensate for lack of information. Sandy further clarified, "it may just be, I assume they're this way, but they really didn't base that off of anything," again revealing the flaws in their apt perception formation.

Effects of Common Knowledge

Without doubt, the lack of verifiable validity found in common knowledge about counselors creates powerful effects for the advancement of counseling as a profession. Namely, not only is the reputation of services potentially marred, but respondents also may be less likely to seek out counseling when needed due to their incorrect assumptions and faulty sources. Respondents reported feeling that the media, through movies, magazines or books, too often generates negative connotations with professional counseling images. Rachel noted: "I think that it [media] negatively affects their perception of professional counselors." When prodded to share more, she continued: "A lot of times in TV and in movies they're portrayed as odd people so I guess that's the image that a lot of people have, because going back to their philosophy in

the way they conduct their counseling." Most definitely, "odd" is not a positive connotation to associate with professional counseling. In times of need, respondents likely will not seek out a source they consider to be odd. Larry offered a similar insight in his comment: "Probably that they're just people who sit there and they try and make you talk to them even though you don't want to and, I don't know, probably the same thing that they would be with a psychologist." This statement is loaded with several faulty assumptions, ubiquitous in other students' comments. First, respondents tend to believe counselors *force* their clients to talk about issues when they do not wish to receive counsel, or that their sessions consist more of passive listening, where clients ramble as the counselor nods occasionally and interjects the expected empathetic reflection. Second, this respondent offhandedly equated counselors with psychologists, illuminating the lack of public awareness in deciphering services offered by counselors compared to psychologists.

Students indicated that the connotations afforded by common knowledge sources of professional counselors sometimes are positive and sometimes negative, depending on the source. Molly used media news as a concrete example: "Well, usually if they hear it in the news it will be negative, if the counselor screws up, they'll hear that, and it might give them a bad image." She continued that one negative news report could be potent enough to prevent her or others from ever seeking a professional counselor, regardless of the intensity of the personal need. Similarly, Kim thinks that movies could "go either way" and the audience "can either think of a positive image of counselors that they really do help someone, or they can portray them as people who are out of touch with reality and don't really help the person necessarily." This phenomenon follows the similar vein relative to the equivocal nature of these sources. Clearly, the common knowledge phenomenon affects the realm of professional counseling by impacting not only expectations of a session on the part of the counselor or the client, but also regarding the tendency to seek professional counseling services.

Discussion

We believe that due deliberation of our findings are warranted on two levels: macro and micro. On the macro level, professional organizations must become more aggressive in advocating for the profession in media and other "common knowledge sources." Specifically, we interpret our results as a clarion call to the American Counseling Association (ACA), the American Mental Health Counselors Association (AMHCA), and the National Board for Certified Counselors (NBCC).

In the past decade, how many times has a major motion picture made central references to a Licensed Professional Counselor (LPC)? A systematic assessment in answering this important question is warranted elsewhere. However, the authors of the present article are unaware of a single time when this has occurred. We do recall, of course, main characters visiting psychiatrists, psychologists, social workers, and even marriage & family therapists. But, it is completely unacceptable for Hollywood to ignore licensed professional counselors.

Our findings suggest that movies are powerful sources by which the public come to generate their perceptions of professional counselors. When movies ignore the profession, then it follows that counselors become vulnerable to unhealthy stereotypes, negative perceptions, or simply empty perceptions. The role of professional counseling organizations is to advance the profession—and our data suggests that much more needs to be done in this domain.

To be more specific, every time a major motion picture is released where main characters interact with human service professionals that are not counselors—advocacy must occur. That is, leaders of ACA, AMHCA, NBCC, state counseling organizations, and others need to issue united statements of protest. Media such as the *Associated Press* need to pick up on these protests, carrying complaints of professional counselors' lack of Hollywood notice.

To proactively accomplish this, the professional organizations must make permanent connections with producers, directors, writers, and other influential individuals in Hollywood as scripts are generated. Hollywood needs to be aware that if they ignore professional counselors as potential sources of human service provision, then the professional counseling organizations will become active. It should be worth their while to ensure that an apt, positive representation of counselors occurs.

On the micro level, individual counselors must be more active when advertising their services to the public.

Specifically, the local media should be utilized to portray positive messages about professional counselors and benefits of service utilization. Local news media frequently look for short stories or opinions from human service professionals on various topics. This particularly is true around holidays or other special occasions—or even traumatic events—when media generate special interest stories. Local television specials can be powerful mediums for perception formation among families and potential clients. Universities with communication arts programs can budget monies for student and/or professionally generated DVDs that highlight and promote professional counselors as quality options during times of personal need.

The same advocacy can occur with school newspapers, web sites, circulars, and other sources of "common knowledge." Respondents from the present study indicated that media is a powerful source and influences their perceptions. Professional counselors, therefore, should seize this medium—using it to generate reoccurring positive messages.

Respondents also told us that parental opinions, former clients, information from friends, and other word of mouth sources were important in how they came to think of professional counselors. There is little that counselors can do to encourage positive word of mouth advertising for professional counselors. However, they can utilize the media to its fullest.

On both macro and micro levels, we are concerned about professional counselors' general tendencies towards passivity. That is, counselors presently are at the mercy of how happenstance may occur in clients' lives to formulate perceptions of counselors. Rather, counselors should architect how they want potential clients to think about them. Draft the message and then market it through public service announcements, movies, the media, and other sources that consumers say are important to their concept formations. In short, be proactive rather than *laissez-faire* on this important matter.

Limitations and Future Research

We believe the present research study provided an apt representation of the students interviewed. However, as with all qualitative research, external validity is a limitation. That is, while replication is important for quantitative research (Cumming, 2005), qualitative research is particularly context dependent, relying on replication ultimately to prove its generalizability (Firmin, 2006b). In this light, we are limited in our ability to apply the present findings to all students at all universities in the United States or the public in general. Further research should replicate this study, assessing students and potential clients in varying parts of the country. Further, national survey data should be collected—providing more breadth to our present findings—although, of course, breadth and depth acquisitions tend to be methodological tradeoffs.

No minority representation was included in the present sample. Of course they were not deliberately excluded; rather, the general psychology class from which the sample was drawn contained only a few minority students. By random sample chance they were not included. As previously indicated, we used random sampling of the students in the study in order to enhance external validity as much as possible. The university from which the sample was taken contains only a 6% total minority population. Consequently, further research should be conducted in this area, possessing greater numbers of minority students in those samples. Also, replicating the present qualitative study with all minority students would provide an interesting comparison to the present findings from a Caucasian sample.

In sum, we believe that the present study has powerful heuristic value. Researchers should take this concept and develop it much further than what we were able to do in the present design. Assuming that professional counseling is going to develop and flourish in the upcoming decades, then the call we make for proactive advocacy must be heard. Students and the public have perceptions of professional counselors. That simply is a fact of human nature. It behooves the professional counselor leaders as well as individual counselors to craft what they wish those perceptions to be.

References

Atkinson, P., Coffey, A., & Delamont, S. (2003). *Key themes in qualitative research*. New York, NY: Rowman & Littlefield.

Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education* (5th ed.). Boston, MA: Allyn & Bacon.

Butterfield, P. J. (1989). The assessment of mental health professionals' public image by means of multidimensional scaling. Digital Dissertations. (No. AAT 9019467)

Cope, C. (2004). Ensuring validity and reliability in phenomenological research using the analytical framework of a structure of analysis. *Qualitative Research Journal, 4,* 5–18.

Cumming, G. (2005). Understanding the average probability of replication: Comment on Killeen. *Psychological Science, 16*, 1002–1004.

Dahlem. G. G. (1969). Counselor image: Crucial target for research. *Counselor Education and Supervision*, *8*, 130–135.

Daytner, K. (2006, June). *Validity in qualitative research: Applications of safeguards*. Paper presented at the 18th Annual Ethnographic & Qualitative Research in Education Conference, Cedarville, OH.

De Wet, J., & Erasmus, Z. (2005). Toward rigor in qualitative research. *Qualitative Research Journal*, *5*, 27–40.

Dixon, N. D., Vrochopoulos, S., & Burton, J. (1997). Public image of counseling psychology: What introductory psychology textbooks say. *The Counseling Psychologist*, *25*, 674–682.

Dotson-Blake, K., Know, D., & Holman, A. R. (2010). Reaching out: College student perceptions of counseling. *Professional Issues in Counseling*. Permanent on-line access http://www.shsu.edu/~piic/Fall2010.html

Erikson, E. (1963). *Childhood and society* (2nd ed.). New York, NY: Norton.

Fall, K. A., Levitov, J. E., Anderson, L., & Clay, H. (2005). African Americans' Perception of Mental Health Professions. *International Journal for the Advancement of Counseling*, *27*, 47–56.

Fall, K. A., Levitov, J. E., Jennings, M., & Eberts, S. (2000). The public perception of mental health professions: An empirical examination. *Journal of Mental Health Counseling, 22*, 123–134.

Firmin, M. (2006a). Using interview waves in qualitative research. In P. Brewer & M. Firmin (Eds.) *Ethnographic and qualitative research in education* (pp. 175–181). Newcastle, UK: Cambridge Scholars Press.

Firmin, M. (2006b, June). *External validity in qualitative research*. Paper presented at the 18th Annual Ethnographic and Qualitative Research in Education Conference, Cedarville, OH.

Firmin, M., Johnson, E., & Wikler, J. (2005, February). *Professional human service occupation biases in general psychology textbooks.* Paper presented at the 8th Annual Conference of the American Association of Behavioral and Social Sciences, Las Vegas, NV.

Flick, U. (2006). *An introduction to qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Gay, L. R., Mills, G. E., & Airasian, P. (2009). *Educational research* (9th ed.). Upper Saddle River, NJ: Pearson.

Gelso, C. J., Brooks, L., & Karl, N. J. (1975). Perceptions of "counselors" and other helpers: A consumer analysis. *Journal of College Student Personnel, 16,* 287–292.

Gelso, C. J., & McKenzie, J. D. (1973). Effect of information on students' perceptions of counseling and their willingness to seek help. *Journal of Counseling Psychology, 20,* 406–411.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*, 59–82.

King, J. H. (2006, July). Identity crisis and a uniform counseling title. *Counseling Today,* 17.

Lewins, A., & Silver, C. (2007). *Using software in qualitative research: A step by step guide*. Thousand Oaks, CA: Sage.

Lundberg, C. C., & Young, C. A. (2005). Modified grounded theory: How defensible is it? *American Association of Behavioral and Social Sciences Journal*, *8*, 90–98.

Marshall, M. N. (1999). Improving quality in general practice: qualitative case study of barriers faced by health authorities. *British Medical Journal, 219*, 164–167.

Maxwell, J. A. (2005). *Qualitative research design* (2nd ed.). Thousand Oaks, CA: Sage.

McGuire, J. M., & Borowy, T. D. (1979). Attitudes toward mental health professionals. *Professional Psychology, 10,* 74–79.

Merriam, S. B. (2002). Assessing and evaluating qualitative research. In S. Merriam (Ed.).*Qualitative research in practice* (pp. 18–33). San Francisco, CA: Jossey-Bass.

Murstein, B. I., & Fontaine, P. A. (1993). The public's knowledge about psychologist and other mental health professionals. *American Psychologist, 48,* 839–845.

Nunnally, J., & Kittross, J. M. (1958). Public attitudes toward mental health professions. *American Psychologist, 13,* 589–594.

Oliver, J. M., Reed, K. S., & Smith, B. W. (1998). Patterns of psychological problems in university undergraduates: Factor structure of symptoms of anxiety and depressions, physical symptoms, alcohol use, and eating problems.

Social Behavior and Personality, 26, 211–232.

Patten, M. L. (1998). *Questionnaire research: A practical guide*. Los Angeles, CA: Pyrczak.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*, *15*, 85–109.

Richardson, P., & Handal, P. (1995). The public's perception of psychotherapy and counseling: Differential views on the effectiveness of psychologists, psychiatrist, and other providers. *Journal of Contemporary Psychotherapy*, *25,* 367–385.

Sarafino, E. P. (2005). *Research methods: Using processes & procedures of science to understand behavior*. Upper River Saddle, NJ: Prentice Hall.

Schindler, F., Berren, M. R., Hannah, T. M., Beigel, A., & Santiago, J. M. (1987). How the public perceives psychiatrists, psychologists, nonpsychiatric physicians, and members of the clergy. *Professional Psychology: Research and Practice*, *18,* 371–376.

Seidman, I. (2006). *Interviewing as qualitative research*: *A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College, Columbia University.

Sharpley, C. F. (1986). Public perceptions of four mental health professions: A survey of knowledge and attitudes to psychologist, psychiatrists, social workers, and counselors. *Australian Psychologist*, *21,* 57–67.

Sharpley, C. F., Bond, J. E., & Agnew, C. J. (2004). Why go to a counselor? Attitudes to, and knowledge of counseling in Australia, 2002. *International Journal for the Advancement of Counseling, 26,* 95–108.

Silverman, D. (2006). *Interpreting qualitative data* (3rd ed.). Thousand Oaks, CA: Sage.

Strauss, A. L., & Corbin, J. (2008). *Basics of qualitative research: Grounded theory procedures and techniques* (3rd ed.). Newbury Park, CA: Sage.

Tinsley, D. J., Hinson, J. A., Holt, M. S., & Tinsley, H. E. A. (1990). Level of psychosocial development, perceived level of psychological difficulty, counseling readiness, and expectations about counseling: Examination of group differences. *Journal of Counseling Psychology, 37*, 143–148.

Tse, L. M., Wantz, R. A., & Firmin, M. (2010). Perceptions of effectiveness among college students towards marriage and family counseling and therapy. *The Family Journal. 18*, 269–274. doi: 10.1177/1066480710371799.

Wantz, R. A., & Firmin, M. (2011). Perceptions of Professional Counselors: Survey of College Student Views. *The Professional Counselor*, 1, 71–81.

Wantz, R., Firmin, M., Johnson, C., & Firmin, R. (2006). University student perceptions of high school counselors. In M. Firmin and P. Brewer (Eds.), *Ethnographic and qualitative research in education: Vol. 2.* (pp. 171–184). New Castle, UK: Cambridge Scholars Press.

Chaotic Environments and Adult Children of Alcoholics

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Martha Nodar

The primary goal of this paper is two-fold: to challenge the belief that adult children of alcoholics tend to abuse alcohol as the result of genetic composition, and to show instead evidence that the unpredictable and chaotic home environment in which alcoholics grow up may be responsible. Adult children of alcoholics syndrome, mood alteration, and family history of alcoholism are explored. Addiction models and treatment plan implications are presented.

Keywords: abuse, addiction, chaos, home environments, alcoholics

According to the National Association for Children of Alcoholics (n.d.), out of the approximately 30 million children of alcoholics in the United States, 11 million are believed to be minors (younger than 18 years old) and the remainder (almost 20 million) are adult children. The term Adult Children of Alcoholics (ACoA) attempts to capture the shared characteristics typically found among those adults who grew up with either one or two alcoholic parents (Jones, Perera-Diltz, Sayers, Laux, & Cochrane, 2007). Alcoholic families are driven by a system of rigidity (arbitrary rules, lack of flexibility) where children develop a sense of chronic shock (Kritsberg, 1985). Kritsberg (1985) refers to chronic shock as an overwhelming fear that is never expressed or resolved, which commonly leads to shutting down. Prevented from expressing their emotions and from learning healthy coping skills in an alcoholic environment, coupled with poor family interaction patterns tend to place ACoAs at a higher risk for alcohol abuse (Woititz, 1984). In a move to augment Woititz's (1984) findings, this essay reviews the risk for alcohol abuse among ACoAs from a complimentary paradigm: growing up in a chaotic family environment rather than having alcoholic parents may account for the tendency of alcohol abuse among ACoAs.

The ACoA Syndrome

A chaotic environment is fertile ground for the shared characteristics of ACoAs, known as the ACoA syndrome (Kritsberg, 1985). The ACoA syndrome is a developmental phenomenon shared by most if not all ACoAs, which describes "common symptoms and behaviors as the result of their common experience" (Kritsberg, 1985, p. 3). A kaleidoscope of characteristics engulf the syndrome, which is mostly grounded in fear: fear of abandonment, fear of intimacy, fear of change, chronic shock (a persistent state of apprehension), fear of making mistakes, feelings of inadequacy (fear of not being good enough) and poor coping skills (Kritsberg, 1985). Ratey and Johnson (1997) explain that syndromes are a constellation of traits that manifest themselves in a continuum depending on the individual's psychological development. In other words, not all ACoAs may present all of the traits, but most ACoAs fall somewhere in the spectrum (Kritsberg, 1985; Woititz, 1984). Kritsberg (1985) insists the ACoA syndrome typically develops in response to a very rigid and chaotic family system that may be centered on the alcoholic.

Alcohol: A Mood-Altering Substance

An *alcoholic* is a person who abuses alcohol despite the consequences to self, finances, and interpersonal relationships. Alcohol is a depressant whose job is to suppress the central nervous system (CNS) while hijacking the brain's mesolimbic reward system (Dodes, 2002). Encompassing a complex pleasure circuit, the mesolimbic reward system activates the limbic system (the seat of emotion), and at the same time deactivates the prefrontal cortex (the seat of reason) (Dodes, 2002). The dynamics involved in the nerve fibers of the reward pathway are believed to be responsible

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for the "sensation" or the feelings of euphoria sought by alcoholics (Heitzeg, Nigg, Yau, Zucker, & Zubieta, 2010, p. 287).

Although there may be different models to explain the etiology of substance abuse and addiction, there is a consensus among scholars that alcoholics attempt to alter their moods, such as depression, anxiety, anger, and feelings of inadequacy, through alcohol consumption (Dodes, 2002). Consequences of alcohol abuse are not only evident in the United States, but also are seen in families around the world. European studies focusing on adolescents from Austria, Germany, Czechoslovakia, Russia, Turkey, and Denmark show that "one family member's substance abuse is often influenced by substance-using behaviors of others in the family" (Grüber, Celan, Golik-Grüber, Agius, & Murphy, 2007, p. 27). While ethnicity does not seem to play a significant role in the propensity toward alcohol abuse, other variables have been found to have an impact (Braitman et al., 2009). For instance, either having two alcoholic parents or having "an alcoholic father" increases the odds of alcohol abuse in both their male and female offspring (Braitman et al., 2009, p. 71).

Family History as a Variable

A longitudinal study that followed participants from 12 years of age to 31 by Warner, White, and Johnson (2007) showed that a combination of both early experimentation with alcohol and a family history of alcoholism are predictors of a "problem-drinking trajectory" (p. 56). Warner et al. reached their arguments based on a number of analyses including the application of Rutgers Alcohol Problem Index (RAPI). The RAPI is a psychometric instrument used to discern how problematic alcohol consumption may be perceived by a population and has received support among scholars. Neal, Fromme, and Corbin (2006) found RAPI to have acceptable validity and reliability and "test-retest correlations between 89 and 92" (p. 402). Warner et al. concluded that age at drinking onset alone is not sufficient to predict a problematic drinking trajectory. Instead, Warner et al. predict those who start drinking at an early age (adolescence) who also have a family history of alcoholism (ACoAs) are at higher risk to abuse alcohol as adults than those who do not have an alcoholic family history (non-ACoAs).

ACoAs vs. Non-ACoAs

Intrigued by the presence of alcohol in the family as a probable variable in the offspring's alcohol abuse, Jones et al. (2007) led a research study to investigate the differences in alcohol consumption between ACoAs and non-ACoAs. With that in mind, the researchers divided the participants in two groups: those who identified themselves as having grown up with a substance-abuse parent and those who did not. Jones et al. applied the Self-Administered, Stand-Alone Screening Instrument (SASSI-3) to the participants. The SASSI-3 is a questionnaire unrelated to substance abuse. The rationale for asking substance-unrelated questions is an attempt to bypass the tendency of denial often found among those abusing a substance. After analyzing the results, Jones et al. noted no difference in the consumption of alcohol between the ACoA and non-ACoA groups. Jones et al. concluded that the culprit in an alcoholic home may not be so much the substance per se, but "the chaos associated with the substance use that may lead to the ACoA traits" (p. 24). In other words, the chaos and unpredictability experienced in alcoholic families may explain the ACoA syndrome, and the high risk of alcohol abuse among ACoAs (Kritsberg, 1985; Woititz, 1984).

Chaos and Unpredictability

In concert with Jones et al.'s (2007) theory of unpredictability, Ross and Hill (2001) conducted a study where participants from different ethnic and socioeconomic backgrounds were recruited from ongoing studies at the University of Michigan Alcohol Research Center. One group of adult children of alcoholics and one group of adults who had parents who drank moderately during social events were investigated. The researchers' mission was to isolate unpredictability (lack of consistency) and chaos in the family as variables in developing alcohol abuse in adulthood. In agreement with Jones et al. (2007), Ross and Hill (2001) propose that "the chaotic nature" and the "unpredictability" in the home may be the precursors to alcohol abuse in adulthood (p. 610). Factors such as parental rejection or uninvolvement, abusive discipline and punishment, and systematic broken promises were the underpinnings measured in the unpredictability index (Ross & Hill, 2001).

Ross and Hill (2001) argued that their study revealed "parental unpredictability, rather than parental alcoholism per se,

was associated with alcohol misuse . . . and [shows] why all children from alcoholic homes do not have problems with alcohol themselves" (p. 630). These researchers point out that the significance of unpredictability, which they found in homes of adult children of divorce, adult children of economic adversity, and among ACoAs is the factor linking these adult children, which cannot be over-emphasized (Ross & Hill, 2001).

Basing their premise on Bowlby's (1969) theory of attachment and loss, Ross and McDuff (2008) contend that unpredictability is a derivative of insecure attachment between caregivers and their children. *Attachment* describes the bond children form with their caregivers. Attachments range in a continuum from secure to insecure (avoidant) depending on the caregiver's availability and willingness to meet children's needs (Bowlby, 1969). Insecure attachments are damaging to children because they tend to send implicit and explicit messages that they are not important enough to receive care (Bowlby, 1969). This mindset is unconsciously carried into adulthood, becoming the underpinning of the ACoA syndrome (Kritsberg, 1985).

In an effort to support their argument on unpredictability, Ross and McDuff (2008) administered both Ross and Hill's (2001) Family Unpredictability Scale (FUS) and Ross and McDuff's (2008) Retrospective Family Unpredictability Scale (Retro-FUS) to the participants in their study. Retro-FUS is specifically designed for ACoAs, and both FUS and Retro-FUS evaluate the degree of inconsistencies in discipline, nurturance, meals, and general family dysfunction. As a corollary, Hodgins, Maticka-Tyndale, El-Guebaly, and West's (1993) Children of Alcoholics Screening Test (CAST) also was used to specifically distinguish ACoAs from non-ACoAs in the study. It is worth mentioning that the CAST has received support among the academic community for its accuracy in measuring specific family dynamics in the alcoholic home (Lease & Yanico, 1995). Ross and McDuff (2008) conclude that growing up in an unpredictable environment is an important factor placing the ACoAs at higher risk for abusing alcohol compared with non-ACoAs.

Addiction Models

Among some clinicians the genetic model has gained clamor because of the frequency of alcoholism observed in certain families (Wang et al., 2011). To identify the contributing gene or genes to alcohol dependence, Wang et al. (2011) conducted a study of a small sample of Australian twins and concluded there is no gene or group of genes responsible for the main effect of alcohol dependence, but rather the possibility that an individual with a certain genotype such as monamine oxidase A (MAOA) may have an increased risk for alcohol dependence. However, this increased risk would most likely only occur when those "subjects are exposed to environmental stressors" (Wang et al., 2011, p.1295). Examples of environmental factors may include the individual's personality, coping strategies, or family system. These researchers conclude by stating that it is unclear how the genetic influence may or may not interfere in alcohol dependence and to what degree.

Also interested in exploring the genetic influence in alcohol abuse, Clarke et al. (2010) analyzed twin studies while conducting their own study. These researchers argue that stress activates certain responses in the brain, such as the locus coeruleus (LC), a structure located in one of the ventricles and sensitive to the activation (by a gene) to produce cortisol during times of stress. Clarke et al.'s argument is based on the notion that this dynamic between the stress and the production of cortisol may drive an individual to alcohol abuse to decrease the activity in LC, supposedly bringing a sense of calm during stressful situations. In other words, the gene activating the LC may be responsible for mediating the effect of alcohol which has been detected in twin studies.

As expected, the genetic model has its critics because they argue it has not yet established a definite or persuasive relationship between genes and alcoholism (Dodes, 2002). In his 1986 article, Peele unveils his concern for the popularity of the genetic model to explain the etiology of alcohol abuse. Peele (1986) argues the data obtained to form the basis of the genetic model for alcoholism do not take into account important variables. These variables may include the unique differences among alcoholics as well as within ACoAs; how the alcohol abuse may unfold in many individuals and how any of these variables may be affected by a family environment that may or may not include a history of alcoholism (Peele, 1986).

Peele (1986) insists there is no evidence that ACoAs inherit a "genetic liability for alcoholism" (p. 63). Peele explains the phenomenon observed in twins from biological alcoholic parents only shows a correlation between having alcoholic

parents and abusing alcohol. Additional information about family dynamics where twins grew up, such as divorce, financial instability, or chaos in the family was not included in the research with twins (Clarke et al., 2010; Wang et al., 2011). Peele (1986) emphasized that the genetic model has "dangerous consequences" because it appears to deny the human complexity involved in substance abuse, and because it may prevent counselors from digging deep into the core issues of addiction with their clients (p. 63). Peele is supported by other scholars who believe ACoAs are modeling substance abuse behavior rather than having a genetic composition for alcoholism (Braitman, 2009).

Moreover, Dodes (2002) concedes that although some genes may "influence the susceptibility to developing alcoholism" (p. 81), it is not realistic to believe that one single gene or even a group of genes would have the power to produce one single specific behavior such as alcohol addiction or dependence. Dodes explains that genes are a sequence of DNA (molecules), but DNA not only contains additional information that is non-genetic, but DNA also controls whether genes are activated or not. The non-genetic factors in the DNA may include variables such as individual experiences, coping strategies, family environment and emotions. Even if a genetic predisposition is in place, that predisposition is not likely to materialize without the significant influence of the environment (Dodes, 2002).

In agreement with Peele (1986), Ross and Hill (2001, 2004) and Ross and McDuff (2008) divert from the genetic model, and instead lean toward the psychological models which focus on the learned maladaptive patterns of behavior. Other approaches include neurobiological models which attribute alcohol abuse as the result of the person's brain functions (Heitzeg et al., 2010). Once the memory circuit makes an association between a substance and pleasure, addicts quickly learn to repeat the process to obtain a relief from their negative feelings such as loss, depression, anxiety and anger (Heitzeg et al., 2010). Some models overlap with each other, but all of them attempt to explain the substance abuse phenomenon.

Conclusion

The evidence presented herewith may carry some important implications for how addiction counselors may want to approach their treatment plan with those suffering from alcohol addiction or dependence. This paper argues that many addiction programs have failed to meet the needs of those suffering from substance abuse because the problem may not be the substance *per se*, but the consequences of growing up with maladaptive coping strategies that might have served to survive in a chaotic environment, but are no longer efficient. This paper claims that those suffering from addiction are able to continue their addiction likely because they have enablers in their household who are either consciously or unconsciously supporting the addiction. Addiction counselors may wish to consider involving those in the family who may be deriving a secondary gain from the addict's addictive behavior. Both the person with addictions and the person supporting the addictions may be getting a payoff—a possible distraction to a traumatic childhood experience based on a chaotic environment.

References

Bowlby, J. (1969). *Attachment and loss: Vol.1, Attachment*. New York, NY: Basic Books.

Braitman, A., Kelley, M., Ladage, J., Schroeder, V., Gumienny, L., Morrow, J., & Klostermann, K. (2009). Alcohol and drug use among college student adult children of alcoholics. *Journal of Alcohol and Drug Education*, *53*(10), 69–88.

Clarke, T., Dempster, E., Docherty, S., Desrivieres, S., Lourdsamy, A., Wodarz, N., Ridinger, M., Maier, W., Rietschel, M., & Schumann, G. (2010). Multiple polymorphisms in genes of the adrenergic stress system confer vulnerability to alcohol abuse. *Addiction Biology*, *17*, 202–208.

Dodes, L. (2002). *The heart of addiction*. New York, NY: Harper-Collins.

Grüber, E., Celan, J., Golik- Grüber, V., Agius, M., & Murphy, S. (2007). The relationship between having smoking or drinking parents and the occurrence of smoking or drinking in their adolescent children. *Alcoholism*, *43*(1), 25–35.

Heitzeg, M., Nigg, J., Yau, W., Zucker, R., & Zubieta, J. (2010). Striatal dysfunction marks preexisting risk and medial prefrontal dysfunction is related to problem drinking in children of alcoholics. *Biological Psychiatry*, *68*(3), 287–295.

Hodgins, D., Maticka-Tyndale, E., El-Guebaly, N., & West, M. (1993). The CAST-6: Development of a short-form of the Children of Alcoholics Screening Test. *Addictive Behaviors, 18*, 337–345.

Jones, A., Perera-Diltz, D., Salyers, M., Laux, J., & Cochrane, W. (2007). Testing hypothesized differences between adult children of alcoholics (ACOAs) and non-ACOAs in a college student sample. *Journal of College Counseling*, *10*, 19–26.

Kritsberg, W. (1985). *The adult children of alcoholics syndrome.* Pompano Beach, FL: Bantam Books.

Lease, S., & Yanico, B. (1995). Evidence of validity for the children of alcoholics screening test. *Measurement and Evaluation in Counseling and Development*, *27*(4), 200–210.

National Association for Children of Alcoholics. (n.d.). Children of addicted parents: Important facts. Retrieved from http://www.nacoa.net/pdfs/addicted.pdf., pp. 1–4.

Neal, D., Corbin, W., & Fromme, K. (2006). Measurement of alcohol-related consequences among high school and college students: Application of item response models to the Rutgers alcohol problem index. *Psychological Assessment*, *18*(4), 402–414.

Peele, S. (1986). The implications and limitations of genetic models of alcoholism and other addictions. *Journal of Studies on Alcohol*, *47*(1), 63–73.

Ratey, J., & Johnson, C. (1997). *Shadow syndromes*. New York, NY: Pantheon Books.

Ross, L. T., & Hill, E. M. (2001). Drinking and parental unpredictability among adult children of alcoholics: A pilot study. *Substance Use & Misuse*, *36*(5), 609–638.

Ross, L. T., & Hill, E. M. (2004). Comparing alcoholic and nonalcoholic parents on the family unpredictability scale. *Psychological Reports*, *94*(3), 1385–1391.

Ross, L. T., & McDuff, J. (2008). The retrospective family unpredictability scale: Reliability and validity. *Journal of Child and Family Studies*, *17*, 13–27.

Wang, K., Liu, X., Aragam, N., Jian, X., Mullersman, J., Liu, Y., & Pan, Y. (2011). Family-Based association analysis of alcohol dependence in the COGA sample and replication in the Australian twin-family study. *Journal of Neural Transmission*, *118*(9), 1293–1299.

Warner, L., White, H., & Johnson, V. (2007). Alcohol initiation experiences and family history of alcoholism as predictors of problem-drinking trajectories. *Journal of Studies on Alcohol and Drugs*, *68*(1), *56*–65.

Woititz, J. (1984). Adult children of alcoholics. *Alcoholism Treatment Quarterly, 1*, 71–99.

A Review of the Literature on Promoting Cultural Competence and Social Justice Agency Among Students and Counselor Trainees: Piecing the Evidence Together to Advance Pedagogy and Research

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There is a call for research on how to effectively foster cultural competence and a social justice advocacy orientation among counselor trainees. A multidisciplinary review of the literature reveals a body of anecdotal and empirical evidence in support of the use of pedagogical strategies grounded in critical theory to this end. Critical pedagogy regarding the development of a social justice origination is emphasized. Privilege, oppression, and experiential classroom activities are presented.

Keywords: critical theory, pedagogy, cultural competence, social justice, advocacy

The promotion of multicultural competence is an established professional training standard in industry and higher education (Musil, 1996). As a fourth force phenomenon within the counseling profession, multicultural education is intimately tied to advancing social justice (Arredondo & Perez, 2003) for trainees in the context of their studies (Ratts & Wood, 2011), and through populating our profession with culturally competent counselors. Its value in training has been empirically validated, yet much is left to discover about how to most effectively deliver multicultural education and ensure that counselors are able to engage in ethical and competent counseling and advocacy with diverse populations (Coleman, 2006; Manese, Wu, & Nepomuceno, 2001; Seto, Young, Becker, & Kiselica, 2006; Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

More recently advocacy competence has been recognized as a distinct professional standard for counselors with the American Counseling Association's (ACA) endorsement of the *Advocacy Competencies* (Lewis, Arnold, House, & Toporek, 2002), the recognition of Counselors for Social Justice (CSJ) as a division of ACA, the 2005 ACA *Code of Ethics*, and the 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards. As such, there is a growing body of literature with respect to the promotion of advocacy competence among counselor trainees grounded largely in critical theories (Bemak, Chi-Ying Chung, Talleyrand, Jones, & Daquin, 2011; Brubaker, Puig, Reese, & Young, 2010; Constantine, Hage, Kindaichi, & Bryant, 2007; Goodman, Liang, Helms, Latta, Sparks, & Weintraub, 2004; Green, McCollum, & Hays, 2008; Hof, Dinsmore, Barber, Suhr, & Scofield, 2009; Lewis, Arnold, House, & Toporek, 2002; Ratts & Wood, 2011; Steele, 2008; Toporek & Reza, 2001). Naturally, counseling research on the relationship between multicultural counseling competence and advocacy competence (Manis, 2008) and effective training methods for promoting advocacy competence (Hays, Dean, & Chang, 2007; Lewis, Davis, Lenski, Mukhopadhyay, & Taylor Cartwright, 2010; Murray, Pope, & Rowell, 2010; Odegard & Vereen, 2010) is early in its development.

Thus, while echoing the synergistic relationship between multicultural counseling competencies and social justice advocacy, Odegard and Vereen (2010) recently concluded "how counselor educators teach these constructs to students is a mystery" (p. 145). Their conclusion resonated with earlier expressions of this conundrum within and beyond the mental health professions. Palmer (2004) spoke to this challenge, indicating that the question of how to teach the constructs had been pondered and studied across disciplines.

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In fact, a multidisciplinary review of the literature on multicultural education, social justice advocacy and critical pedagogy revealed not only a paucity of research on effective training practices in counselor education and supervision (Odegard & Vereen, 2010; Toporek, Lewis, & Crethar, 2009), but also a lack of attention and investment in training for social justice advocacy within counselor education programs (Hays et al., 2007; Nilsson & Schmidt, 2005; Ratts, 2006; Ratts & Wood, 2011). It further provided a pragmatic rationale for infusing attention to culture and social justice throughout program curricula (Brubaker, Puig, Reese, & Young, 2010; Dinsmore & England, 1996; Goodman et al., 2004: Green et al., 2008; Hays et al., 2007; Hill, 2003; Paylo, 2007; Ratts & Wood, 2011; Stadler, Suh, Cobia, Middleton, & Carney, 2006; Sue, Bingham, Porché-Burke, & Vasquez, 1999; Watts, 2004), and empirical evidence that suggested theoretically grounded pedagogies could be twice as effective as ungrounded approaches in delivering multicultural education (Smith et al., 2006). The literature also offered anecdotal and empirical evidence that critical pedagogical strategies are effective in raising the social consciousness of students and fostering social justice advocacy.

An analysis of the existing evidence, along with more recent findings specific to the field of counselor education and supervision offered a compelling case for further exploration of critical pedagogical strategies in training counselors and research on its efficacy. A brief overview of critical theory and pedagogy is presented, followed by a summary of key research findings. This is followed by a discussion of implications for counselor education and supervision practice, as well as future research.

Critical Pedagogy

Critical pedagogy is rooted in the work of Paolo Freire, who developed this approach with the explicit goal of empowering Brazilian peasants to advocate on their own behalf for social justice. Freire (1974) theorized that becoming aware of one's sociopolitical reality and position through reflection and dialogue, or attaining critical consciousness, would serve as a catalyst for social justice advocacy.

The application of critical pedagogy in multicultural education has been described as "a deep examination, through dialogue with others, of the legitimacy of the social order in terms of access to socioeconomic resources and opportunities" (Sleeter, Torres, & Laughlin, 2004, p. 82), or in other words, *social justice* (Chang, Crethar, & Ratts, 2010; Fouad, Gerstein, &Toporek, 2006). *Decoding* is the term designated by Freire (1974) for this process whereby sociopolitical realities become transparent and a sense of empowerment as change agents is possible.

Freire (1974) used the term *praxis* to refer to social justice advocacy. He was deliberate in specifying that praxis is a manifestation, rather an outcome of critical consciousness. Thus, he emphasized the undeniably catalytic nature of developing critical consciousness, and the inherent charge which accompanies it regardless of one's social positions of privilege or oppression. Freire also was explicit in observing the inherently value-laden nature of praxis, or social justice advocacy. He explained: "praxis (which can never be limited to mere activity of the consciousness) is never neutral; in the same way, education can never be neutral. Those who talk of neutrality are precisely those who are afraid of losing their right to use neutrality to their own advantage" (p. 132).

Sue, Bingham, Porché-Burke and Vasquez (1999) echoed Freire and elucidated the relationship between multiculturalism and social justice relative to mental health training and practice. They made it plain that multiculturalism, "…is not value neutral [and actually] … stands against beliefs and behaviors that oppress other groups and deny them equal access and opportunity" (p. 1064). Recognizing this valence is critical not only to advancing the practice standards of our profession (Ratts & Wood, 2011), but also to how we understand and frame our role as counselor educators and supervisors. "Our task as teachers is to clarify the complexity of the many overlapping economies of power and to work with our students to build the critical skills necessary to examine their own location in such a system and to find strategies of resistance to it" (Chan & Treacy, 1996, p. 214).

Enns and Forrest (2005) underscored the connection between the emergence of critical pedagogy from human rights movements and its regular use in multicultural education. They described the scope of multicultural education grounded in these theories as extending beyond the classroom and entailing: (a) a critical examination of the construction of knowledge, (b) an exploration of the relationships among diverse people, and (c) the recognition that cultural identities are dynamic and complex. The intuitive fit of critical pedagogy for raising the social consciousness of counselor trainees,

as well as its regular employment in multicultural education lends the theory for investigation as an effective theoretical grounding for training culturally and advocacy competent counselors.

Cultivating Critical Consciousness: A Developmental Process

Critical pedagogical approaches reflect an appreciation of the socializing role of seasoned professionals and educators (Cornelius, 1998; Prilleltensky, 1989), the non-traditional and relational nature of the instructor–student relationship, and the developmental nature of the process of consciousness raising and becoming advocates (Ford & Dillard, 1996; Kathleen May, personal communications, 2006; Sleeter et al., 2004). Indeed, Ford and Dillard (1996) described multiculturalism in these terms: "… it is more than just a learning process, it is a socialization process that involves qualitative degrees of self-development" (p. 5). Sleeter et al. (2004) emphasized the importance of scaffolding students in this process of reflection on their own and others' identities relative to social positions and experiences of privilege and oppression. The theoretical (Bemak et al., 2011; Green et al., 2008; Hof et al., 2009; Rasheed Ali, Ming Liu, Mahmood, & Arguello, 2008; Sleeter et al., 2004) and research literature (Hays et al., 2007; Murray et al., 2010; Nilsson & Schmidt, 2005; Paylo, 2007) has been consistent in the valuing of experiential learning as a means of cultivating social consciousness among students, and affording opportunities to practice and engage in advocacy.

Developing a Social Justice Orientation

Broido (2000) explored how college students from privileged positions actively engaged in advocacy for social justice understood their own development as advocates. Her findings initially suggested students' willingness and ability to act as social justice allies developed through having increased information on social justice issues. She reported: "participants gained an overwhelming share of their knowledge of social justice issues from their experiences in the classroom" (p. 9).

The second critical factor in students' willingness and ability to act as social justice allies was engagement in a dialectical meaning-making process. Broido (2000) concluded that it was "through reflection, discussion, and perspective taking, [that] the participants developed clarity regarding—and confidence in—their own position on social justice issues" (p. 10). The third finding pointed to the impact of self-confidence on the participants' willingness to reflect on the role of privilege in their success.

These findings pointed to the potential importance of introducing material on social justice in counseling instruction. They also demonstrated the value of specific critical pedagogical practices, namely reflection, dialogue and decoding in the participants' development of critical consciousness and change agency. Finally, they underscored self-confidence as a student quality that supported a critical examination of their own privileged positions.

Exploring Dynamics of Privilege and Oppression

Exploring dynamics of privilege and oppression is at the heart of critical pedagogy. A critical examination of one's own social positions, as well as those of others, is considered integral to developing critical consciousness and social change agency. The findings of Chizhik and Chizhik (2002) highlighted the need for faculty to attend to student meaning with respect to dynamics of privilege and oppression.

Chizhik and Chizhik (2002) investigated middle class college students' conceptions of privilege and oppression. They emphasized the importance for instructors of understanding students' meaning-making with respect to those dynamics as a means of preparing to effectively guide them. They stated: "Knowing students' preconceived notions about these terms should help instructors 'scaffold students' learning to a more multicultural and social justice orientation (if one does not already exist)" (p. 794).

Chizhik and Chizhik (2002) observed that both privileged and oppressed students as defined in terms of racial identity failed to understand these phenomena in systemic terms. They found that, "White students were more likely to blame oppression on internal factors [and believed that] the oppressed are and should be responsible for helping themselves" (p. 805). They also found that students of color were more likely to attribute privilege to factors external to the individual,

but not to systemic factors. Furthermore, they found that students of color viewed "social change as a collective act rather than an individual act" (p. 805).

Chizhik and Chizhik (2002) identified the "lack of connection between privilege and oppression…[as] perhaps, the greatest challenge in multicultural discourse" (p. 806). They further suggested: "Understanding the compensatory relationship between privilege and oppression may be an important first step leading to an obligatory call for action through understanding one's responsibility to act for social justice" (p. 806). Their findings underscored the need for exploration and collective meaning-making of the dynamics of privilege and oppression with students. They also suggested the relevance of this process for all students (Hays, 2008; Lark & Paul, 1998; Rooney, Flores, & Mercier, 1998). And finally, the findings have implications for helping students to resolve resistance to multicultural education and social justice advocacy.

Scaffolding the Development of Critical Consciousness

The challenging and potentially painful nature of decoding raises the importance of scaffolding students as they engage in reflection and dialogue. Broido's (2000) findings pointed to the significance of confidence to the willingness and success of students of privileged social positions in decoding their experiences. The findings presented by Chizhik and Chizhik (2002) suggested the importance of attending to students' preconceived ideas about privilege and oppression, and pointed to possible sources of resistance to engaging in open and active exploration of dynamics of privilege and oppression.

Clearly decoding requires unusual vulnerability within the classroom for both students and instructors (Garcia & Van Soest, 1997; Lark & Paul, 1998; Locke & Kiselica, 1999). Chan and Treacy (1996) captured the heart of the challenge more fully. They observed:

> Any serious examination of a system of domination that usually cloaks its relationships of power makes many people uncomfortable; these are topics that are often skirted around. Moreover, this approach asks participants in the inquiry (students and teachers alike) to acknowledge [their] lack of knowledge, to examine what [they] do not know about [their] histories, [their] political and legal systems, [their] education, and the contexts in which [they] seek to understand [their] experiences. As we teach and learn about these power relationships, the world looks different and we take a different place in it; we are at least temporarily decentered from our usual normative self (p. 214).

Garcia and Van Soest (1997) conducted an exploratory study of master's-level social work students engaged in a required course on diversity, particularly how their understanding of privilege and oppression changed over the course. Course objectives centered on familiarizing students with dynamics of social power, oppression, privilege and empowerment. A key pedagogical strategy was paying "considerable attention…to helping students assimilate information that challenged their world views, self-image, and professional self-concepts" (p. 122).

Their findings indicated that the majority of students' in the course experienced increased social consciousness at the end of the course (Garcia & Van Soest, 1997). Changes reported by the White/non-Jewish students included increased awareness of privilege, increased understanding of the dynamics of oppression, increased hope and the identification of an action plan. Changes reported by the multiethnic students in the class also fell into the three areas of change reported by the White/non-Jewish students. Their changes were reported in terms of increased understanding "of their own oppression" (p. 125). One African-American student reflected: "This course has opened my eyes… It is easy for me to see how different rules can be racist, whereas in the past, I believed they were fair…I have become increasingly aware of how I am treated" (pp.125–126). In addition, among the reports of the students of color were increases in self-confidence, reflection and awareness of the oppression of other groups, as well as positive plans for change. These findings further supported the value and importance of scaffolding students in decoding dynamics of privilege and oppression for all students, and in this case for students in the mental health field.

The relevance of attending to dynamics of privilege and oppression in counselor education and supervision is further underscored by research within the field on social justice advocacy. Hays et al. (2007) conducted a qualitative study of counselors' perceptions regarding how privilege and oppression were addressed in their training, and how these

phenomena impacted counseling relationships. Their findings pointed to inadequate training in multicultural and advocacy competence, and a lack of attention to social justice advocacy specifically around the phenomena of privilege and oppression.

Experiential Activities: Moving Beyond the Classroom

Based on their findings Hays et al. (2007) proposed strategies to address the training deficits identified by counselors in practice. These resonated with critical pedagogy, and included: (a) addressing social justice advocacy in instruction, (b) attending to counselor self-efficacy as related to cultural and advocacy competence, (c) exploring the systemic nature of oppression in the context of case conceptualization, and (d) building from strategies used to enhance cultural competence such as guest speakers and experiential activities.

Nilsson and Schmidt (2005), among others (Ratts, 2006), also observed a deficiency in counselor training. They pointed out that while social justice advocacy has been emphasized in the literature, "this value appears not to have filtered through graduate training programs to its trainees" (p. 277). They further reported "little evidence that educators encourage students to act individually or in groups to produce social change" (p. 277).

Their findings pointed to a desire to advocate and political interest as two factors that may lead to advocacy and indicated a need for further research on differences in this regard between students of oppressed or privileged social statuses (Nilsson & Schmidt, 2005, p. 275). Nilsson and Schmidt (2005) arrived at conclusions with respect to counselor training that were similar to those of Hays et al. (2007). Specifically they noted: "counselors' concern for others needs to be guided beyond the individual level and extended to societal and political levels" (p. 276). They also proposed incorporation of pedagogical strategies resonating with critical theory. These included engaging students in dialogue around political and social issues, exposing students to culturally diverse peers and individuals, providing opportunities for campus or community outreach, and teaching advocacy skills.

Paylo's (2007) study of the characteristics of counselors who advocate also led to similar conclusions and recommendations. Paylo found that counselors who consider advocacy important are more likely to act as advocates. He stressed: "… it is imperative for counselor educators to infuse the importance of advocacy throughout the curriculum. They may not be able to directly affect counselors-in-training's actual advocacy behaviors but by instilling the importance of advocacy, they may increase advocacy behaviors indirectly" (p. 134). He went on to suggest hands-on, relationally-oriented strategies such as bringing in guest speakers, infusing advocacy concepts within field and coursework, and service projects.

The literature provided both anecdotal and empirical support for service learning across disciplines as a strategy for promoting critical consciousness and social justice agency among students. McAllister and Irvine (2000) offered empirical support that "providing opportunities for students to interact with individuals from other ethnic backgrounds in authentic cultural settings" (p. 20) enhances the multicultural learning process. Beilke (2005) proposed community service as an effective intervention in facilitating the development of critical consciousness in pre-service teachers. She asserted that the "first task of developing a critical multicultural perspective is to see oneself more objectively by 'unpacking' power, privilege, and racial identity" (p. 3).

Research within counselor education also supported the practice of service learning as effective (Arthur & Achenbach, 2002), particularly immersion experiences or those involving direct contact with diverse individuals and communities (Burnett, Hamel, & Long, 2004; Coleman, 2006; Díaz-Lázaro & Cohen, 2001; Dickson & Jepsen, 2007).

Piecing the Evidence Together: Implications for Counselor Training and Research

Theory and research across the humanities addressing multicultural education, advocacy and social justice supported the developmental and process oriented nature of developing critical consciousness. It also provided compelling evidence to guide the use and further investigation of critical pedagogical strategies within the field of counselor education and supervision as a means of training counselors who are culturally competent and prepared to act as advocates for social

justice. Key themes among the findings were the value of: (a) introducing social justice material in coursework, (b) incorporating examination, dialogue and reflection with respect to dynamics of privilege and oppression in society, (c) scaffolding all students in their meaning-making of the dynamics of privilege and oppression in their own experiences regardless of their identities and relative social positions, and (d) providing opportunities for experiential activities beyond the individual client level and classroom.

Teaching

Consonant with the developmental nature of counselor training and the research findings discussed relative to critical pedagogy, the more recent literature in the fields of counseling and psychology promoted critical theoretical approaches (Brubaker et al., 2010), models (Green et al., 2008) and training strategies (Bemak et al., 2011; Hof et al., 2009; Rasheed Ali et al., 2008). These recommendations pointed to the value of pedagogies that: (a) incorporate a tone of equality, de-ideologize dominant paradigms and incorporate experiential training (Brubaker et al., 2010); (b) recognize the link between social justice advocacy and professional advocacy (Hof et al., 2009); and (c) address the domains of awareness, knowledge and skill in infusing social justice advocacy throughout curricula (Green et al., 2008). Green et al. (2008) proposed an advocacy counseling paradigm that builds from awareness of injustice, to knowledge to empowerment of self and others, up to skills to perform and teach to others. Their model is consistent with the guidance offered by Rasheed Ali, Ming Liu, Mahmood, and Arguello (2008), who advised: "Before the actual practical training of social justice begins, it is equally important for students to understand the meaning and implications of social justice as a theory as well as implementing theory to practice" (p. 3).

In their reflections on infusing social justice advocacy, Bemak et al. (2011) provided a number of suggestions. These included beginning with the faculty and engaging in collective meaning-making about social justice and how it applies across courses and content. They went on to address the relevance of personal experiences of students with respect to their worldview and their identities as counselors, and emphasized the need to explore the challenges of social justice work with students. They recommended utilizing real life situations and news in role plays and further suggested service learning as an important component of hands-on training.

Experiential learning, particularly in terms of service learning was a consistent recommendation in the most current literature. Murray et al. (2010) pointed out that experiential learning is already an essential component of counselor training through fieldwork. In addition to affording students the opportunity to apply gains in awareness, knowledge and skills, they asserted that service learning also encourages civic commitment. Rasheed Ali et al. (2008) described a homeless shelter practicum as an apt example of a practicum experience that reaches an underserved population and that could include attention to public policy initiatives. Ali emphasized the need for sensitivity and care in assessing community needs, placing students, and evaluating the impact of service learning projects when developing fieldwork opportunities for counselor trainees where they will have an opportunity to confront social injustices and engage in advocacy at the client, community and public policy levels.

Supervision

Falender and Shafranske (2004) offered a clear description of diversity competent supervision as a process that not only promotes social justice, but also is in essence a social justice intervention. They asserted that diversity-competent supervision:

> includes incorporation of self-awareness by both supervisor and supervisee and is an interactive process of the client or family, supervisee-therapist, and supervisor, using all of their diversity factors. It entails awareness, knowledge, and appreciation of the interaction among the client's, supervisee-therapist's, and supervisor's assumptions, values, biases, expectations, and worldviews; integration and practice of appropriate, relevant, and sensitive assessment and intervention strategies and skills; and consideration of the larger milieu of history, society, and sociopolitical variables (p. 125).

Their conceptualization of the infusion of diversity and social justice within the supervisory relationship and the supervision process is in alignment with the critical pedagogical recommendations of Brubaker et al. (2010) for the infusion of advocacy in counselor training, as well as the recommendations of Glosoff and Durham (2010) for

incorporating social justice advocacy in supervision. In short, their recommendations centered on calling supervisee attention to the continuum along which advocacy may occur, encouraging supervisee examination of their own place on the continuum, and scaffolding supervisee development of critical consciousness through reflective questioning, supervisor self-disclosure, and the incorporation of self-assessment and explicit examination of the counseling process in terms of dynamics of privilege and oppression.

Research

Since research on social justice advocacy in counselor education and supervision is so young, the possibilities for investigation appear limitless. First, establishing a clear understanding of the state of social justice advocacy training in counselor education and supervision programs is needed. Surveying current practices would not only shed light on how the field has embraced the charge to train counselors who are competent advocates, but also would provide perspective on the range of practices currently in use. This would include investigation of (a) strategies for promoting advocacy competence currently employed in counselor education and supervision programs overall, (b) theoretical approaches to counselor training for social justice advocacy, (c) exploring the efficacy of standalone courses on cultural competence and/or advocacy as compared to infusion of training throughout a curriculum, and (d) the state and practice of social justice within counselor education and supervision programs.

Further qualitative inquiry into the training experiences of counselor trainees and counselors would lend an important perspective to the knowledge base. Immediate foci may include desires for training, reflections on the process of developing critical consciousness and committing to social justice advocacy, critical incidents in training, and social justice needs within counselor education. Similarly, qualitative investigation of the experiences of counselor educators and supervisors who are charged with implementing training initiatives would bring additional perspective to the challenges and opportunities inherent in this endeavor. In addition, qualitative investigations of the clients and communities with whom service-learning initiatives are planned or conducted could be useful in assessing not only needs but also the impact of such projects and advocacy initiatives (Murray et al., 2010; Rasheed Ali et al., 2008).

Examination of the relationship between multicultural counseling competence and advocacy competence also is indicated as an area in need of exploration. Understanding this relationship could lead to economies in programming and more effective facilitation of student development, as suggested by current practices and understanding of the synergistic relationship between the two competencies (Hays et al., 2007; Manis 2008). In addition, further investigation into how best to assess competence in both areas of practice would be useful (Smith et al., 2006).

Finally, experimental research that assesses the efficacy of critically grounded pedagogical strategies in short- and long-term approaches would be helpful in assessing its ongoing utility in counselor education and supervision curricula, and in considering the question of efficacy of stand alone versus infusion approaches (Manis, 2008). This could be limited to specific strategies such as examination of dynamics of privilege and oppression, or expanded to testing full models or approaches as presented in the literature. And while there is promising evidence of the efficacy of critically grounded approaches for counselor education and supervision, this does not rule out the potential utility of investigating the efficacy of approaches grounded in other theories (Smith et al., 2006).

Conclusion

A review of the literature pointed to an appreciation of critical theories in grounding training for competent social justice advocacy. These approaches call upon counselor educators to attend to social justice across the curriculum and remain alert to their role in socializing counselor trainees as advocates. They also emphasize the importance of attending to the individual meaning-making of counselor trainees with respect to culture and dynamics of privilege and oppression. Lastly, they underscore the developmental nature of developing critical consciousness and the need to incorporate strategies that both instruct counselor trainees, and allow them to apply concepts in the field.

Adopting a critical pedagogical approach demands a high degree of investment from faculty and trainees. Counselor education and supervision practices are inherently reflective and experiential, and thus consonant with critical pedagogies.

Critical approaches offer tremendous potential for enhancing the process and content of existing counselor education and supervision curricula so as to better meet the training needs of diverse students and ultimately the clients and communities they will serve.

The time to delve more deeply into transformational practices in our field is now (Ratts & Wood, 2011). It has been five years since Smith et al. (2006) heralded the end of the debate on multicultural education, validated its value in training and called for research to examine the efficacy of theoretically grounded pedagogical interventions in multicultural education. A review of the literature points to the efficacy of critical theory in social justice pedagogy. This offers a sound basis for incorporating critical pedagogical strategies now, while collective efforts to fully investigate the effectiveness of critical pedagogy are undertaken to advance the most efficacious training within the field of counselor education and supervision.

References

American Counseling Association (2005). *ACA code of ethics.* Washington, DC: Author.

Arredondo, P., & Perez, P. (2003). Expanding multicultural competence through social justice leadership. *The Counseling Psychologist, 31*, 282–289.

Arthur, N., & Achenbach, K. (2002). Developing multicultural counseling competence through experiential learning. *Counselor Education and Supervision*, *42*, 2–15.

Beilke, J. R. (Spring 2005). Whose world is this? *Multicultural Education*, *12*, 2–7.

Bemak, F., Chi-Ying Chung, R., Talleyrand, R.M., Jones, H., & Daquin, J. (2011). Implementing multicultural social justice strategies in counselor education training programs. *Journal for Social Action in Counseling and Psychology*, *3*, 29–43.

Broido, E. M. (2000). The development of social justice allies during college: A phenomenological investigation. *Journal of College Student Development*, *41*, 3–18.

Brubaker, M. D., Puig, A., Reese, R. F., & Young, J. (2010). Integrating social justice into counseling theories pedagogy: A case example. *Counselor Education and Supervision*, *50*, 88–102.

Burnett, J. A., Hamel, D., & Long, L. L. (2004). Service learning in graduate counselor education: Developing multicultural counseling competency. *Journal of Multicultural Counseling and Development*, *32,* 180–191.

Chan, C. S., & Treacy, M. J. (1996). Resistance in multicultural courses: Student, faculty, and classroom dynamics. *American Behavioral Scientist*, *40*, 212–221.

Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision [Special issue]. *Counselor Education and Supervision, 50,* 82–87.

Chizhik, E. W., & Chizhik, A. W. (2002). Decoding the language of social justice: What do "privilege" and "oppression" really mean? *Journal of College Student Development, 43*, 792–807.

Coleman, M. N. (2006). Critical incidents in multicultural training: An examination of student experiences. *Journal of Multicultural Counseling and Development, 34,* 168–182.

Constantine, M. G., Hage, S. M., Kindaichi, M. M., & Bryant, R. M. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling & Development, 85*, 24–29.

Cornelius, D. (1998). Walking the walk: Socializing students to social activism. *Teaching Sociology, 26,* 190–197.

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 CACREP standards*. Alexandria, VA: Author.

Díaz-Lázaro, C. M., & Cohen, B. B. (2001). Cross-cultural contact in counseling training. *Journal of Multicultural Counseling and Development*, *29,* 41–56.

Dickson, G. L., & Jepsen, D. A. (2007). Multicultural training experiences as predictors of multicultural competencies: Students' perspectives. *Counselor Education and Supervision*, *47,* 76–95.

Dinsmore, J. A., & England, J. T. (1996). A study of multicultural counseling training at CACREP-accredited counselor education programs. *Counselor Education and Supervision, 36, 58–76.*

Enns, C. Z., & Forrest, L. M. (2005). Toward defining and integrating multicultural and feminist pedagogies. In C. Z. Enns & A. L. Sinacore (Eds.), *Teaching and social justice: Integrating multicultural and feminist theories in the classroom* (pp. 3–23). Washington, DC: American Psychological Association.

Falendar, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Ford, T. L., & Dillard, C. B. (1996). Becoming multicultural: A recursive process of self- and social construction. *Theory into Practice*, *35,* 232–238.

Fouad, N. A., Gerstein, L. H., & Toporek, R. L. (2006). Social justice and counseling psychology in context. In R. L. Toporek, L. H. Gerstein, N.A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology* (pp. 1–17). Thousand Oaks, CA: Sage.

Freire, P. (1974). *Education for critical consciousness.* New York: Continuum.

Garcia, B., & Van Soest, D. (1997). Changing perceptions of diversity and oppression: MSW students discuss the effects of a required course. *Journal of Social Work Education, 33,* 119–129.

Glosoff, H. L., & Durham, J. C. (2010). Using supervision to prepare social justice counseling advocates. *Counselor Education and Supervision, 50*, 116–129.

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist, 32*, 793–836.

Green, E. J., McCollum, V. C., & Hays, D. G. (2008). Teaching advocacy counseling within a social justice framework: Implications for school counselors and educators. *Journal for Social Action in Counseling and Psychology, 1*(2), 14–30.

Hays, D. G. (2008). Assessing multicultural competence in counselor trainees: A review of instrumentation and future directions. *Journal of Counseling & Development, 86,* 95–101.

Hays, D. G., Dean, J. K., & Chang, C.Y. (2007). Addressing privilege and oppression in counselor training and practice: A qualitative analysis. *Journal of Counseling & Development, 85,* 317–324.

Hill, N. (2003). Promoting and celebrating multicultural competence in counselor trainees. *Counselor Education & Supervision, 43,* 39–51.

Hof, D. D., Dinsmore, J. A., Barber, S., Suhr, R., & Scofield, T. R. (2009). Advocacy: The T.R.A.I.N.E.R. model. *Journal for Social Action in Counseling and Psychology, 2*, 15–28.

Lark, J. S., & Paul, B. D. (1998). Beyond multicultural training: Mentoring stories from two white American doctoral students. *The Counseling Psychologist, 26*, 33–42.

Lewis, J., Arnold, M. S., House, R., & Toporek, R. L. (2002). *Advocacy competencies: Task Force on Advocacy Competencies.* Alexandria, VA: American Counseling Association. Retrieved on February 10, 2007 from http://www.counseling.org/Files/FD.ashx?guid=24135fca-b378-4fe2-ae35-a467487858f7

Lewis, R., Davis Lenski, S., Mukhopadhyay, S., & Taylor Cartwright, C. (2010). Mindful wonderment: Using focus groups to frame social justice. *Journal for Social Action in Counseling and Psychology, 2*, 82–105.

Locke, D. C., & Kiselica, M. S. (1999). Pedagogy of possibilities: Teaching about racism in multicultural counseling courses. *Journal of Counseling & Development, 77,* 80–86.

Manese, J. E., Wu, J. T., & Nepomuceno, C. A. (2001). The effect of training on multicultural counseling competencies: An exploratory study over a ten-year period. *Journal of Multicultural Counseling and Development, 29,* 31–40.

Manis, A. A. (2008). Promoting multicultural and advocacy competence in counselor trainees: Testing a critical pedagogical intervention (Doctoral Dissertation, University of Virginia, Charlottesville, 2008). Retrieved from ProQuest Digital Dissertations (ATT 3302213).

McAllister, G., & Irvine, J. J. (2000). Cross cultural competency and multicultural teacher education. *Review of Educational Research, 70*, 3–24.

Murray, C. E., Pope, A. L., & Rowell, P. C. (2010). Promoting counseling students' advocacy competencies through service-learning. *Journal for Social Action in Counseling and Psychology, 2*, 29–46.

Musil, C. M. (1996). The maturing of diversity initiatives on American campuses: Multiculturalism and diversity in higher education. *American Behavioral Scientist, 40*, 222–232.

Nilsson, J. E., & Schmidt, C. K. (2005). Social justice advocacy among graduate students in counseling: An initial exploration. *Journal of College Student Development, 46*, 267–279.

Odegard, M. A., & Vereen, L. G. (2010). A grounded theory of counselor educators integrating social justice into their pedagogy [Special issue]. *Counselor Education and Supervision, 50*, 130–149.

Palmer, L. K. (2004). The call to social justice: A multidiscipline agenda. *The Counseling Psychologist, 32*, 879–885.

Paylo, M. J. (2007). *Characteristics of counselors that advocate for clients* (Doctoral dissertation). Retrieved from Pro Quest Dissertations and Theses Database. (3260661).

Prilleltensky, I. (1989). Psychology and the status quo. *American Psychologist, 44*, 795–802.

Rasheed Ali, S., Ming Liu, W., Mahmood, A., & Arguello, J. (2008). Social justice and applied psychology: Practical ideas for training the next generation of psychologists. *Journal for Social Action in Counseling and Psychology, 1*, 1–13.

Ratts, M. J. (2006). *Social justice counseling: A study of social justice counselor training in CACREP-accredited counselor preparation programs* (Doctoral dissertation). Retrieved from Pro Quest Dissertations and Theses Database. (3214372).

Ratts, M. J., & Wood, C. (2011). The fierce urgency of now: Diffusion of innovation as a mechanism to integrate social justice in counselor education. *Counselor Education and Supervision, 50,* 207–223.

Rooney, S. C., Flores, L. Y., & Mercier, C. A. (1998). Making multicultural education effective for everyone. *The Counseling Psychologist, 26*, 22–32.

Seto, A., Young, S., Becker, K. W., & Kiselica, M. S. (2006). Application of the triad training model in a multicultural counseling course. *Counselor Education and Supervision, 45*, 304–318.

Sleeter, C., Torres, M. N., & Laughlin, P. (2004). Scaffolding conscientization through inquiry in teacher education. *Teacher Education Quarterly,* 81–96.

Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*, 132–145.

Stadler, H. A., Suh, S., Cobia, D. C., Middleton, R. A., & Carney, J. S. (2006). Reimagining counselor education with diversity as a core value. *Counselor Education & Supervision, 45*, 193–206.

Steele, J. M. (2008). Preparing counselors to advocate for social justice: A liberation model. *Counselor Education and Supervision, 48*, 74–85.

Sue, D. W., Bingham, R. P., Porché-Burke, L., & Vasquez, M. (1999). The diversification of psychology: A multicultural revolution. *American Psychologist, 54*, 1061–1069.

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling and Development, 87*, 260–268.

Toporek, R. L., & Reza, J. V. (2001). Context as a critical dimension of multicultural counseling: Articulating professional and institutional competence. *Journal of Multicultural Counseling and Development, 29,* 13–30.

Watts, R. J. (2004). Integrating social justice and psychology. *The Counseling Psychologist, 32*, 855–865.

Addiction Counseling Licensure Issues for Licensed Professional Counselors

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This article addresses the obstacles of effectively integrating addiction counseling into a nationwide definition of professional counseling scope of practice. The article covers an overview of issues, specific licensure and credentialing frameworks (LPC, CADC, LCADC) in two U.S. states, and recommendations to effectively bridge the gap between professional and addiction counseling. Historical origins and an overview of addiction counseling are presented.

Keywords: addiction, licensure, credentialing, LPC, CADC, LCADC

The question of professional identity within the counseling profession, first considered during the founding of the American Personnel and Guidance Association (Sweeney, 1995), still exists today (Calley & Hawley, 2008; Cashwell, Kleist, & Schofield, 2009; Mellin, Hunt, & Nichols, 2011; Myers, Sweeney, & White, 2002; Nassar-McMillan & Niles, 2011; Remley & Herlihy, 2009). One possible reason for the continual debate around professional identity may lie in the multitude of specialty fields (e.g., addiction, career, and school) within counseling (Gale & Austin, 2003; Myers, 1995; O'Brien, 2010). Remley (1995) underscores that unlike psychology, psychiatry and social work, counseling is the only mental health profession that licenses specialty areas. Specialty areas such as career and school counseling only denote a practice area or population; whereas addiction counseling actually entails a DSM-IV-TR Axis I disorder (i.e., Substance Use Disorders; American Psychiatric Association, 2000). No other Axis I or Axis II disorder receives such attention.

Addiction is considered a part of professional counseling as implied by the latest CACREP standards (2009). However, a separate licensure track exists for the profession of addiction counseling. If the practice of addiction counseling really is a part of counseling (as implied by the latest 2009 CACREP standards), then the time has come to *recalibrate* the rest of the counseling profession to better fit an inclusive and unifying professional counseling identity that *includes addiction counseling*. Thus, the purpose of this paper is to start the dialogue regarding the mixed messages on the issue of counselor identity and specialization for addiction counseling (Morgen, Miller, Culbreth, & Juhnke, 2011; Tabor, Camisa, Yu, & Doncheski, 2011). The article is divided into an overview of issues, specific licensure and credentialing frameworks in two sample states (New Jersey and North Carolina), and recommendations in response to the concerns discussed.

Overview of Issues

Henriksen, Nelson, and Watts (2010) criticize the counseling specialty system by arguing that counseling specialties do not define counseling but merely denote a practice area, and that counseling specialty licensure/credentialing implies that only a small proportion of the counseling profession is qualified to work with this population. The addiction area is one such area of specialization that comes with a separate licensure/credentialing process. The authors believe that in regard to addiction counseling, the additional supervisory and training hours required for addiction licensure/credentialing (in addition to the supervisory and training hours required for licensure as a professional counselor) *implies* that addiction

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content falls *outside* the professional counseling scope of practice.

For instance, if the graduate counseling program does not possess an addiction track, a cursory review of curriculum at CACREP and non-CACREP programs found the typical option of *one* addiction course as an elective. However, curricular reviews of numerous programs find few to no electives on other DSM-IV-TR disorders (e.g., mood, anxiety). Thus, the authors argue this produces a confusing mixed message in that licensure as a professional counselor covers practice areas that typically receive minimal *exclusive* attention (e.g., one-week discussion on anxiety disorders in a maladaptive behavior course), yet an area where one (or more) electives are typically offered for in-depth study of a disorder (such as addiction) comes with an entirely unique and separate licensure process.

The presence of a separate licensure/credentialing process for addiction counseling seems antiquated considering the extensive training required for a graduate counseling degree. Furthermore, most states consider addiction work within the professional counselor scope of practice (Tabor et al., 2011). Thus, the pioneering issue this paper addresses is whether it is time to thoughtfully reconsider how addiction is conceptualized in professional counseling (beyond the inclusion in the most recent CACREP standards) and *recalibrate* the education and licensure processes accordingly. In order to begin this dialogue a brief review of the history of the licensure/credentialing process of addiction counselors needs to be provided.

Historical Origins of the Issue

Historically across most states, the advent of addiction counseling licensure/credentialing standards occurred parallel with the professionalization of the counseling field (i.e., the master's-level state licensure laws). States mandated that graduate school-level professionals conduct counseling, leaving many long-time and effective addiction counselors (many of whom possessed only a high school diploma or GED) out of the counseling mainstream. Consequently, addiction licensure/credentialing boards were established to achieve two goals. The first goal was to professionalize the addiction counseling field in a manner similar to professional counseling via mandated supervised practice hours and education across a subscribed addiction curriculum. The second goal was to provide a mechanism to grandfather into the profession those addiction counselors who had long worked in the field and provided outstanding services. Without the grandfather clause, many of these addiction counselors would have lost their profession or would have needed to put their career on pause as they obtained the required education and/or training.

The professionalization of addiction counseling, including licensure and credentialing, strengthened the field and provided a higher quality of care to those struggling with addiction. Unfortunately, a system also was established that over 30 years reinforced the notion that addiction falls outside the scope of practice for professional counseling (i.e., the presence of a separate licensure and certification processes focused on *addiction* counseling). While the addiction counseling field did need professionalization, perhaps the original high standards (e.g. upwards of 3,000 hours of clinical practice with supervision) now require *recalibration* that takes into account a new era where counselor training for those engaged in addiction work extends far beyond a high school diploma or GED.

Professionalization or Deterrent?

The authors' perspective in this paper is that imbedded in the current licensure and credentialing process for addiction counseling is the message that LPCs cannot or should not do addiction work. The message comes from a confusing mixed array of information. Using the graduate trainee (the next generation of counseling professional) as an example, it becomes clear as to how future LPCs may shy away from addiction work. For instance, in the classroom graduate students read about how counseling includes working in the addiction area (as per the latest CACREP standards). Graduate students are trained in a graduate counseling curriculum that offers advanced addiction course electives and the possibility of doing practicums or internships at an addiction facility. Many of these graduate students may even attend school in a state where addiction work is covered in the professional counseling scope of practice. But, these students also see professional counselors with separate addiction licenses (e.g., LPC *and* LCADC) and employment announcements requesting/requiring an addiction license. Even the National Board of Certified Counselors (NBCC) Master Addiction Counselor Credential (MAC) focused on this one DSM-IV-TR disorder class (with no other NBCC credential so narrowly focused on one DSM-IV-TR disorder). Because the student does not see an NBCC credential for mood disorders or sees a licensure for anxiety disorders, the imbedded message is strengthened.

The mixed messages coupled with the burdensome task of meeting the mandates for two professional bodies (professional counseling and addiction) may drive some new counselors from the addiction field. For example, at the end of a panel discussion on this topic at the 2011 American Counseling Association Conference (Morgen et al., 2011), a new graduate of a professional counseling master's program said she would like to start accruing practice hours in a substance use disorders clinic as she had completed some internship hours there and took a course on substance use disorders. However, the facility where she wanted to work required her to obtain an addiction license in addition to her professional counseling license. She subsequently indicated that she did not have the time, money, or the energy to do both and was thus looking outside the substance use disorders field for employment. This anecdote clearly demonstrates how newly graduated counseling professionals (especially those working in the provisional licensure period) may be inhibited from entering the addiction counseling field.

How many qualified, talented and motivated students are we turning away from the addiction counseling field due to these extra training requirements unique to working with the specific DSM-IV-TR Axis I Substance Use Disorder diagnosis at a time when there is an ever-growing need for services (e.g., addiction in returning veterans or the chronically unemployed)? Effective training of LPCs who work with addiction requires coordination between educational training institutions and actual practice that reflects *reasonable* experienced-based requirements for working in the area of addiction as well as *respect* for the graduate-level degree (e.g., master's or doctorate) and training the counselor has already received. Such coordination varies from state to state and without a guarantee of such coordination the danger is that well-intentioned, well-trained counselors will enter the field *technically* qualified to counsel individuals, but *philosophically* lacking the integration of theory and practice necessary for treating addiction. This could mean, for example, that the counselor is more vulnerable to enabling the active addictive process and thereby not providing counseling in the best interest of the client.

In an effort to initiate the dialogue on how to perhaps *recalibrate* the system, it first seems warranted to review the professional and addiction counseling licensure laws and policies within two states. The authors intend to (over the next few years) review the state laws and policies for all 50 states. However, for the purposes of this initial paper, New Jersey and North Carolina will be discussed below.

Specific State Issues

New Jersey

New Jersey operates a professional counseling license (LPC) with a minimum education of a graduate counseling degree, a certified alcohol and drug abuse counselor credential (CADC) requiring a minimum education of bachelor's degree, associate degree, high school diploma or GED, and a licensed clinical and alcohol and drug abuse counselor (LCADC) with a minimum education of a graduate counseling degree and qualification for the CADC. The LPC is governed by the Professional Counselor Examiners Committee (imbedded within the Marriage and Family Therapy Board), whereas the CADC/LCADC is governed by the Alcohol and Drug Counselor Committee.

According to the regulations for professional counseling, New Jersey defines counseling in part as "using currently accepted diagnostic classifications including, but not limited to the DSM-IV" (NJ Board of Marriage and Family Therapy Examiners, 2009, 13:34-10.2, p. 34-22). Substance use disorders fall within Axis I of the DSM-IV-TR, thus work with substance use disorders seems in line with the professional regulations of the LPC. Further evidence of this fact exists within the LCADC regulations (NJ Alcohol and Drug Counselor Committee, 13:34C-2.6, p. 34C-10) that states the following individuals are *exempt* from the LCADC licensure requirement:

> A person doing work of an alcohol or drug counseling nature, or advertising those services, when acting within the scope of the person's profession or occupation and doing work consistent with the person's training, including physicians, clinical social workers, professional counselors, marriage and family therapists, psychologists, nurses or any other profession or occupation licensed by the State, or students within accredited programs of these professions, if the person does not hold oneself out to the public as possessing a license or certification issued pursuant to the Act or this chapter.

As long as an LPC does not advertise oneself as an addiction or substance abuse counselor, they are completely free to practice counseling with individuals presenting with addiction.

However, new counselors and LPCs who wish to accrue hours toward addiction licensure/credentialing face obstacles within the hiring process for addiction-focused positions. For example, despite the clear language in the LPC and CADC/LCADC regulations, advertised positions in the addiction counseling field in New Jersey typically include language stating "actively pursuing CADC/LCADC" or "must hold a New Jersey CADC/LCADC." These requirements (which again, contradict the language of the New Jersey LPC and LCADC regulations) are typically in place due to a mandate of the program funding source (e.g., state or federal). Private practice counselors (who do not operate any funded programs with the above-mentioned requirements) are free to practice addiction work if qualified. However, most (if not all) of the addiction counseling positions where a new professional counseling graduate can accrue hours are housed in some type of treatment facility that very likely must adhere to the LCADC mandate, thereby limiting access to positions for those seeking to accrue LPC hours within the addiction counseling field.

In New Jersey, the typical master's student who wants to accrue hours for licensure as an LPC must produce approximately 4,500 supervised counseling hours. This process comes immediately after the challenging two to three years of graduate study and passing the National Counselor Exam (NCE). However, to obtain the LCADC these students must complete an additional and separate 3,000 supervised addiction counseling hours, 270 clock hours of education focused on counseling and addiction, and 300 hours of supervised practical training in core counseling areas such as screening, intake, assessment, etc. The primary and most time-consuming problem lies in the need to accrue the supervised addiction counseling hours. Since the supervised counseling hours cannot be combined (e.g., there is no language in either the LPC or LCADC regulations permitting *or* denying the "double-dipping" of an hour for inclusion in both the LPC and LCADC hours accrual for licensure; this alone is confusing and indicates a need for clarification), the trainee working towards licensure who wishes to work in an addiction facility must accrue thousands of extra hours or opt to only work towards the LCADC. No other DSM-IV-TR disorder class comes with this burdensome extra mandated training requirement.

Recent efforts to integrate the mental health and addiction licensure processes in New Jersey are in motion, but still in an early phase. Much of this work is coming from a project sponsored by the New Jersey Division of Mental Health and Addiction Services designed to train the next generation of dual-licensed and trained (mental health and addiction) practitioners. However, this need to streamline the process is only present because of the dual licenses already in place. Furthermore, the premise of the program (though an excellent contribution) still propels the notion that addiction falls outside the scope of LPC practice and there needs to be a process to merge the two together. Despite the benefits of this new initiative, the end result is still the same: two different licenses. Again, this is the only DSM-IV-TR disorder that receives this treatment.

North Carolina

North Carolina has a well-coordinated system for addiction counselors. All professionals who want to be licensed to work in the addiction counseling field need to go through the same board, the NC Substance Abuse Professional Practice Board (the Board), which is "recognized as the registering, certifying, and licensing authority for substance abuse professionals" (Practice Act, 2005, Senate Bill 705, North Carolina General Assembly, **§** 90 113.32). One board eliminates competition between boards and the related issues that arise. In fact, the Licensed Professional Counselors Act (LPC law) specifically exempts substance abuse counselors from the counseling law by declaring that nothing in the LPC law "shall prevent a person from performing substance abuse counseling or substance abuse prevention consulting" (NC Board of Licensed Professional Counselors, 2009, § 90-332.1.d). Having one board brings together individuals from various professions in a concerted effort to address the issues related to addiction counseling and to advocate for the field at a state level. This framework has the strength of cooperation between different professional groups and the absence of competition within a state.

This cooperation is enhanced by a *tiered system* (licensure and credentialing). Individuals may apply for licensure as a Licensed Clinical Addictions Specialist. With regard to entry at the licensure level, there are *four main routes or criteria* (Criteria A, Criteria B, Criteria C, and Criteria D). Although initially the system may be confusing to determine the criteria under which one fits, the advantage is that there is greater flexibility for the individual applying for licensure. This

flexibility is the result of minimum requirement variation in the areas of *education*, *training*, *experience*, and *supervision* (Criteria A, B, & C), as well as *professional discipline* (e.g., psychology, social work, counseling—Criteria D). For specific guidelines and clarification of this summary, the reader is referred to: http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_90/Article_5C.html.

In terms of similarities for the individual applying for licensure, there are *two aspects that remain the same* under *Criteria A, B,* and *C*: the submission of three letters of reference (there is some variation allowed for the individuals who can write these letters) and a passing score on a master's level written examination administered by the Board. The variations under these criteria are as follows. In the area of *education, Criteria A* and *B* require a minimum of a master's degree with a clinical application in a human services field from a regionally accredited college or university. In addition, in terms of *training*, *Criteria A* requires 180 hours of substance abuse specific training from either a regionally accredited college or university, which may include unlimited independent study or from training events of which no more than fifty percent (50%) shall be in independent study. *Criteria C* combines the *education and training* requirement in the minimum requirement of a master's degree in a human services field with both a clinical application and a substance abuse specialty from a regionally accredited college or university that includes 180 hours of substance abuse specific education and training. In the area of *experience*, *Criteria A* requires two years postgraduate supervised substance abuse counseling experience, while *Criteria B* requires the applicant to be certified as a substance abuse counselor. Finally, regarding *supervision*, *Criteria A* requires documentation of a minimum of 300 hours of supervised practical training and provision of a board-approved supervision contract between the applicant and an applicant supervisor, while *Criteria C* requires one year of postgraduate supervised substance abuse counseling experience. *Criteria D* simply requires that the applicant has a substance abuse certification from a professional discipline that has been granted deemed status by the Board (i.e., possession of a certification to practice addictions work under another discipline, such as social work, and that certification is recognized by the counseling board).

Note that the Board also offers numerous credentials through certification for non-master's-level professionals. These include the Certified Substance Abuse Counselor (CSAC), Certified Substance Abuse Prevention Consultant (CSAPC), Certified Criminal Justice Addictions Professional (CCJP) and the Substance Abuse Residential Facility Director (CSARFD) credentials. In terms of the CSAC and the CSAPC, the applicant needs to be of good moral character, not be (or have been) engaged in any practice or conduct that would be grounds for disciplinary action, have a minimum of a high school diploma or a high school equivalency certificate, sign a form attesting to the intention to adhere fully to the Board's ethical standards, and submit a complete criminal history record check.

Additionally, a CSAC who completes a clinical master's degree program in a human services field can seek the LCAS via *Criteria B* as outlined above. This criterion recognizes the fact that the CSAC has already completed a 300-hour supervised clinical practicum and has substance abuse specific work experience. In addition to submitting proof of one's master's degree, all one has to do to obtain the LCAS via this criteria is to submit three letters of reference from LCAS's and/or master's level CSAC's and pass the LCAS examination.

This tiered system allows the counselor to enter the field with or without a masters' degree and allows the master's=level counselor to have an accelerated process if they acquire clinical application experience enhancing the possibility they are both technically and philosophically prepared to work in the addiction counseling field. The requirement of the clinical application experience may be a barrier for some counselors, but the intent is to serve the best interests of the public.

Finally, there is collaboration between the Board and specific university degree programs regarding the type and quality of the courses, thus increasing the chance that counselors are effectively trained to work in the addiction counseling field. While there is not "board approval" on the content areas, programs are approved for addiction counseling. Students who graduate from these master's degree programs may seek the LCAS license via *Criteria C* (outlined above). The Board maintains a current list of school programs approved for application under *Criteria C* on its website: http://www.ncsappb.org/certificationssteve/criteriaschools2.htm.

While North Carolina's tiered system of licensure and credentialing allows for greater flexibility for the individual applying to work in the addiction counseling field, the system can be overwhelming and does contribute to the perception

that addiction counseling is a separate profession with separate education, training, supervision and practice. Kaplan and Gladding (2011), King (2011), and Gladding, Kaplan, Linde, Mascari, and Tarvydas (2011) have advocated along with others about the importance of a unified counseling identity with common skills, training and practice (particularly among counseling specialties).

Recommendations

Overall, there appears to be a need for a *recalibration* of the experienced-based training required for LPCs at a national level that will enhance their entrance into the field of addiction counseling. Currently, states that do not allow for multiple entries into the field have a tiered system of entry, or an approval mandate of the type or quality of the addiction training program, that may inhibit LPCs from practicing in the addiction counseling field. In states where there are significant barriers, professional counselors (fully licensed or in-training) entering the addiction counseling profession with a graduate degree may be required to complete additional training requirements that were created during a time when the addiction counseling professional possibly possessed no more than a high school diploma or GED, and such credentialing requirements (e.g., thousands of supervised hours) were imposed as a mechanism to professionalize the field. Considering the graduate counseling degree (and associated supervised counseling hours) held by a LPC or counselor-in-training accruing licensure hours, these mandates currently seem excessive and possibly even redundant. Presently, the North Carolina system may be one of the few in the United States that provides the fewest barriers for LPCs entering the addiction counseling field.

In the following section, two remedies for the licensure/credentialing problems are presented. Although myriad issues complicate the process (e.g., counselors are called different titles in different states and different state requirements are present for licensure/credentialing as an addiction counselor), the following suggestions in some conceptualization may spur more tangible action. Any formal action should likely come from a national committee set up through the American Counseling Association (ACA) and in conjunction with the ACA addiction division, The International Association of Addictions and Offender Counselors (IAAOC), as well as CACREP, and national bodies such as the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification and Reciprocity Consortium (IC&RC). Committee representatives from these parties could examine the coordination of experience and training. Such a committee could develop guidelines for balancing these concerns for states to use in their individual *recalibration* of requirements.

Possible Solution #1: Nationally Recognized Tiered System of Addiction Counselor Credentialing

One of the difficulties in terms of the current state of addiction credentialing in the U.S. is the absence of uniform national curriculum training standards in the addiction field. Also, there are two main national credentialing groups: NAADAC and the IC&RC. Issues arise because affiliation with one of the two main credentialing groups and credentialing variations between these organizations can result in issues in terms of competition and the nature of the boards and exams required for credentialing. Miller, Scarborough, Clark, Leonard, and Keziah (2010) recommend the following with regard to addiction counseling: (a) portability of credentials, (b) competition reduction between credentialing groups and state boards, (c) national standards for addiction education and training, and (d) a standardized national licensure/credentialing process. Unfortunately, these recommendations have not yet been fully implemented.

One possible solution is to develop a tiered system of addiction counseling credentials at a national level that takes into account professional experience as well as educational training. There needs to be a balance between the idea that anyone with a general counseling degree can do addiction counseling and the idea that only a few select counselors can do the work. Furthermore, this balance should be firmly based upon the ACA Ethical Code that indicates that counselors only practice within their area(s) of competence (2005).

For example, graduates of professional counseling programs (e.g., those working towards LPC status) who have taken a nationally-approved addiction counseling curriculum and have completed practicum/internship experiences could be designated as having addiction credentials in addition to the LPC (i.e., a nationally approved addiction concentration). Therefore, graduate counseling coursework that includes addiction counseling education and practical experiences would enable new graduates to move seamlessly into the addiction counseling profession without the need for additional supervision hours or educational components (i.e., beyond the required supervised counseling hours and educational

components required for the LPC). The system would eliminate the need for a professional counselor to acquire an additional and separate addiction license/certification. In addition, the national standards could promote portability of credentials. This compromise works to maintain the licensed/certified addiction counseling credentials in each state while also providing the LPC with the documented expertise required for many addiction facility positions. This tiered system also could facilitate enhanced training during the process of accruing hours for licensure by better focusing the training hours upon the *interface* between addiction and other mental health issues as opposed to the current parallel and disparate relationship between addiction and other mental health issues.

Possible Solution #2: Nationally Recognized Addiction Counseling Concentration Curriculum

There are issues regarding standardization of training that need to be addressed within the context of academia. In essence, what are the theoretical and practical skills required of an addiction counselor nationwide? There are numerous initial places to look into the process of establishing a nationally recognized addiction counseling concentration, such as the 2009 CACREP standards for addiction counseling and the Center for Substance Abuse Treatment's (2006) *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* By using these (and other) standards, all counseling programs (regardless of CACREP accreditation) can follow a standard recommended education experience for students who desire the addiction credential discussed in the first possible solution. Curricular issues would likely include standalone addiction courses, infusion of addiction content into other courses, faculty expertise in the addiction area and practicum and internship hours focused on addiction counseling practice.

In addition, the NCE and National Clinical Mental Health Counselor Examination (NCMHCE) would require some *recalibration* to take into account the curricular changes to a professional counseling education that includes the addiction counseling concentration. One caution is that any discussion of these and other training issues may produce opposing forces within academia, the counseling profession, the addiction counseling profession, state licensing/credentialing boards (both professional counseling and addiction) and individual counselor education professors and college/university departments. Again, that is why a national committee comprised of all involved parties is necessary to navigate this challenging process.

Concluding Comments

Two students graduate with a master's degree in counseling. Both took elective courses in their area of interest; one in mood disorders, the other in addiction, and both did an internship in a counseling setting focused on their interest area. Upon graduation, the student with an interest in mood disorders can easily be brought onto the clinical roster of a mood disorders clinic and immediately start accruing hours towards licensure. Their provisional license is all that is required during the training period. Unfortunately, the graduate with an interest in addiction may face competing licensure and/or credentialing requirements between professional and addiction counseling, mandated extra training coupled with thousands of extra supervised hours, and/or the possibility of a denial of employment without the appropriate addiction credential.

The purpose of this article is to start the dialogue on how to effectively incorporate addiction counseling into the scope of practice and accepted role of the professional counselor. We firmly believe that effective counseling focused on addiction issues requires specific and rigorous counselor training. However, we also believe the current national practice of training and credentialing for addiction counseling must change. State-by-state, burdensome (and in some instances outdated) rules and regulations are keeping countless qualified, capable, and motivated counselors from entering the addiction field. The time has come to recalibrate the rest of the counseling profession to better fit an inclusive and unifying professional counseling identity that includes addiction counseling.

References

American Counseling Association. (2005). *Code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed.). Washington, DC: Author.

Council for Accreditation of Counseling Related Educational Programs (2009). *CACREP standards*. Alexandria, VA:

Author.
Calley, N., & Hawley, L. (2008). The professional identity of counselor educators. *The Clinical Supervisor*, *27*(1), 3–16. doi:10.1080/07325220802221454
Cashwell, C., Kleist, D., & Schofield, T. (2009, August). A call for professional unity. *Counseling Today, 52*(2), 60–61.
Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice*. Technical Assistance Publication (TAP) Series 21. DHHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.
Gale, A., & Austin, B. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling & Development*, *81*(1), 3–10.
Gladding, S. T., Kaplan, D., Linde, L., Mascari, J. B., & Tarvydas, V. (2011, March). *20/20: A vision for the future of counseling – The new consensus definition of counseling.* Educational session presented as the ACA 2011 Conference, New Orleans, LA.
Henriksen, R. C., Nelson, J., & Watts, R. E. (2010). Specialty training in counselor education programs: An exploratory study. *Journal of Professional Counseling: Practice, Theory, and Research, 38(1)*, 39–51.
Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 principles for unifying and strengthening the profession. *Journal of Counseling & Development, 89*(3), 367–372.
King, J. H. (2011). The role of ethics in defining a counseling professional identity. Unpublished Ph.D. dissertation proposal, Capella University, United States: Minnesota.
Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*, *89*(2), 140–147.
Miller, G. (2010). *Learning the language of addiction counseling* (3rd ed.). Hoboken, NJ: Wiley.
Miller, G., Scarborough, J., Clark, C., Leonard, J. C., & Keziah, T. B. (2010). The need for national credentialing standards for addiction counselors. *Journal of Addictions & Offender Counseling, 30,* 50–57.
Morgen, K., Miller, G., Culbreth, J., & Juhnke, G. (2011, March). *Analysis of professional and addiction counseling licensure requirements, scope of practice, and training: National findings.* Educational session presented at the American Counseling Association Conference & Exposition, New Orleans, LA.
Myers, J. (1995). Specialties in counseling: Rich heritage or force for fragmentation? *Journal of Counseling & Development*, *74*(2), 115–116.
Myers, J., Sweeney, T., & White, V. (2002). Advocacy for counseling and counselors: A professional imperative. *Journal of Counseling & Development*, *80*(4), 394.
Nassar-McMillan, S. C., & Niles, S. G. (2011). *Developing your identity as a professional counselor*. Belmont, CA: Brooks/Cole.
New Jersey Alcohol and Drug Counselor Committee. NJSA 45:2D-1 through 45:2D-18, 13:34C-1.1 through 13:34C-6.4.
New Jersey Board of Marriage and Family Therapy Examiners, NJSA 45:8B-13 and 34, Professional Counselor Regulations 13:34-9.1 through 13:34–19.6.
North Carolina Board of Licensed Professional Counselors, Licensed Professional Counselors Act § 90-332.1 (2009).
North Carolina Substance Abuse Professional Practice Board, North Carolina Substance Abuse Professional Practice Act § 90 113.32 (2005).
Remley Jr., T. (1995). A proposed alternative to the licensing of specialties in counseling. *Journal of Counseling & Development*, *74*(2), 126–129.
Remley, T., & Herlihy, B. (2009). *Ethical, legal, and professional issues in counseling* (3rd ed.). Upper Saddle River, NJ: Merrill.
Sweeney, T. (1995). Accreditation, credentialing, professionalization: The role of specialties. *Journal of Counseling & Development*, *74*(2), 117–125.
Tabor, J., Camisa, K., Yu, F., & Doncheski, M. (2011, March). *Addressing nationwide Inconsistencies in the scope of practice for licensed professional counselors regarding substance abuse counseling.* Poster presented at the American Counseling Association Conference and Exposition, New Orleans, LA.

College-Student Personal-Growth and Attributions of Cause

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Little is known about levels of personal growth attributed by students to typical college life experiences. This paper documents two studies of student self-reported and posttraumatic growth and compares growth levels across populations. Both studies measure student attributions of cause to academic and non-academic experiences, respectively. It is suggested that future research on the outcome of college life experiences can use a similar approach with a variety of variables.

Keywords: college life, personal growth, posttraumatic growth, life experiences, attributions of cause, outcome of college

The results of a rapidly growing number of studies document high levels of adversarial growth attributed by survivors in retrospect to coping with negative life experiences (Linley & Joseph, 2004) including war, bereavement, or loss of a child. The Posttraumatic Growth Inventory (PTGI) by Tedeschi & Calhoun (1996) has been the most popular measure of adversarial growth to date (Joseph, Linley, & Harris, 2005; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004). In this context, *adversarial* refers to the negative nature of an experience of interest to researchers. *Growth* refers to personal growth defined as the positive psychological changes described by assessment-instrument items, changes such as the building of interpersonal relationships, a greater appreciation of the value of life, and a realization of new possibilities in life (examples after Tedeschi & Calhoun, 1996). Thus, adversarial growth is personal growth attributed by participants to a naturalistic negative *event* of particular interest to researchers. We stumbled on the PTGI and the relationship between adversarial and personal growth while searching for an instrument for measuring personal growth attributed in retrospect to the sum of naturalistic experiences (both positive and negative) occurring during a *time period* of interest to researchers.

The growth of immediate interest to us is not adversarial, but rather the total personal growth of college students because our long-term goal is to determine how educators can best facilitate growth, whether adversarial or otherwise. Developmental theorists (Chickering, 1969; Chickering & Reiser, 1973; Pascarella & Terenzine, 1991; Perry, 1970) have suggested that students grow in response to the combination of typical experiences of college life. Although researchers have used a variety of instruments to measure both academic and personal growth (for recent examples see Hassan, 2008; Higgins, Lauzon, Yew, Brasweth, & Morley, 2009), little is known about how college-student growth compares to adversarial growth because comparisons require measures obtained with the same instrument. Therefore, we want to measure college-student growth with an instrument that has been used to measure adversarial growth. Tedeschi and Calhoun (2004) implied that the PTGI might be suitable for our purposes by characterizing its items as capturing the core of personal growth (without distinguishing between adversarial and personal growth). We decided to use the PTGI after noting that the developers themselves conducted the first study of non-adversarial growth based on the PTGI by using it to measure levels of personal growth described by college students in a small (n = 32) non-trauma comparison group (see study 3 in Tedeschi & Calhoun, 1996).

We conducted the second and third studies of interest (N = 347, N = 117) by using the PTGI to measure levels of college student personal growth, whether adversarial or otherwise attributed to a single semester of college life (Anderson & Lopez-Baez, 2008, 2011). All three previous studies documented mean levels of student personal growth near the midpoint of the range reported for posttraumatic studies (range 46.00–83.47 for 14 studies summarized by Linley & Joseph, 2004). In our second study, we elicited brief explanations from students to learn how they accounted for their growth (see Anderson & Lopez-Baez, 2011). Explanations were in the form of percentage attributions of total personal

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growth to student-identified naturalistic experiences and to a researcher-identified 3-hour course designed to facilitate growth (student explanations like: college internship accounted for 30% of my total personal growth, finding a job for 40%, 3-hour course of interest to researchers for 15%, miscellaneous other experiences for the remaining 15%). We refer to these explanations as *attributions of cause*. Student attributions of cause to academic experiences supported the appealing idea (to counselors and educators) that personal growth as defined and measured by the PTGI can be intentionally facilitated by activities designed to do so.

The two studies described in the current paper are the fourth and fifth based on the PTGI to measure college-student personal growth that was not strictly adversarial. Both samples are generally similar to those of our previous studies (Anderson & Lopez-Baez, 2008, 2011). The current studies extend the results of our previous ones by (1) measuring the growth attributed by sample members to substantially longer periods of college life and (2) eliciting separate attributions of cause for academic and non-academic experiences, respectively. The primary purpose of Study 1 was to examine the internal validity of student data collected with the PTGI by comparing the descriptive statistics among the results of Study 1 with those of the three previous studies described above (Anderson & Lopez-Baez, 2008, 2011; Tedeschi & Calhoun, 1996). The primary purpose of Study 2 was to measure graduating college-senior attributions of annual personal growth, in retrospect to their freshman, sophomore, junior, and senior years, respectively. Study 2 was descriptive.

Study 1: Cumulative Growth

Research questions 1 and 2 are designed to collect descriptive data. Research question 3 is designed to collect information about the internal validity of our data by testing hypotheses on the basis of comparisons of the results of Study 1 with the results of previous studies (Anderson & Lopez-Baez, 2008, 2011).

Research question 1. What levels of cumulative personal growth do participants describe for their college undergraduate years (descriptive statistics for PTGI scores)?

Research question 2. What cumulative percentage attributions of cause do participants describe for academic experiences (college credit) and non-academic (all other) experiences, respectively, during their college undergraduate years (descriptive statistics for attributions of cause)?

Research question 3. To what extent do the results of comparable studies reflect internal validity (comparisons of statistical results across studies)?

Method

Participants

We recruited participants from among the 147 students in a 3-hour elective course, *Problems of Personal Adjustment,* taught by the first author at a southeastern university. The course covered topics of psychological adjustment and included activities to facilitate student personal growth. Data was collected at the end of the fall semester of 2007. Most students were third- and fourth-year undergraduates in the College of Arts and Sciences or the School of Commerce. A total of 137 students elected to participate (response rate 93.20%). After 15 questionnaires with missing data were eliminated, sample size was 122 (67 men, 55 women). Most participants were Caucasian (4 African Americans, 4 Hispanics, Asians, and Asian Americans) with a mean age of 21.05 (.79) years and a mean college career of 6.54 (1.34) completed semesters. Students were given extra credit for electing to participate.

Measures

Posttraumatic Growth Inventory. Each of the 21 PTGI items (Cronbach alpha = .90, test-retest r = .71) describes a single positive psychological change (Tedeschi & Calhoun, 1996). Examples (with corresponding subscale and number of subscale items) include: “A sense of closeness with others” (Relating to Others, 7 items), “I developed new interests” (New Possibilities, 5 items), “A feeling of self-reliance” (Personal Strength, 4 items), “A better understanding of spiritual matters” (Spiritual Change, 2 items), and “My priorities about what is important in life” (Appreciation of Life, 3 items). Participants of trauma studies are instructed to describe the degree of each change resulting from their trauma. Responses are positions on a 6-point Likert-type scale anchored by 0 (no change) and 5 (great change). Total score range is 0 to 105 (per-item basis 0 to 5.00). Tedeschi and Calhoun (1996) reported evidence for concurrent and discriminant validity (their second study 1996) and construct validity (their third study). We have previously reported mean levels of college-student

growth of 59.07 (*SD* = 15.77, *N* = 347; Anderson & Lopez-Baez, 2008) and 60.42 (*SD* = 16.61, *N* = 117; Anderson & Lopez-Baez, 2011).

Blank table. We use a blank, 2-column table to elicit attributions of cause (see Appendix A). In column 1, participants list life experiences thought to have contributed most to their growth during their college years. Participants list estimates of corresponding percentage contributions to total growth in column 2. For purposes of this study, we tailored the table to provide subtotals of attributions of cause to academic experiences (lines 1–5) and non-academic experiences (lines 6–10). We pre-labeled Lines 4, 5, and 10. Line 4 refers to the course taught by the principal author from which participants were recruited.

Procedure

Like subjects in our two previous studies, participants were instructed to complete a preliminary exercise to stimulate thinking about personal growth by answering questions that distinguished between level and salience of growth. We do not report the results because the research questions of the current study do not involve salience.

After completing the preliminary exercise, participants were given the following instructions for completing the PTGI (after study 3, Tedeschi & Calhoun, 1996):

> Consider the degree to which each change listed below [21 items] has occurred in your life during your years as an undergraduate, *whether or not* the change was directly related to university class work. For each change, select the best response from the following scale [6 Likert-type options of Tedeschi & Calhoun, 1996] and write the number in the space provided.

Participants provided attributions of cause by completing the form in Appendix A. Participants were instructed to complete lines 1–10 of column 1 (brief descriptions of experiences thought to have contributed most to total growth) and column 2 (corresponding percentage contributions). Participants also provided 1-line qualitative explanations of how each experience on lines 1–10 of column 1 contributed to their growth (entries not analyzed because not required by research questions).

Results

Cronbach alphas for each subscale calculated from the data of Study 1 are: .87 (all), .82 (Relating to Others), .65 (New Possibilities), .56 (Personal Strength), .82 (Spiritual Change), and .54 (Appreciation of Life). The mean female PTGI score of 71.71 (11.72) is greater than the mean male score of 66.94 (10.98), t (120) = 2.32, $p = .022 \leq \alpha = .05$ (2-tail), d = .42. Male and female scores were combined because no significant gender differences were found by t-tests of corresponding subscale means (Bonferroni-corrected $\alpha = .01$).

Research Question 1

Table 1 contains descriptive statistics for participant PTGI scores on a total and per-item basis. Magnitudes of Cronbach alphas reported above can be seen to reflect the variations in magnitude among the standard deviations reported for per-item subscale scores in Table 1 (larger Cronbach alphas are associated with larger standard deviations). This observation suggests that restricted ranges among our data for Personal Strength and Appreciation of Life account for the low values of alpha for each subscale.

The mean total of 69.09 (*SD* = 11.52) is greater than the midpoint of 52.50 for the maximum range of 0–105 and greater than the midpoint of 64.74 for the range of 46.00–83.47 reported for trauma studies (Linley & Joseph, 2004). The

per-item mean of 3.29 (*SD* = .55) exceeds 3 or "moderate growth" on the 0 to 5 response scale (scale midpoint = 2.50). The per-item means for four of the five subscales are between 3.30 (*SD* = .77) and 3.65 (*SD* = .62), inclusive. The per-item mean for Spiritual Change is lower, 1.68 (*SD* = 1.17).

Table 1

Personal Growth Scores (N = 122): Descriptive Statistics (total and per-item basis)

	Total		Per-item		Subscale inter-correlations					
S	M	SD	M	SD	1	2	3	4	5	6
1	23.10	5.40	3.30	.77	--	.46	.48	.44	.55	.88
2	17.84	3.18	3.57	.64		--	.35	.26	.37	.68
3	14.58	2.48	3.65	.62			--	.38	.39	.68
4	3.35	2.33	1.68	1.17				--	.46	.64
5	10.22	1.99	3.41	.66					--	.71
6	69.09	11.52	3.29	.55						--

Note. S Subscales: 1 Relating to Others, 2 New Possibilities, 3 Personal Strength, 4 Spiritual Change, 5 Appreciation of Life, 6 total. *Probability note:* PPA inter-correlations, $p < .00$ (two-tailed) for all *r*.

Research Question 2

Table 2 contains descriptive statistics for participant percentage attributions of cause to academic and non-academic experiences, respectively (from column 2 of Appendix A). Both subtotals are large although the non-academic subtotal is larger by a ratio of approximately 3:2. The three academic experiences thought by each participant to have contributed most to his or her growth account for 30.76% (14.79 + 8.03 + 7.94%) of the mean subtotal of 39.63% (*SD* = 11.94) of total personal growth. Illustrative examples include internships, terms abroad, and three-credit semester courses. Participants attribute the third largest contribution (7.94%) to a course designed to facilitate growth. Three non-academic experiences account for 50.31% (25.96 + 15.18 + 9.17%) of the mean subtotal 60.36% (*SD* = 11.94). Examples include illnesses, extracurricular activities, deaths of family members, and positive and negative changes in significant relationships.

Table 2

Contributions to Total Personal Growth of Selected Academic and Non-academic Experiences (Attributions of Cause): Descriptive Statistics of Column 2 in Appendix A (N = 122 students)

	Academic		Non-academic	
Experience	M	SD	M	SD
First	14.79	7.64	25.96	10.12
Second	8.03	4.44	15.18	6.34
Third	4.19	3.12	9.17	4.66
Course	7.94	6.46	--	--
Fourth	--	--	4.89	3.71
Misc.	4.68	4.53	5.16	6.01
Sum	39.63	11.94	60.36	11.94

Note. First, Second, Third, Fourth = student-identified experiences from Lines 1, 2, 3, and 6, 7, 8, 9 of Appendix A listed in descending order of magnitude, Course = Problems of Personal Adjustment course from Line 4.

Research Question 3

Numerical PTGI scores and percentage attributions of cause are subjective assessments by participants, as are most self-reports. Our research purposes require data with a degree of internal validity (veridicality or truthfulness; that is, correspondence between self-reports and actual subjective impressions). Internal validity can be assessed by comparing results of analyses across samples of multiple studies. For purposes of the following comparisons, we will use words to number our previous studies and a numeral to designate Study 1 of the current paper. Thus, our *sample one* (Anderson & Lopez-Baez, 2008) was a group of 347 students who described total growth in 2005 and 2006 for their preceding semester, $M = 59.07$ ($SD = 15.77$). Our *sample two* (Anderson & Lopez-Baez, 2011) was a group of 117 students who described total growth and attributions of cause in May of 2007 for their preceding semester, $M = 60.42$ ($SD = 16.61$). Our *sample 1* is that of the current study. Samples are characterized by similar demographic characteristics.

Comparison one. Members of samples one and two described total growth for a single semester. Therefore, we expected samples one and two to have similar mean PTGI scores (null 1: unequal mean PTGI scores). A visual inspection finds similar means. Null 1 is rejected on the basis of that visual inspection, Cohen's *d* of .08 (minimal effect size), and 95% C. I. of – 4.71 to 2.01 that includes 0.00 (SE difference = 1.71). As expected, mean total scores of samples one and two are similar.

Comparison two. Members of sample 1 described total growth over more semesters than did members of samples one or two. Therefore, we expected our sample 1 mean PTGI score to be higher than the mean of either sample one or sample

two (nulls 2 and 3: sample 1 mean less than or equal to means of samples one and two, respectively). Nulls 2 and 3 are rejected on the basis of a 1-way ANOVA F (2, 593) = 20.02, $p = .000$, $\eta^2 = .064$ with an independent variable of 3 groups and dependent variable of student PTGI scores; and Bonferroni *post-hoc* t-tests of student PTGI scores: sample one and sample 1, t (467) = 6.44, $p = 0.000 < \alpha = .0167$ (2-tail), $d = .73$; sample two and sample 1, t (237) = 4.70, $p = 0.000 < \alpha = .0167$ (2-tail), $d = .61$; sample one and sample two, t (462) = .79, $p = .430 > \alpha = .0167$ (2-tail), $d = .08$. As expected, the sample 1 mean of 69.09 is greater than the means of both sample one and sample two.

Comparison three. Visual inspection of the subscale per-item mean scores of sample one (Anderson & Lopez-Baez, 2008) and sample two (Anderson & Lopez-Baez, 2011) found that four of the per-item means in each sample are approximately equal and that all four are greater than the corresponding mean Spiritual Change score by 1.50 to 2.00 scale divisions. Therefore, we expected the subscale scores of our sample 1 to exhibit the same pattern. Visual inspection (Table 1) finds that they do. Thus, as expected, the five subscale per-item mean scores of each of our three samples are characterized by four comparatively high and approximately equal subscale mean scores and a comparatively low mean Spiritual Change score.

Comparison four. Members of all three samples completed the same 3-credit course (during different semesters) designed to facilitate personal growth. Members of sample two and sample 1 were asked for attributions of cause for the course (Anderson & Lopez-Baez, 2011). The resulting attributions of cause to a course designed to facilitate growth are themselves evidence of internal validity. We expected members of sample two to attribute a larger percentage of total growth for one semester to the class than members of sample 1 attributed for the longer period of several semesters (directional null 4: sample two mean attributions of cause to course less than or equal to corresponding mean of sample 1). Null 4 is rejected on the basis of an independent t (237) = 12.18, $p = .000 \leq \alpha = .05$ (1-tail), $d = 1.56$. As expected, the sample two mean attribution of cause to the course of 25.28 (14.28)% is greater than the corresponding sample 1 mean attribution of 7.94 (6.46)%.

Comparison five. Concurrent validity is the extent to which different measures of the same construct agree. We formulated Comparison five only after we saw an opportunity to investigate concurrent validity among the data of sample 1 by measuring the correspondence between high and low Spiritual Change scores in sample 1 and the presence or absence of corresponding written attributions of cause, respectively (null 5: no agreement). We defined high participant Spiritual Change scores as per-item mean scores of at least 3.50 scale divisions (at least 1 division above scale midpoint 2.50). Sample 1 contains 11 high scorers (2 students scored 5.00, 1 scored 4.50, 3 scored 4.00, 5 scored 3.50). We defined low Spiritual Change scores as per-item mean scores no larger than 1.50 scale divisions. Sample 1 contains 64 low scorers (14 students scored .00, 17 scored .50, 20 scored 1.00, and 13 scored 1.50). We added 19 questionnaires selected at random from those of the 64 low scorers to provide a sample of 30 questionnaires for analysis.

We examined each sample member's written attributions of cause for evidence of spiritual growth. We defined evidence of spiritual growth narrowly by the wording of the Spiritual Change items (PTGI items 5 and 18). Thus, we defined evidence of spiritual growth as student descriptions of one or more attributions of cause with at least one explicit reference to religion or spirituality including references to worship, God (or other deity or deities), prayer, or religious writings; but not references to ethics, morality, or meaning of life in the absence of the required explicit references. (Example attributions interpreted as evidence include: my faith deepened, came to accept God's will, learned more about Bible; but not: grew in commitment to boyfriend, learned importance of moral behavior, decided on career choice, or obtained new understanding of life). We easily reached consensus on all identifications because of the simple and specific definition of evidence adopted beforehand. Attributions by 6 of the 11 high scorers and 2 of the 19 low scores contained at least one reference to spiritual growth. Half of the 8 attributions with references to spiritual growth referred to religious studies classes.

High and low Spiritual Change scores corresponded to the presence or absence, respectively, of attributions of cause for 24 of 30 sample 1 members, percentage agreement = 80.00%. Spearman r is a measure of agreement between two series of nominal data that does not take into account the probability of chance matches. The probability of chance matches is high among data of interest because the sample is characterized by many low scores and many non-positive attributions of cause. Cohen's κ (1960) is a measure of agreement between two series of nominal data that accounts for the probabilities of chance matches. Cohen's κ was originally developed to assess inter-rater agreement and is widely used

for that purpose. We used it instead to measure agreement after accounting for chance between two series of nominal data rated jointly by consensus. Kappa values have a range 0 to 1 and are interpreted like positive correlation coefficients. Null 5 is rejected on the basis of a Spearman $r = .51$, $p = .005$ (1-tail) and $\kappa = .44$, approximate SE = .19, approximate $p = .013$.

Discussion

Measures

This study is based on a mixed-methods design with two measures for data collection. The first is the PTGI, a self-report instrument developed from standard psychometric techniques. Posttraumatic researchers use the PTGI to measure personal growth attributed to a trauma of interest to researchers. We use the PTGI as described by the instrument developers (Tedeschi & Calhoun, 1996) to measure total personal growth attributed to the sum of experiences during a time period of interest. Our second measure is an open table for obtaining participant attributions of cause for total personal growth. Participants complete the table with written descriptions of personal experiences and estimates of corresponding percentage contributions. The table design is adapted from one introduced in a previous study (Anderson & Lopez-Baez, 2011).

Validity

The purposes of the current study require a degree of veridicality (truthfulness), a form of internal validity. Researchers have reported little evidence of any kind for the validity of subscale scores beyond the results of exploratory factor analysis (see review in Anderson & Lopez-Baez, 2008). This is perhaps the reason why researchers have drawn few conclusions about growth from subscale scores in their results. Our comparisons one to three in the current study demonstrate the existence of predicted relationships among total PTGI scores of three samples and therefore a degree of internal validity for the collection of individual items and total PTGI scores. Comparison four demonstrates the existence of a predicted relationship between the attributions of cause from two studies and therefore a degree of internal validity for data obtained with the table-based approach. Comparison five demonstrates a degree of concurrent validity for both the subscale of Spiritual Change and the table-based approach.

Posttraumatic Growth Inventory as a Measure of Personal Growth

The PTGI was developed as a measure of posttraumatic growth. Tedeschi and Calhoun (2004) described their instrument as reflecting the core of personal growth. The results of the current study offer strong support for Tedeschi and Calhoun's description because the results report high levels of personal growth for students without regard to prior experiences of trauma. We believe that if the PTGI can be used to measure the personal growth of samples of populations as dissimilar as college students and trauma survivors, then the PTGI can probably be used as a measure of personal growth under other circumstances in future studies.

College-Student Growth and Posttraumatic Growth

Magnitude. Theorists have identified the college-student undergraduate years as a time of personal growth in response to both academic and non-academic experiences (Chickering, 1969; Chickering & Reisser, 1993; Perry, 1970) in terms that suggest the definition of personal growth embodied in the items of the PTGI. Researchers have generally confirmed theorist predictions of student growth (c.f., Hassan, 2008; Higgins et al., 2009), but not with measures that allow for comparison of personal growth in response to trauma. Therefore, we are not surprised that the results of the current study reflect student growth. We are surprised, however, by the magnitude of that growth, $m = 69.09$ ($SD = 11.52$) because it is so near the maximum of the range reported in previous studies of posttraumatic growth (Linley & Joseph, 2004). We believe that this comparison helps readers appreciate the magnitude of growth described by each population.

Factor structure and subscales. The developers of the PTGI reported a 5-factor structure for the items of their instrument on the basis of an exploratory factor analysis (Tedeschi & Calhoun, 1996) and developed five corresponding subscales of unequal length. Subsequent posttraumatic studies have reported 2- and 3-factor structures (see review in Anderson & Lopez-Baez, 2008). Taken together, we interpret these EFA results as evidence that the factor structure of posttraumatic growth is not highly differentiated or stable across different samples. The results of several EFA described in our first study (Anderson & Lopez-Baez, 2008) demonstrated that the factor structure of a sample of student scores also lacked differentiation and stability, and therefore resembled that of posttraumatic growth.

Posttraumatic researchers have typically reported descriptive statistics for the total PTGI score and for the original five subscales. We report our results this way in Table 1, but also include recalculations on a per-item average basis (total score and subscale scores divided by number of corresponding items). The per-item format allows for comparisons of scores for subscales of unequal length. The reader can verify by inspection of Table 1 that all of our subscale scores round to 3.50 (to nearest .5 scale units) except the score for Spiritual Change, which rounds to 1.50. We have observed a similar pattern among the results of our previous studies (Anderson & Lopez-Baez, 2008, 2011).

During preparation of this manuscript, we conducted an informal visual comparison (not based on comparative statistics) of intra-sample per-item subscale scores listed in the results of posttraumatic studies cited by Linley and Joseph (2004) and observed that most subscale scores in each sample were of almost equal magnitude. Most of the few exceptions were low subscale scores (greater than 1.00 per-item average scale value) for Spiritual Change. We do not interpret our observation of this pattern as empirical evidence of anything; however, the observation makes us wonder about the empirical relationship between Spiritual Change and the other four subscales and highlights the importance of assessing the internal validity of Spiritual Change to lay the groundwork for any future studies of the internal structure of growth.

Spiritual Change and spiritual growth. Tedeschi and Calhoun (2004) described the PTGI subscales as measures of five domains of personal growth. The results of our comparison three (see results section) reflect a pattern among mean subscale scores in which the per-item mean score for the Spiritual Change subscale is relatively low. This pattern is empirical evidence that growth does not occur uniformly across all domains at the same time, at least for spiritual growth as measured by Spiritual Change. The occurrence of the similar pattern we observed in the samples of many studies invites the following attempt to explain the pattern. An explanation might be especially important to educators and administrators of religious colleges and universities who actively seek to promote spiritual growth of students.

Developmental factors are probably at least partly responsible for the larger Spiritual Change scores in posttraumatic studies. Trauma study participants have generally been older than participants in samples of college students. Perhaps older people like those in many of the trauma-study samples are more likely than college undergraduates to describe spiritual growth. Perhaps spiritual growth is more characteristic of growth in response to trauma than of growth in response to college life. However, these two possibilities do not completely account for the pattern of interest (similar per-item subscale scores for four subscales and lower subscale score for Spiritual Change) because the pattern is not as pronounced among the five per-item subscale means reported by Tedeschi and Calhoun (1996) for their non-trauma comparison group of college undergraduates. The results of our comparison five (see results section) suggest another developmental factor. Comparison five is based on the narrow definition of spiritual growth embodied in the 2-item Spiritual Change scale. Participant interpretations of item content necessarily influence patterns among subscale scores. In particular, differences in religious background could contribute to different interpretations of Spiritual Change items. We recruited our sample members 12 years after Tedeschi and Calhoun recruited theirs, and we recruited ours from a different university in a different part of the United States. Perhaps our sample members have different religious backgrounds than the members of Tedeschi and Calhoun's sample.

Intentional facilitation of growth. Personal growth can occur in response to very different kinds of experiences, from coping with horrible trauma to caring deeply for friends and significant others. Most of these experiences, certainly most of the traumatic ones, seem to arise spontaneously. This conclusion is important to philosophers and developmental theorists because it suggests that personal growth is central to the human condition. Developmental theorists have suggested that personal growth also can occur in response to planned academic activities. This prediction is important to educators and others concerned with how to facilitate growth.

Students in the current study sample attributed 40% of their personal growth to academic activities (see Table 1). We interpret these results as strong support for the prediction of personal growth in response to academic activities. Students in the current study and in the sample of our second study (Anderson & Lopez-Baez, 2011) also attributed substantial growth to a single 3-hour course designed to facilitate personal growth. We interpret these results as support for the prediction that substantial levels of personal growth can be facilitated by specific academic activities designed to do so.

Current study results include attributions of cause for a single academic course designed in part to facilitate growth. The course is generally similar to that described by Hassan (2008) in a study of growth attributed to a health education course. The percentage attributions of cause to the course described in the current study (Table 2) are consistent with percentages reported in our previous study (Anderson & Lopez-Baez, 2011). The results of that preceding study and the study of Hassan (2008) strongly suggest that personal growth can be intentionally facilitated if not taught explicitly. The results of the current study suggest that substantial growth is attributed by students to coursework in general.

Current study results include subtotals of attributions of cause for academic and non-academic experiences, respectively. Sample members report attributions of almost 40% of total personal growth to academic coursework and provide further evidence that personal growth can be intentionally facilitated.

Study 2: Annual Growth

Taken as a whole, the results of Study 1 and three previous studies (Tedeschi & Calhoun, 1996; Anderson & Lopez-Baez, 2008, 2011) suggest that college students like those in the samples attribute substantial personal growth to both academic and non-academic experiences of their college years. These conclusions lead us to wonder just how much growth graduating seniors attribute to each college year. We believe the answer is of interest to college educators and administrators charged with fostering student growth. Answering this question requires a descriptive study of a representative sample drawn from a population of interest. Study 2 uses a simple descriptive design to answer the question for the population of students similar to those in the sample of Study 1.

Research Question

What levels of personal growth do members of a sample of college seniors attribute to each year of their 4-year college careers and what percentages do they attribute to academic and non-academic experiences, respectively?

Method

Participants

Participants were recruited from graduating college seniors enrolled during the spring semesters of 2009 and 2010 in the course described in Study 1. Students earned extra course credit for participating. A total of 117 participants were recruited (70 of the 84 graduating seniors among the 142 students enrolled in the spring of 2009 and 47 of the 67 graduating seniors among the 144 students enrolled in the spring of 2010). A total of 108 participants (59 women and 49 men) remained after eliminating 9 questionnaires with missing data. Most participants were Caucasian (5 African American, 9 Hispanics, Asians, Asian Americans and other). Mean age was 21.64 (SD = .48) years. Academic concentrations (and number of students) were: college of arts and sciences (77), commerce school (18), college of engineering (12) and school of architecture (1). Participants completed the survey at the end of the last class meeting, approximately three weeks before graduation.

Measures

We used the PTGI to measure total personal growth. We used the table in Appendix B to elicit attributions of cause. Participants completed the table with annual estimates (in percent) of their personal growth, growth from academic experiences, and growth from non-academic experiences. We also asked participants to identify on a separate page (not shown in Appendix B) the experiences that they thought contributed most to their growth each year and to identify these experiences as either academic or non-academic.

Procedure

The first two pages of the Study 1 and Study 2 questionnaires (warm-up exercise and PTGI) were identical. Study 2 participants followed the instructions in Appendix B to provide attributions of cause.

Results

Subscale Cronbach alphas for our data are .85 (Relating to Others), .57 (New Possibilities), .59 (Personal Strength), .88 (Spiritual Change), and .77 (Appreciation of Life). The male mean PTGI score of 65.71 (*SD* = 12.27) is less than the female mean of 70.02 (*SD* = 11.50), but not significantly less, t (106) = 1.93, p = .056, α = .05 (2-tail). A single significant gender difference was found among subscale scores between the male mean RTO score, M = 21.27 (*SD* = 6.05) and the corresponding female mean, M = 24.46 (*SD* = 5.51), t (106) = 2.87, p = .005, α = .01 (Bonferroni-corrected 2-tail). Subsequent analyses of PTGI scores in the sample of the current study are based on the combined scores shown in Table 3.

No gender differences were suggested by the results of independent t-tests of corresponding male and female percentages of total, academic, or non-academic growth, respectively, for any college year, α = .0125 (Bonferroni-corrected 2-tail for each set of 4 analyses). Therefore, subsequent analyses of percentages of growth are based on the combined scores in Table 4.

Table 3 contains the descriptive statistics for the sample of Study 2. A visual comparison of the contents of Table 3 with those of Table 1 shows that all corresponding entries are approximately equal. Table 4 documents mean attributions of substantial levels of personal growth to both academic and non-academic experiences for each of four years. The mean attribution to non-academic experiences exceeds the mean attribution to academic experiences for every year. The greatest mean growth is attributed to the senior year; the least is attributed to the sophomore year.

Table 3

Personal Growth Scores (N = 108): Descriptive Statistics (total and per-item basis)

	Total		Per-item		Subscale inter-correlations					
S	M	SD	M	SD	1	2	3	4	5	6
1	23.01	5.96	3.29	.85	--	.36	.34	.39	.55	.86
2	17.83	3.18	3.57	.64		--	.42	.31	.30	.66
3	14.55	2.71	3.64	.68			--	.25	.35	.63
4	2.63	2.39	1.31	1.19				--	.35	.60
5	9.99	2.40	3.33	.80					--	.70
6	68.01	12.01	3.24	.57						--

Note. S Subscales: 1 Relating to Others, 2 New Possibilities, 3 Personal Strength, 4 Spiritual Change, 5 Appreciation of Life, 6 total.

Table 4

Student percentage attributions of yearly growth in retrospect to academic and non-academic experiences by year (N = 108 students)

	Experience					
	Total		Per-item		Total	
Year	M	SD	M	SD	M	SD
Freshman	8.83	7.63	15.59	9.22	24.35	11.72
Sophomore	7.13	4.33	10.37	6.43	17.50	7.66
Junior	11.52	7.74	15.29	10.10	26.85	10.13
Senior	11.11	7.74	20.23	10.28	31.30	10.49
Total	38.59	14.81	61.41	14.81	100.00	--

Probability note. Attributions of men and women are combined because no sex differences were by row for *t*, α =.05 (2-tail).

Participants were asked to identify the year of occurrence of the single experience (as defined by participants) to which they attributed the most personal growth (question not shown in Appendix B). Year and corresponding frequencies of selection by participants are: freshman (22), sophomore (9), junior (35), and senior (42). Participants also were asked to identify whether the experience that contributed most to growth was academic or non-academic. Type of experience and frequencies of selection are: academic (27) and non-academic (81). Finally, participants were asked to describe (in words) the experience that contributed most to their growth. Illustrative descriptions include: "getting a job," "finding a new girlfriend," "death of a friend," "learning to live with fraternity brothers," and "finishing my undergraduate thesis."

Discussion

Measures

The current study is the fourth we have conducted based on the PTGI for measuring student personal growth and the third based on a table for collecting attributions of cause in the form of quantitative percentages and qualitative descriptions. We believe the results of the four studies support the utility of both measures for measuring growth and the flexibility of both for measuring growth under different circumstances.

College-Student Personal Growth

The mean PTGI score and standard deviation described by the 108 college seniors with a college career of exactly 8 semesters in the sample of Study 2, $M = 68.01$ ($SD = 12.01$) are almost identical to the corresponding statistics described by the 122 college students with a mean college career of 6.54 ($SD = 1.34$) semesters in the sample of Study 1, $M = 69.09$ ($SD = 11.52$). We had expected the mean PTGI score of Sample 2 to exceed that of Sample 1 because the results of our previous studies reflected higher mean scores for more college semesters (Anderson & Lopez-Baez, 2008, 2011; Study 1 of this paper). The simplest way to explain the similarity between the total scores of Study 1 and Study 2 is to remind ourselves that we are comparing data from a cohort as opposed to longitudinal studies, and remind ourselves that college student growth varies widely among students in each sample as illustrated by the large standard deviations for total PTGI scores in each of our studies. The results reflected in Table 4 suggest that the college seniors in our sample attributed substantial growth to both academic and non-academic experiences during all four college years. We believe this pattern is evidence that college faculty and staff can influence the personal growth of many students during every year of a student cohort's progression toward graduation.

General Discussion

We believe Study 1 provides substantial information about the validity of total PTGI scores and also of subscale scores for Spiritual Change. For this reason, we believe the results of Study 1 are of interest to researchers using the PTGI to measure adversarial or personal growth. The high levels of personal growth attributed by students to the sum of their college years and attributions of cause to academic activities will probably interest college administrators and educators.

The same results led us to wonder how student growth and attributions of cause might be distributed over each college year. For this reason, Study 2 seemed a natural extension of Study 1. The descriptive results of Study 2 are among the first to reflect levels of growth attributed by graduating seniors in retrospect to each year of their undergraduate careers. We believe these results will also interest college personnel concerned with facilitating student growth.

We developed the table-based approach used in Studies 1 and 2 to measure attributions of cause. Researchers can adapt the approach for use in future studies of personal growth. We believe that researchers with other research interests can use a similar approach to study a wide variety of other variables.

Limitations

The two studies described in the current paper are based on self-reports. Thus, the results of both are subject to the many potential validity threats associated with self-reports including additional threats to the historical validity of retrospective self-reports. Our research purposes require data with sufficient internal validity. Comparisons of the results of our three studies reflect a degree of internal validity as described in Study 1. However, PTGI scores might be associated with ceiling effects if higher levels of growth are attributed to longer time periods at diminishing rates, and percentage attributions might be associated with recency effects if more vivid recall of recent experiences leads to larger attributions of growth. Finally, because our samples are representative of populations of similar students, but not university students in general, our conclusions do not necessarily apply beyond the population represented by our samples.

Future Research

We plan more studies of college student growth with the long-term goal of learning how best to facilitate growth. We hope that readers can adapt our approach to measuring attributions of cause for use in future studies of personal growth and other variables.

References

Anderson, W. P., & Lopez-Baez, S. I. (2008). Measuring growth with the Posttraumatic Growth Inventory. *Measurement and Evaluation in Counseling*, *40*, 215–227.

Anderson, W. P., & Lopez-Baez, S. I. (2011) Measuring personal growth attributed to a semester of college life using the Posttraumatic Growth Inventory. *Journal of Counseling and Values, 56,* 73–81.

Chickering, A. W. (1969). *Education and identity.* San Francisco, CA: Josey-Bass.

Chickering, A. W., & Reisser, L. (1993). *Education and identity.* San Francisco, CA: Josey-Bass.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20,* 37–46.

Hassan, K. L. (2008). Identifying indicators of student development in college. *College Student Journal*, *42*, 517–530.

Higgins, J. W., Lauzon, L. L., Yew, A., Bratseth, C., & Worley, V. (2009). University students' wellness—What difference can a course make? *College Student Journal, 43,* 766–777.

Joseph, S., Linley, P. A., & Harris, G. J. (2005). Understanding positive change following trauma and adversity: A structural clarification. *Journal of Loss and Trauma, 10,* 83–96.

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17,* 11–21.

Pascarella, E. T., & Terenzine, P. T. (1991). *How college affects students: A third decade of research.* San Francisco, CA: Jossey-Bass.

Perry, W. G. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. New York, NY: Holt, Rinehart and Winston.

Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455–472.

Tedeschi, R. G., & Calhoun, L. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence *Psychological Inquiry, 15,* 1–18.

Appendix A

Specific Experiences that Contributed to your Personal Growth

Consider the experiences (both academic and personal) that contributed most to your Personal Growth during your undergraduate years, *whether or not* the experiences were directly related to work for which you earned academic credit. Name and briefly describe the 3 academic experiences (besides PPA) that contributed most to your Personal Growth on lines 1–3 of Column 1 in Table 1 below. For purposes of this study, academic experiences are defined as those for which you earned academic credit. Note that PPA (including your project) is listed on line 4 for comparison purposes. Next, on lines 6–10, name and briefly describe the 4 non-experiences that contributed most to your Personal Growth.

Column 1 Specific experiences	Column 2 Contribution (%)

Academic credit experiences that contributed most to your Personal Growth during your undergraduate years (i.e., classes, internships, practicums, etc.)

1. _____ _____ %
2. _____ _____ %
3. _____ _____ %
4. PPA (including project) _____ %
5. Misc. other academic experiences _____ %

Subtotal: Personal Growth from academic experiences _____ %

Non-academic experiences (if any) that contributed most to Personal Growth during your undergraduate years (i.e., friends, relationships, gains, losses, etc.)

6. _____ _____ %
7. _____ _____ %
8. _____ _____ %
9. _____ _____ %
10. Misc. other non-academic experiences _____ %

Subtotal: Personal Growth from academic experiences _____ %

TOTAL GROWTH FROM ALL EXPERIENCES 1–10 **100** %

Appendix B

History of Personal Growth during your College Undergraduate Years

Step I. Recall the beginning and ending dates of each of your undergraduate years including the current one. Fill in dates in the blanks of the line below to describe each year.

	Freshman year	Sophomore Year	Junior Year	Senior Year
Dates	__/__ – __/__ Mo Yr Mo Yr	__/__ – __/__ Mo Yr Mo Yr	__/__ – __/__ Mo Yr Mo Yr	__/__ – __/__ Mo Yr Mo Yr

Step II. Consider the total Personal Growth you have experienced during your undergraduate years. Estimate the percent of that total experienced during each year including the current year and place your estimate in the corresponding blank of the following line. *Make sure that the total of your entries on the following line = 100%.*

% of total _____ % (1a) + _____ % (2a) + _____ % (3a) + _____ % (4a) = 100 %

Step III. For each year above consider what percent of your Personal Growth that year resulted from *academic* experiences (experiences for which you earned academic credit) and how much from *non-academic* (all other) experiences. Fill in the corresponding percentages in the two lines below. Make sure that your academic and non-academic growth for each year (column entries) equal the entry for the corresponding year in Step II (above). *That is, make sure: 1b + 1c = 1a, 2b + 2c = 2a, ...*

Growth in response to academic experiences

_____% (1b) _____% (2b) _____% (3b) _____% (4b)

Growth in response to non-academic experiences

_____% (1c) _____% (2c) _____% (3c) _____% (4c)

Class Meeting Schedules in Relation to Students' Grades and Evaluations of Teaching

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A six-year retrospective study of a university career course evaluated the effect of four different class schedule formats on students' earned grades, expected grades and evaluations of teaching. Some formats exhibited significant differences in earned and expected grades, but significant differences were not observed in student evaluations of instruction. Career services providers, including curriculum designers, administrators and instructors, will find the results of this study helpful in the delivery of services, especially with high-risk freshman students.

Keywords: career, teaching, course, instruction, evaluation, grades

While individual counseling has been shown to be effective in helping students develop career decision-making skills (Brown & Ryan Krane, 2000; Reese & Miller, 2006; Whiston & Oliver, 2005; Whiston, Sexton, & Lasoff, 1998), undergraduate career courses also can be effective interventions (Folsom & Reardon, 2003; Reardon, Folsom, Lee, & Clark, 2011; Whiston et al., 1998).

Although college career courses have been shown to offer substantial benefits (Brown & Ryan Krane, 2000; Osborn, Howard, & Leierer, 2007; Reed, Reardon, Lenz, & Leierer, 2001; Reese & Miller, 2006; Whiston & Oliver, 2005; Whiston et al., 1998), the content and format of such courses vary greatly (Folsom & Reardon, 2003). The present study sought to focus on one aspect of such career course variability: alternative class schedule formats.

Effective career classes can be characterized by these features: (a) structured course approaches appear to be more effective than unstructured approaches (Smith, 1981); (b) individual career exploration should be a cornerstone of the course (Blustein, 1989); and (c) five components (written exercises, individualized interpretations and feedback, in-session occupational exploration, modeling, and building support for choices within one's social network) (Brown & Ryan Krane, 2000; Brown et al., 2003).

What is the effect that class schedule might have on course effectiveness? Only one study (Vernick, Reardon, & Sampson, 2004) has examined this issue, and the results showed that such courses should be designed to meet more than once a week and avoid over-exposure to materials and activities so as not to overwhelm the student. Extending this concept, we hypothesized that certain course schedule formats (weekly meeting frequency and term length) could make a difference in student learning and evaluation of teaching.

Alternative Career Class Schedules

This study focused on a course based on cognitive information processing theory incorporated into the course textbook, *Career Planning and Development: A Comprehensive Approach* (Reardon, Lenz, Sampson, & Peterson, 2000). All sections of the course followed a prescribed curriculum comprising a mixture of lectures, panel presentations, small and large group instructional activities, personal research, and field work; however, the classes differed in terms of the class meeting schedule (class duration, number of weekly meetings, and number of weeks a class met during an academic term).

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We examined 57 course sections that met over a six-year period and were team-taught by lead instructors and co-instructors with an instructor/student ratio of about 1:8. Lead instructors included both professional staff and faculty who supervised the co-instructors. During the time of this study, four class schedule formats were used. In the case of a 16-week semester, the class met once per week for 3 hours; twice per week for 1.5 hours; or three times weekly for 1 hour. A fourth schedule option was for a 6-week term with the class meeting four times weekly for about 8 hours per week. In the 16-week semester, the class met once per week for 3 hours on Wednesdays (W); twice per week for 1.5 hours on either Monday/Wednesday or Tuesday/Thursday (MW/TuTh); or three times weekly for 1 hour on Monday, Wednesday, and Friday (MWF). A fourth schedule option was for a 6-week term where the class met four times weekly for about 8 hours per week on Monday, Tuesday, Wednesday, and Thursday (MTuWTh). In summary, we sought to evaluate the influence of these four class schedule formats upon the educational experience of the students as measured by expected grades, earned grades, and student evaluations of teaching.

Course Measures

The following section gives details about the three measures of student learning and perceptions of teaching used in this study.

Earned Grade (EG)

Although a student's grade point average has limitations as a measure of academic achievement, class grades are nevertheless a widely accepted method of quantifying students' level of educational achievement and future success in graduate school or employment (Plant, Ericsson, Hill, & Asberg, 2005). Specific to career development, Reardon, Leierer, and Lee (2007) showed that grades might be useful measures of career course interventions, "especially if the treatment variables are carefully described and the grading procedures are fully explained and replicable by other researchers" (p. 495). For this study, we assumed that a student's final EG would accurately reflect learning in the course.

Expected Grade (XG)

Grade expectations are a complex phenomenon that combines realistic data-driven grade expectations with unjustified optimism or wishful thinking (Svanum & Bigatti, 2006). The XG reflects the student's assessment of course demands and optimism about successfully meeting those demands. This grade prediction may be informed or uninformed; however, after completing multiple assignments over the course of the semester, Svanum and Bigatti (2006) noted that students lower the value of their XG such that it will be only moderately inflated and will reliably predict their final EG. Because students in our course had the course grading scale in the syllabus, a signed performance contract, and predicted their grades during the last week of the semester when 85% of their grade had already been accounted for, we hypothesized that in aggregate their predictions would be only moderately inflated and thus a reliable predictor of their earned grades and success in the course. We felt this grade variable was important as a measure of students' confidence in their mastery of the career development subject matter and the problem-solving skills taught in the course, and therefore a valid measure of the relative effectiveness of different class schedule formats.

In addition, comparing EG and XG informs us about students' self-evaluation of learning and their actual performance in the course. When there is not a significant difference between the two scores, we might suppose that students have a fairly accurate understanding of their performance on completed assignments and those still to be graded. By contrast, a significant difference between XG and EG indicates a discrepancy between students' self-evaluations of graded and as-yet-ungraded assignments and the official final grades. If XG is significantly higher than EG in a section, one may conclude that the academic work has been undervalued by the instructor or overvalued by the students. Conversely, if XG is significantly lower than EG, one might conclude that students' estimates were conservative or instructors recognized a level of performance not seen by the students.

Student Evaluation of Teaching (SET)

Student evaluation of classes and teaching effectiveness is standard practice at most postsecondary institutions. There is substantial anecdotal and experimental evidence supporting the usefulness of SETs (Centra, 1993; Marsh & Dunkin, 1992; Marsh & Roche, 1997). Certain student ratings forms provide important feedback that can be used to improve teaching performance (Greenwald & Gillmore, 1997; Marsh & Roche, 1997; McKeachie, 1997), and when asked most faculty members support the use of SETs as a tool for teaching improvement (Baxter, 1991; Griffin, 1999; Schmelkin, Spencer, &

Gellman, 1997). Although SET is not without its critics, it appears to be a pragmatic way to access and compare student perceptions of teachers' effectiveness and therefore a potential measure of the relative efficacy of different class schedules.

In an effort to better evaluate students' course experiences, the influence of EG (Goldman, 1985) and XG (Greenwald & Gillmore, 1997) on SET is receiving considerable attention in the literature. The present study provided an opportunity to examine the relationship of SET to both EG and XG relative to four different class schedule formats.

Research Questions

In seeking to discover if particular class schedules were more effective in a team-taught career course, we evaluated grades and participant feedback from undergraduate students. The goal was to determine if any of the four differing class schedules produced significant differences in the course evaluation measures EG, XG, and SET. Although we were examining these measures from the students' perspective and such measures are typically scored at the individual student level, we chose to examine class section level scores because XG and SET data were only available to us in this way.

The first group of research questions examined differences between mean evaluative measures, aggregated by class format and averaged for classes that met one (W), two (MW/TuTh), or three times per week (MWF) for 16 weeks, or four times per week (MTuWTh) for 6 weeks.

Research Question 1: Were there any significant differences in the career course evaluation measures among the four class formats?

RQ 1.1: Are there differences in mean EG between formats?
RQ 1.2: Are there differences in mean XG between formats?
RQ 1.3: Are there differences in mean SET between formats?

The second group of research questions explored the differences between the evaluation measures (EG, XG, and SET) within the sections.

Research Question 2: Within any given format, are there significant differences between the mean of the aggregated class evaluation measures?

RQ 2.1: Is the mean XG significantly different than the mean EG?
RQ 2.2: Is the mean XG significantly different than the mean SET?
RQ 2.3: Is the mean EG significantly different than the mean SET?

Method

Participants

Over a 6-year period, 1,479 students were enrolled in 57 sections of a career course to fulfill elective requirements for the baccalaureate degree. The class met in a standard classroom in academic buildings on the campus. Although the class was offered for variable credit, over 95% of the students took it for 3 credit hours. The number of students per section ranged from 19–34 with a mean of 26.5.

Ethnic diversity was generally proportional to the general student population of the university: Caucasian, 74%; African American, 12%; Hispanic American, 7%; Other, 4%; Asian, 3%; and American Indian, .4%. The course typically enrolled about 60% females and 40% males, including freshmen (15%), sophomores (45%), juniors (20%), and seniors (20%). Depending on the semester, between 15% and 25% of the course was composed of students with officially undeclared majors, and the large percentage of sophomores was the result of academic advisors referring these undeclared students to the class. While almost 40% of the members in a typical class reported satisfaction with their present career situation, about 60% were unsure, dissatisfied, or undecided.

Course Grading Procedures

Student grades were computed using scores earned on assignments contained in the performance contract. This contract was comprised of 28 different graded activities spread across the three units of the course. Given the use of the performance contract, students in this course should have had a very good idea of what their final grade would be when

they filled out the SET and estimated their grade, because only two of the 28 activities accounting for 125 of 653 total points were still ungraded at that point.

Student Evaluation of Teaching Ratings

We used a standardized instrument for SETs, the Student Instructional Rating System (SIRS; Arreola, 1973), a student course on form developed at Michigan State University (Davis, 1969) and adapted for use at our university. SIRS provided an opportunity for instructors to obtain reactions to their instructional effectiveness and course organization and to compare these results to those of similar courses offered within the university.

The SIRS consisted of 32 items and 25 of these items enabled students to express their degree of satisfaction with the quality of instruction provided in the course by using a 5-point Likert scale. For example, *the course was well organized* could be marked *strongly agree, agree, neutral, disagree,* or *strongly disagree.* One item on the SIRS was of special interest in this study: *What grade do you expect to receive in this course? A, B, C, D, or F.*

We also employed a second instructional rating instrument, the State University System Student Assessment of Instruction (SUSSAI) which had been used at the university for five years prior to this study. This instrument consisted of eight items focused on class and instructor evaluation. One item was of special interest in this study: *Overall assessment of instructor: Excellent=4, Very Good=3, Good=2, Fair=1, Poor=0.*

Data Collection

After obtaining permission from the university institutional review board, we received the archived career course grade data for a six-year period. We aggregated the grades of these 1,479 students by class schedule and averaged the results to achieve a mean EG for each class schedule format.

The data relating to students' perceptions of what they had achieved and the quality of instruction they had received was collected as follows: On the last week of class, while filling out their teacher evaluations, all students in a section were asked to indicate the grade they expected to receive and the results were tallied and averaged to determine a class mean XG. These class averages of 57 sections were forwarded to the researchers, and the results were tallied and averaged to find the mean XG for each class schedule format. In addition, we retrieved overall class ratings of instructors for an ad hoc sample of career classes over the 6-year period. These data enabled us to examine the relationships between mean EG and XG, EG and SET, and XG and SET.

Procedures

In this team-taught course where all instructors were involved in making large- and small-group presentations, each co-instructor had primary responsibility for evaluating the progress of students in his or her small group and assigning a grade, while the lead instructor of the team had overall responsibility for course presentations and management. In completing the SIRS and SUSSAI items for the SET, students were asked to provide a composite rating of the instructional team for their section. SETs were completed anonymously during the final two class meetings while instructors were out of the room and then returned by a student proctor to the university's office of evaluation services.

Data Analysis

We examined how different class formats influenced mean EG, XG, and SET. The independent variable of class schedule format had four levels. The first three levels met over the course of a 16-week fall or spring semester for either 3 hours once a week (W), 1.5 hours twice a week (MW/TuTh), or 1 hour three times a week (MWF). The final level met for 2 hours four times a week over the course of a 6-week semester (MTuWTh). Because the assumptions related to independence for the three evaluative measures could not be met (i.e., the evaluations for each class section were correlated), we analyzed the data using a split-plot design.

Results

As is the case for other ANOVA and MANOVA tests, the dependent variables were assumed to be normally distributed. We tested the dependent variables to determine if they were normally distributed by computing skewness and kurtosis of

each of the dependent variables to see if they fell between −1.0 and +1.0. Both the SET and EG scores did not violate the assumptions of normality as measured by skewness and kurtosis. However, while the skewness of XG did fall within the appropriate range, the kurtosis score was 1.04. Although this score is above 1.00, we believe this minor violation does not seriously affect the results and their interpretation.

Research Question 1

Using the split-plot MANOVA, we found a significant interaction of the three evaluative measures across the four class formats F (6, 106) = 4.47, $p < .0005$, $\eta^2 = .20$. Specifically, there was a significant difference in EG between the four course formats, F (3, 53) = 19.15, $p < .0005$, partial $\eta^2 = .52$. The EG for schedule MTuWTh ($M = 3.50$) was significantly higher ($p < .005$) than that of formats W, MW/TuTh, and MWF ($M = 3.25$, 3.32, and 3.31, respectively). Next, there was a significant difference in XG between the four course formats, F (3, 53) = 3.62, $p = .019$, $\eta^2 = .02$. The means for XG for the W, MW/TuTh, MWF, and MTuWTh were 3.71, 3.57, 3.34, and 3.64, respectively. There was not a significant difference for XG between formats W, MW/TuTh, and MTuWTh. However, there was a significant difference between format MWF and format MTuWTh ($p = .036$), and format MWF was trending lower when compared with format W ($p = .097$) and format MW/TuTh ($p = .051$). Finally, there was not a significant difference on SET scores across the four formats, F(3, 53) = 1.36, p = ns. The mean SET scores for formats W, MW/TuTh, MWF, and MTuWTh were 2.88, 3.15, 3.31, and 3.11, respectively.

Research Question 2

When we compared evaluation measures within each format, we found significant differences with each one, F (2, 52) = 23.61, $p < .0005$, $\eta^2 = .47$. We found XG significantly greater than EG within schedule format W (.46, $p = .002$) and format MW/TuTh (.35, $p < .0005$). By contrast, the difference between XG and EG was smaller and not statistically significant within format MWF (.13, p = ns) and format MTuWTh (.13, p = ns). This lack of a significant difference between EG and XG indicates that these students earned grades very similar to the grades they expected to receive. It is apparent that the students and instructors used similar evaluation and grading methods. Stated another way, this finding suggests that students in classes meeting more frequently per week have a slightly more accurate perception of how they are doing in the class.

We also found that mean XG was significantly greater than mean SET for format W (.83, p =.003), format MW/TuTh (.42, $p < .0005$), and format MTuWTh (.53, $p < .0005$). However, there was not a significant difference between XG and SET for format MWF (.13, p = ns). Finally, in comparing the difference between mean EG and mean SET within each of the four formats, we found a significantly higher EG only for format MTuWTh (.40, $p < .0005$). No significant differences were observed for formats W, MW/TuTh, and MWF, which had differences of .37, .07, and .13, respectively.

In summary, we found significant differences in the evaluation measures of XG, EG, and SET across the four different career course formats. Class sections which met four times a week for 6 weeks had a significantly higher EG than classes meeting one, two, or three times a week for a 16-week semester. Interestingly, formats W, MW/TuTh, and MTuWTh all had mean XG scores over 3.55, while format MWF's XG was not only lower than the other formats, but significantly lower than that of format MTuWTh. Finally, mean SET scores were not significantly different from one another. Notably, they were all well above the rating of "good" (good = 2.0), with a mean of 3.15 on a 4-point scale. Means for the sections ranged between 2.88 and 3.31; thus we concluded that students found the instruction to be very good or excellent.

Discussion

Career course interventions have been developed to help students improve their academic and career decision-making skills. Comprehensive career courses offered for academic credit represent a cost-effective intervention that could be described as a "mega-dose" of career services (Reardon et al., 2011). While the benefits of college career courses are clear, it is unclear what contributions specific class formats (differing by length of class period, number of classes per week, length of course in weeks) might make to their effectiveness. Thus, the purpose of our study was to analyze the influence of different schedule formats on earned and expected grades and students' evaluation of their instructors.

Previous studies on career development classes have described various limitations (see Gold, Kivlighan, Kerr, & Kramer, 1993; Reese & Miller, 2010), and we attempted to address these in the following ways. First, although we did not

directly address random selection and random assignment issues, we aggregated class section scores instead of individual student scores, thus reducing the effect of individual outliers. By using the aggregate mean for each career planning section, individual students' evaluation of the teacher remained anonymous yet the evaluation of the course section remained intact. The second limitation described by other researchers is the small number of participants in the career class analyzed. Over a six-year period we were able to collect data from almost 1,500 students from 57 sections of the course. The third limitation we attempted to address was the lack of equal representation of different ethnic groups. While we did not have equal percentages of students from different ethnicities, the demographic composition of our sample closely matched the composition of our university.

Perhaps the greatest strength of this study's design was the replication of the intervention. That is, because the course structure and specific assignments were very similar for all sections, in effect the replication of the career course occurred across all 57 of the course sections analyzed. In each section, the course content and procedures were clearly specified and grades were based on the successful execution of a performance contract by the student.

Earned and Expected Grades

We examined how schedule influenced mean earned grade (EG) and expected grade (XG) scores. Like Vernick et al. (2004), we found that sections meeting only once per week over 16 weeks (format W) had the lowest EG, though not significantly lower than formats MW/TuTh and MWF. By contrast, schedule MTuWTh had a significantly higher EG than all the other formats, suggesting that a 6-week semester of 2-hour class meetings four times a week was more conducive to learning than a 16-week semester of classes meeting one, two, or three times per week for 3 hours, 1.5 hours, or 1 hour, respectively; that is, the "mega-dose" of career development interventions given in the course were intensified with MTuWTh.

Further analysis of the difference between mean section EG and XG scores enables us to compare the students' view of their performance in the course with their actual performance. Ideally, we would prefer that there not be a significant difference between XG and EG in order to increase students' confidence about the fairness of the grading and their sense of having mastered the material in the course. Expanding on these points, when the section mean XG was significantly higher than the mean EG, students could have left the course with a sense of failure and disappointment. Interestingly, in this study schedules W and MW/TuTh had significantly higher mean XG than mean EG, indicating an incongruity between the expected and earned grades. By contrast, for both schedules MWF and MTWF, the difference between mean XG and mean EG was not significant. One might conclude that fewer course meetings per week increased the difference between XG and EG scores.

Student Evaluation of Teaching

With regard to SET, there were no significant differences between the four class schedule formats, although we had suspected this might be the case. Perhaps a significant difference between section means for SET and XG would describe an incongruity between the students' estimate of instruction quality and their evaluation of their own performance in the course. If XG were significantly higher than SET, this finding might indicate that students in these sections believed their performance was more related to their abilities and efforts rather than course instruction. By contrast, sections with significantly lower XG than SET scores may have rated instructors' presentation of material higher than their own performance in the course. Interestingly, for schedules W, MW/TuTh, and MTuWTh, XG was significantly higher than SET, suggesting that students evaluated themselves more favorably than they did their instructors. We found it curious that for schedule MWF alone, XG was not significantly higher than SET.

Finally, EG is assigned to the student by the instructor, while SET is assigned to the instructor by the student. By comparing mean EG with SET, we can examine the relationship between an instructor's evaluation of his or her students with students' evaluation of the instructor. When EG is greater than SET, this means that instructors evaluated their students more favorably than they themselves were evaluated; conversely, when SET is greater than EG, students evaluated instructors more favorably than they themselves were evaluated. For schedules W, MW/TuTh, and MWF, there were no significant differences between mean EG and SET scores. However, for MTuWTh, in which students achieved a significantly higher mean EG than the other formats, the EG also was significantly higher than the SET, suggesting that this high-performing group had higher expectations for their instructors than they felt the instructors met.

Limitations

Because this study is field research, there are a few limitations to discuss. First, participants were undergraduates taking a career planning course from one university. The advantage to using this approach was consistency of teaching content, training and quality control of teaching personnel, administration of tests, and assignments, thus reducing the possibility that course differences were responsible for random error variance. But, because these results come from only one university's career course, caution should be exercised when generalizing them to other courses.

Second, participants were not randomly selected. In fact, random assignment was impossible given the students' autonomy in selecting this course. Random selection is seldom an option in field research at an educational institution, but this fact does restrict the robustness and generalizability of results to other populations (Babbie, 2001).

Third, participants in the study may have been experiencing more career-related difficulties than other students who did not elect to take the course. It is to be expected that participants perceived a career course as more important to their progress than nonparticipants, which limits generalizability of these findings (Smith & Glass, 1987).

Fourth, because the data were collected over a six-year period, it is difficult to determine the effect of historical events on the behavior and attitudes of participants (Smith & Glass, 1987; Van Dalen, 1979). For example, students from the initial semester of the study took the class at the height of the tech bubble, while others took the class in the shadows of the 9-11 tragedy. Although we were not able to control for these events, we acknowledge that researchers and practitioners must be aware of the influence of external events upon any college course.

Implications

There are several implications regarding the findings of this study. The significant differences found between schedule formats in the outcomes of EG and XG serve to remind instructors, those who supervise them, and those managing career courses about the potential impact of this variable. For example, these findings indicate that classes meeting one time per week for three hours are not characterized by higher earned grades, and by implication this means student learning. Additional studies should isolate and evaluate format variables such as length of the entire course, number of classes per week, and length of individual classes so that those evaluating teachers might consider this in their evaluations. At the same time, the absence of any differences in student evaluations of teaching across the four schedule formats is reassuring for those teaching and supervising instructors, at least in a course that was as highly structured and standardized as the one in this study.

Career services providers, curriculum designers, administrators, and instructors may wish to consider these findings when making decisions about the design and delivery of career courses, especially for high-risk freshmen (Osborn et al., 2007). Students meeting for four classes a week over a 6-week semester earned and expected significantly higher grades overall than students meeting over a 16-week semester. Taking the 6-week intensive course during the summer term before beginning the freshman year could both increase students' chances of academic success and their confidence in navigating the college experience.

References

Arreola, R. A. (1973). A cross-institutional factor structure replication of the Michigan State University SIRS faculty evaluation model. *College Student Journal, 7*, 38–42.

Babbie, E. (2001). *The practice of social research*. Belmont, CA: Wadsworth/Thomson Learning.

Baxter, E. P. (1991). The TEVAL experience, 1983–88: The impact of a student evaluation of teaching scheme on university teachers. *Studies in Higher Education, 16,* 151–179.

Blustein, D. L. (1989). The role of career exploration in the career decision making of college students. *Journal of College Student Development, 30,* 111–117.

Brown, S. D., & Ryan Krane, N. E. (2000). Four (or five) sessions and a cloud of dust: Old assumptions and new observations about career counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology*

(3rd ed., pp. 740–766). New York, NY: John Wiley & Sons.

Brown, S. D., Ryan Krane, N. E., Brecheisen, J., Castelino, P., Budisin, I., Miller, M., & Edens, L. (2003). Critical ingredients of career choice interventions: More analyses and new hypotheses. *Journal of Vocational Behavior, 62,* 411–428.

Centra, J. A. (1993). *Reflective faculty evaluation: Enhancing teaching and determining faculty effectiveness.* San Francisco, CA: Jossey-Bass.

Davis, R. H. (1969). *Student Instructional Rating System (SIRS) Technical Bulletin*. East Lansing, MI: Michigan State University, Office of Evaluation Services.

Folsom, B., & Reardon, R. (2003). College career courses: Design and accountability. *Journal of Career Assessment, 11,* 421–450.

Gold, P. B., Kivlighan, D. M. Jr., Kerr, A. E., & Kramer, L. A. (1993).The structure of students' perceptions of impactful, helpful events in career exploration classes. *Journal of Career Assessment, 1*, 145–161.

Goldman, L. (1985). The betrayal of gatekeepers: Grade inflation. *Journal of General Education, 37*, 97–121.

Greenwald, A. G., & Gillmore, G. M. (1997). Grading leniency is a removable contaminant of student ratings. *American Psychologist, 52,* 1209–1217.

Griffin, B. W. (1999). *Results of the faculty survey on student ratings of instruction: Preliminary report*. Statesboro, GA: Georgia Southern University, Student Ratings Committee.

Marsh, H. W., & Dunkin, M. (1992). Students' evaluations of university teaching: A multidimensional perspective. In J. C. Smart (Ed.), *Higher education: Handbook on theory and research* (Vol. 8, pp. 143–234). New York, NY: Agathon Press.

Marsh, H. W., & Roche, L. A. (1997). Making students' evaluations of teaching effectiveness effective: The critical issues of validity, bias, and utility. *American Psychologist, 52*, 1187–1197.

McKeachie, W. J. (1997). Student ratings: The validity of use. *American Psychologist, 52,* 1218–1225.

Osborn, D. S., Howard, D. K., & Leierer, S. J. (2007).The effect of a career development course on the dysfunctional career thoughts of racially and ethnically diverse college freshmen. *Career Development Quarterly, 55*, 365–377.

Plant, E. A., Ericsson, K. A., Hill, L., & Asberg, K. (2005). Why study time does not predict grade point average across college students: Implications of deliberate practice for academic performance. *Contemporary Educational Psychology 30*, 96–116. doi:10.1016/j.cedpsych.2004.06.001

Reardon, R. C., Folsom, B., Lee, D., & Clark, J. (2011). *The effects of college career courses on learner outputs & outcomes: Technical report No. 531.* Tallahassee, FL: Center for the Study of Technology in Counseling and Career Development, Florida State University. Retrieved from http://career.fsu.edu/techcenter/whatsnew/TechRept53.pdf.

Reardon, R. C., Leierer, S. J., & Lee, D. (2007). Charting grades over 26 years to evaluate a career course. *Journal of Career Assessment, 15*, 483–498. doi:10.1177/1069072707305767.

Reardon, R. C., Lenz, J. G., Sampson, J. P., Jr., & Peterson, G. W. (2000). *Career development and planning: A comprehensive approach*. Pacific Grove, CA: Wadsworth-Brooks/Cole.

Reed, C., Reardon, R., Lenz, J., & Leierer, S. (2001). Reducing negative career thoughts with a career course. *Career Development Quarterly, 50*, 158–167.

Reese, R. J., & Miller, C. D. (2006). Effects of a university career development course on career decision-making self-efficacy. *Journal of Career Assessment, 14*, 252–26.

Reese, R. J., & Miller, C. D. (2010). Using outcome to improve a career development course: Closing the scientist-practitioner gap. *Journal of Career Assessment, 18*, 207–219.

Schmelkin, L. P., Spencer, K. J., & Gellman, E. S. (1997). Faculty perspectives on course and teacher evaluations. *Research in Higher Education, 38,* 575–592.

Smith, G. E. (1981). The effectiveness of a career guidance class: An organizational comparison. *Journal of College Student Personnel, 22,* 120–124.

Smith, M. L., & Glass, G. (1987). *Research and evaluation in education and the social sciences.* Englewood Cliffs, NJ: Prentice-Hall.

Svanum, S., & Bigatti, S. (2006). Grade expectations: Informed or uninformed optimism, or both? *Teaching of Psychology, 33*, 14–18.

Van Dalen, D. (1979). *Understanding educational research: An introduction.* New York, NY: McGraw-Hill.

Vernick, S. H., Reardon, R. C., & Sampson, J. P. Jr. (2004). Process evaluation of a career course: A replication and extension. *Journal of Career Development, 30*, 201–213.

Whiston, S. C., Sexton, T. L., & Lasoff, D. L. (1998). Career-intervention outcome: A replication and extension of Oliver and Spokane. *Journal of Counseling Psychology*, *45*, 150–165.

Whiston, S. C., & Oliver, L. W. (2005). Career counseling process and outcome. In W. B. Walsh & M. Savickas (Eds.), *Handbook of vocational psychology* (3rd ed., pp. 155–194). Hillsdale, NJ: Erlbaum.

Wellness in Mental Health Agencies

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Burnout and impairment among professional counselors are serious concerns. Additionally, counselors' work environments may influence their levels of wellness, impairment and burnout. This phenomenological study included the perspectives of 10 professional counselors who responded to questions about how their work environments influence their sense of wellness. Five themes emerged: (a) agency resources, (b) time management, (c) occupational hazards, (d) agency culture, and (e) individual differences. Implications for professional counselors and future research are discussed.

Keywords: professional counselors, agencies, wellness, burnout, impairment

Wellness promotion focuses on individual strengths and emphasizes holistic growth and development. For example, Myers, Sweeney and Witmer (2000) defined wellness as:

> A way of life oriented towards optimal health and well-being in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

The authors' definition of wellness alludes to one's overall well-being. Counselors often advocate holism, exploration of self and self-actualization for their clients (Cain, 2001). Such aspirations may be achieved through a holistic wellness approach (i.e., attending to intellectual, emotional, physical, occupational and spiritual well-being; Witmer & Young, 1996). Therefore, counselors view wellness as an important aspect of overall human functioning. Although this fundamental view has historically been applied to clients, professional counselors themselves now recognize that they also may benefit from a wellness focus (Maslach, 2003).

Professional counseling organizations (e.g., American Counseling Association [ACA]; American Mental Health Counselors Association [AMHCA]; National Board for Certified Counselors [NBCC]) specifically emphasize the importance of counselor wellness and impairment prevention. For example, counselors are ethically required to recognize when they are impaired. The ACA (2005) ethical standards state that "Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others" (Standard C.2.g). The AMHCA (2010) ethical standards further state that counselors:

> recognize that their effectiveness is dependent on their own mental and physical health. Should their involvement in any activity, or any mental, emotional, or physical health problem, compromise sound professional judgment and competency, they seek capable professional assistance to determine whether to limit, suspend, or terminate services to their clients. (Standard C.1.h)

Furthermore, the NBCC (2005) ethical standards indicate that certified counselors discontinue providing services "if the mental or physical condition of the certified counselor renders it unlikely that a professional relationship will be maintained" (Standard A.15).

The Governing Council of the ACA states that "Therapeutic impairment occurs when there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to

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the client" (Lawson & Venart, 2005, p. 3). In 2003, this council became proactive in addressing the issue of counselor wellness by creating a task force on counselor wellness and impairment. The task force seeks to educate counselors about impairment prevention, promote resources for prevention and treatment of impaired counselors and to advocate within ACA and its division to address the broader issue of counselor impairment. As a result, they have distributed information on risk factors, assessment, resources and wellness strategies. Thus, a wellness focus is essential for professional counselors to prevent impairment and provide effective counseling services to clients (Witmer & Young, 1996).

Unfortunately, professional counselors encounter multiple factors that threaten their wellness (Lawson, 2007). For instance, counselors are at a particularly high risk for burnout due to the intense and psychologically close work they do with clients (Skovholt, 2001). Although there are many definitions of burnout, Pines and Maslach (1978) described it as "a condition of physical and emotional exhaustion, involving the development of a negative self-concept, negative job attitude, and loss of concern and feelings for clients" (p. 233). Additional consequences of burnout may include low energy and fatigue, cynicism towards clients, feelings of hopelessness and being late or absent from work (Lambie, 2006). When counselors fail to address burnout it can lead to impairment. Counselors also may experience occupational hazards such as compassion or empathy fatigue and vicarious traumatization (Figley, 2002; Lawson, 2007; Stebniki, 2007). Stebniki (2007) defined empathy fatigue as a state wherein counselors are exhausted by their duties because of their constant exposure to the suffering of others, which induces feelings of hopelessness and despair. Similarly, vicarious traumatization occurs when a counselor becomes emotionally impaired due to being exposed to an accumulation of traumatic stories from multiple therapy sessions (McCann & Perlman, 1990). Therefore, the actual nature of counselors' work is a potential threat to their ability to be well.

In addition, environmental factors in counselors' work settings also may be detrimental to their wellness (Ducharme, Knudsen, & Roman, 2008; Knudsen, Ducharme, & Roman, 2006; Vredenburgh, Carlozzi, & Stein, 1999). In a survey that included 501 professional counselors, Lawson (2007) found that those working in community agencies experienced higher levels of burnout and compassion fatigue and vicarious traumatization than those working in private practice. Agency variables that are associated with burnout include: work overload, low remuneration, lack of control over services, unsupportive or unhealthy work peers and ineffective or punitive supervisors (Lloyd, King, & Chenoweth, 2002). For example, low remuneration is a specific concern in many Southeastern states. Lambie and Young (2007) offered the following example of a work environment in a specific agency: "an employee assistance program in this area requires its counselors to conduct sessions for 35 clients a week…the counselor in such an organization faces stresses and work hours similar to a first year lawyer in a large firm, without the mitigating effects of financial compensation" (p.101). Additional stressors stem from nonprofit agencies' dependence on government and state funding sources to operate. Agency compliance with government and state policies to maintain funding often require administrations to focus on the "*bottom line,*" sometimes to the detriment of client services and employee wellness (Rupert & Morgan, 2005). Counselors who experience such stressors are at serious risk for burnout. Nevertheless, counselors are ethically expected to avoid burnout because it ultimately reduces the quality of services provided to clients, compromises client care and creates potential for harm to the clients (Lawson & Venart, 2005).

Leaders in the counseling profession strongly encourage counselors to be proactive in maintaining their own wellness and self-care. Counselors need to "fill the well" of their own sense of well-being continually, so they can "pour it out" for their clients (Shapiro, Brown, & Biegel, 2007). For example, Lawson (2007) reported that counselors who endorsed 15 highly valued career sustaining behaviors scored higher on compassion satisfaction and lower on burnout. However, despite individuals' efforts to maintain a wellness lifestyle, the work environment may have a significant role in impeding or supporting wellness efforts. If the work environment does not allow for rejuvenation, or if wellness is not valued, employees (counselors) may become distressed and impaired (Maslach, Leiter, & Schaufeli, 2008). Witmer and Young (1996) suggested that counselor education programs promote and model wellness for their students so they can prepare themselves to make lasting changes in their life to reduce the risk of impairment. Further, if counselors create an individual sense of wellness, they can advocate for their personal well-being in the agency and redirect energies towards organization wellness (Lambie & Young, 2007).

Previous authors suggested that the agencies in which counselors work can help to create wellness environments that contribute to counselors' overall functioning. For example, Witmer and Young (1996) posited that counselor education programs, employing organizations and regulatory boards should develop systemic preventative wellness protocols to prevent counselor impairment. Their recommendations to agencies included equally distributing the most difficult cases,

providing employee assistance programs that include family counseling, adequate peer support, and supervision and team building exercises. Stokes, Henley, and Herget (2006) offered some concrete suggestions to increase wellness including healthy food options, on-site exercise facilities, smoke-free environments, break stations away from the work areas, wellness challenges, support groups, social activities, health risk assessments, self-care information, employee counseling, financial incentives for long term employees and conflict resolution training for supervisors. Further, Lambie and Young (2007) recommended that mental health agencies reduce stress and promote wellness among their employees (counselors) by reducing paperwork and cutting "red tape," adopting a collaborative management style, improving interpersonal relationships and teamwork, developing ways to reduce role stress, helping counselors grow on the job (e.g., professional development) and improving environmental conditions.

Although the potential hazards related to counselor's work have received some attention (Gaal, 2009), there is limited research about how counselors conceptualize their wellness in relation to the influence of their work environment. Thus, the purpose of this exploratory study was to gain a greater understanding of how counselors experience wellness and how their work environment influences their sense of wellness. A qualitative phenomenological approach was the most appropriate method to implement because we were seeking to understand the participants' lived experience of the phenomena (Creswell, 2007). Following the phenomenological tradition, we sought to uncover the central underlying meaning of their experience by reducing data, analyzing specific statements, searching for all possible meanings and creating meaning units (Creswell, 2009). Thus, we developed two research questions. The first question was, "How do you relate to the concept of wellness as a professional counselor?" and the second question was, "How do you perceive your agency influences your sense of wellness?" The first open-ended question was designed to gain information on each of the counselors' thoughts about wellness and how they interpret the concept. The second question was designed to obtain information about how they believe their work environment affects their sense of wellness.

Method

Research Team

The research team consisted of two counselor educators who at the time of the study were doctoral students at a university in the southeastern U.S. The first author is a Caucasian male and the second author is a Caucasian female. The first author has previous work experience in a residential treatment setting and in a secondary school setting where he experienced a high level of turnover and burnout among the staff. The second author has previous work experience in a variety of agency settings and experienced different levels of emphasis on wellness in each agency. She became interested in researching in this area to assist counselors in the field. Both authors believe a wellness focus is important for professionals in the helping professions. Furthermore, the authors believe that one's work environment affects each counselor's ability to be well.

Procedure

Prior to facilitating the interviews and focus groups, we obtained approval from the Institutional Review Board (IRB) to conduct the study. Next, we recruited the 10 participants through a mixture of criterion-based and snowball-sampling strategies (Teddlie & Yu, 2007). The criterion included contacting counselors or agency directors who were currently or very recently employed at mental health agencies in a southeastern state. The snowball strategy included contacting individuals from the first and second authors' previous employers, e-mailing invites on group servers for counselors who are alumni from a university that educates counselors and through following up recommendations from other counselors. After we secured participants for the study, we obtained informed consent and confirmed dates for the interviews and focus group.

Participants

The sample included seven female and three male professional counselors whose ages ranged from 25 to 53. Seven of the counselors were Caucasian, one counselor was of Indian descent, one was Latino, and one was of Middle Eastern descent. Two participants were employed by an agency that provides palliative care by way of in-home visits. One participant was a clinical director of an adolescent residential unit. One was previously a clinical director of a domestic violence shelter and a community counseling clinic. One participant worked in a behavioral hospital while another participant worked in an inpatient facility and previously in a residential setting. Three of the participants worked in a university-based clinic. Three counselors were present in the focus group interview and seven counselors were interviewed individually on separate occasions. See Appendix for pseudonyms and demographics.

Data Collection

Demographic questionnaire. Participants completed a demographic questionnaire consisting of questions about their age, race/ethnicity, socioeconomic status, gender, years in the field and work setting prior to participating in the interviews.

Individual interviews. The second author facilitated individual, semi-structured interviews with seven of the participants. Each interview lasted between 60 and 90 minutes. The interview started with the interviewer explaining the purpose of the study and then posing the first question: "How do you relate to the concept of wellness as a professional counselor?" Once this area was completely explored between the researcher and the interviewee, the researcher posed the second question: "How do you perceive your agency impacts your sense of wellness?" The researchers used follow-up, open-ended questions to elicit significant depth for each of the questions.

Focus group. The focus group included three counselors at a university-based counseling clinic and was facilitated by the second author. Prior to the group, the researcher reminded the interviewees about confidentiality and its limitations. The group lasted approximately 90 minutes and followed the same protocol as the individual interviews.

Data Analysis

After completing the interviews, we transcribed the audio-recorded sessions. All identifying information of the participants and location of employment were altered to maintain confidentiality. Next, the first and second authors read through transcripts to find initial categories. We employed inductive coding to devise categories that represented the overall essential message that was being conveyed in each interview and the focus group. The coding categories that emerged were recorded as well as thoughts about possible relationships between the categories (Glesne, 2006). Next, using the qualitative research software ATLAS.ti (Muhr, 2004), we loaded the documents and reduced the data using a chunking method, which requires the researcher to highlight sections of the transcription and assign codes or categories. Finally, we numbered the code list and noted connections among the interviewees' coded chunks. This procedure consists of the researcher reviewing the codes to determine if a pattern, theme or relationship occurs (Glesne, 2006).

Verification Procedures

We implemented multiple verification procedures in order to ensure the trustworthiness of the study (Creswell, 2008). First, we performed member checks with participants to verify that the themes developed captured the essence of their experience. We addressed the threat of subjectivity through revealing our positionality and attempting to view information as objectively as possible. Additionally, we employed a peer-debriefer who continuously asked the primary author questions about the study, reviewed the relationship between the data and the research questions and reviewed the accuracy of the data analysis in comparison to the transcriptions.

Findings

In this study, we conducted seven individual interviews and a focus group to explore wellness for professional counselors in various mental health agencies. From the two research questions, "How do you relate to the concept of wellness as a professional counselor?" and, "How do you perceive your agency influences your sense of wellness?" five themes emerged: (a) resources, (b) time management, (c) occupational hazards, (d) agency culture, and (e) individual differences. We discuss each theme with thick, rich descriptions.

Agency Resources

Resources within the agency appeared to be a common theme that influenced participants' sense of wellness. Participants consistently discussed areas such as salary, staff coverage and workloads as barriers to wellness. For example, participants discussed how financial compensation affected their feelings of being valued as well as their means to do things to maintain wellness. One participant, Anne, explained, "I am a 37-year-old woman who has to live with a roommate… I'm paid half of what nurses [at the same facility] are paid for the same amount of time." When asked how she handled being paid less than other helping professionals, Anne responded, "I commiserate with other people in the field about being underpaid and undervalued. I can't beat my head against a wall." Another participant, Brian, discussed how his salary often impeded his ability to engage in wellness activities:

> One of the struggles I had at the beginning was pay. Because it didn't afford me, literally, the chance to do things to take care of myself, that I wanted to do to take care of myself. So if I had a weekend I couldn't take a trip to the beach for the weekend. It had to be a quick jaunt and back because I couldn't afford a hotel.

Resources also included counselor workloads, specifically in terms of how many clients each counselor had to see a day to maintain reimbursement policies. Brian discussed the lack of funding and explained that agencies must work "bare bones…skeleton crew basically." One participant, Helen, commented on her caseload:

> Money can drive a lot of things. Like the choices that you could make [before reimbursement] were more about the clients and what was needed, or what you wanted to try, and then you know Medicaid or other external forces enter, and then decisions have to be made on a different basis. The number of people you would even take would change. [before Medicaid]… There was a lot of flexibility, there was no external pressure to take a certain amount of clients and then there were great conversations and the ability to envision what you should do, and there was the time do it, and there was opportunity to review what you have done, and build the relationships and get feedback on your work, and whereas now, you have put in the time and you have to make the numbers and you lose the time to create relationships or talk about what you are doing.

Similarly, Brian discussed how large caseloads and working with clients back-to-back affected his performance when stating:

> Basically, it took away from the services I was able to offer. But most of all it took away from me. You know my energy level, and just across the board I wasn't able to do all of the things you would like to do as a quality counselor like planning…often it was sort of on the cusp.

Participants described the various resources within their agencies that influenced their sense of wellness. They identified the lack of resources as a barrier to their wellness, which also affected the quality of client care and enthusiasm for their work.

Time Management

Participants discussed time constraints as barriers to their wellness and their ability to maintain optimal performance with clients. They mentioned heavy caseloads as well as administrative duties and paperwork requirements as obstacles to their wellness that also reduced the quality of client services. Additionally, they believed that there was not adequate time for other important aspects of their development, such as supervision. One participant, David, discussed his frustration with not being able to sufficiently prepare for sessions, stating, "there was kind of this disconnect with how long it took to prepare for a session to do it right, or how long it would take to do a group, and to do it right." He further proposed that the problem may be lessened even without reducing the caseload; "maybe it's not about the number of clients as much as, maybe it's just about a scheduling thing too, if you could just spread these clients out, thin enough."

Participants also discussed administrative duties such as paperwork as wellness barriers that take away from the true meaning of their work. For instance, David stated that, "what was most stressful wasn't working one-on-one with clients, it was just the amount of paperwork and catch up. You literally feel like you're running a marathon when you walk in the room." Brian described the draining effects of paperwork by stating, "I found myself very disenchanted because the work that I wanted to do was with people and often I found I was just doing documentation."

Finally, participants discussed the importance of making time for appropriate supervision and consultation in maintaining their wellness. For example, when comparing an agency where she felt greater wellness to her previous agency, Fatin stated that the difference is:

> The support and the peer consultation, and the time to do that. The level of respect is much higher. There is respect for the administrator; you can approach her with feedback. [There are] high ethical standards and consulting, and the open-door policy. Just makes it so you never feel worried that you will make a mistake, because a lot of people are holding you up.

When talking about the need to differentiate client staffing from clinical supervision, Brian explained that supervisors often, "don't do supervision with their employees…or supervision is staffing. It's the same." He further explained, "Ideally, you have a sit-down with a person and do supervision. So they have a chance to talk about how they're feeling,

the problems they are having, in a safe place to do that." He conceded that time constraints often hinder this process because, "there's a lot of crisis and things come up at any given moment. So, you have a schedule, but something trumps it very quickly." David discussed the benefits of having a positive supervisor who made time for clinical supervision with him, stating:

> It was a really important part of me so when I was getting close to burnout or when I was stressed out or in a funk or whatever, I could talk to him and that kind of supervision process which was more than just once a week for an hour. It was more of an as needed kind of a thing and was very, very helpful. It was more than just clients, so it was very helpful for personal growth and so I was totally happy to have that.

Participants described time constraints as significant barriers to their wellness and consequently their ability to provide the best care to clients. However, they also discussed how access to human resources (e.g., supervisors) can positively influence their sense of wellness and development.

Occupational Hazards

A second theme that emerged was occupational hazards. This theme involved the psychologically intense characteristics of the work itself that threaten wellness and included concepts such as empathy fatigue, vicarious traumatization, depersonalization, lack of meaning and wounded healing. Participants discussed the challenges of helping difficult clients while attempting to maintain their own wellness.

One participant, Peter, discussed his struggle to not personally take on too much of the clients' concerns. He stated that:

> I think the biggest challenge that I've faced, and I can't say this challenge is gone to this day, is that I took on a lot of my clients' stuff. You know, you hear as a counselor you develop empathy for your clients with their challenges and their stories and experiences can be very traumatic and you know can be very impactful. So I think the biggest thing that I had that was impactful is I feel I would take on a lot and I would feel a lot more of what others struggled to face, as opposed to be there in the moment and then walk away from it… That was something, if you think about wellness as this bubble around me and that bubble keeps me from taking on too much of people's stuff and keeps me mentally and personally safe, then my wellness was gone, the bubble was gone.

Another participant, Anne, discussed the burden that builds when occupational hazards are ignored by the agency and/or supervisors:

> A lot of vicarious trauma, grief trauma left unprocessed. When a patient dies it is like—okay next. My administrator actually said that we assume you are coming in with the clinical skills and you will take care of yourself with that. There is no facilitative process or it is not acknowledged in our agency—that it could be happening to us as counselors. We are not given a moment to have that time. [The administrators say] be sure your taking care of yourselves out there—it is sort of you take care of yourself out there.

Yet another participant, David, discussed how the quick client turnaround in the inpatient facility led him to question the value and meaning in his work when he stated:

> It was a lot of treat and street, so in other words they come in, you're basically working on discharge paperwork from the first day you meet them, so you are already thinking about where they need to go…I mean they had lost everyone else in their lives and they felt isolated and alone, so the relationship was incredibly crucial and I think most people would agree that the relationship is the most important part of the counseling process, and you can't build a relationship if basically when they are coming in you are looking at the chart trying to get the form filled out and trying to get them out the door because either insurance won't pay or it's a bed that needs to be emptied out so it can be filled with someone who can maybe last longer.

David went on to discuss his resulting emotions:

> There is almost like this shame/guilt you are kind of feeling or struggling with where you feel like you can't seem to get anywhere, or I am not doing anything, or what am I doing…Am I helping?...Does this matter? And I think that once you have lost that meaning in your work, that passion for what you are doing then it just kind of all, it's a sinking ship at that point and wellness is just kind of out the window, you just get frustrated.

Participants also discussed the potential setbacks that can occur when professional counselors over-identify with their clients (e.g., wounded healer). Helen comments on how unfinished business unfolds in an agency:

> It isn't quite a straight line. In other words, it is whatever the underlying energy of the agency that draws people in. If people come and then they go, they may not relate to it, but those people who stay for a while, for [more than] three years, that is an issue. You have to constantly reflect back 'why am I here?' What is it about this job that has pulled me here and what is it that I need to learn. I think you could stay in the field and never reflect or heal from anything.

One participant, Romie, who also does clinical supervision, discussed the importance of processing empathy fatigue and often spends her time processing the "heaviness of the work." She responded that "managing the occupational hazards is a matter of keeping the counselors happy…if they are happy and they feel good, and if they feel rewarded in their work they are going to produce and stay."

Participants discussed that intense and emotionally close work they do with clients is a potential barrier to their wellness. They alluded to the need to set personal boundaries while still finding meaning in their work. Additionally, participants discussed needing time to process the emotions that may arise.

Agency Culture

The next theme that emerged was agency culture. The participants expressed that the messages the administration convey as well as the morale of the agency often influence their sense of wellness. Participants discussed wanting to feel valued and respected by their agency. Sarita stated that she felt valued by her agency. When she was asked how that message was conveyed to her, she replied:

> I have been made to feel okay about my developmental level, just…you know…. normalizing my learning level. Everyone can speak up about what their opinion is, even if they are new, you feel part of the team. You know you have been selected for a reason to work here. They have confidence in you and they remind you of that.

Romie paralleled Sarita's statement:

> I happen to believe that wellness comes from the agency itself through feeling valued as an employee, [when] someone hears you in the company and that you have a voice. Having a sense that you say things and that they are respected. Feeling like that if there is anything that the company could do to help, they would. People feel happier, more rewarded and better. What that is in an agency I think is different for each one. It is more of a relationship and personal style.

Brian discussed the value when agencies respect the employees' need to take care of their family:

> Most of the programs that I've been in—they are more than willing to let you take care of your family as long as you are doing your job. That's been the biggest piece I think from a wellness standpoint is the understanding of that from the top.

Participants also discussed how the overall morale of the agency and coworker relationships influence their sense of wellness. For example, Helen commented on how one of her previous places of employment communicated messages of wellness through promoting coworker relationships:

> A lot that has to do with the attitude with the people running the place, what they valued, that fact they were invested in relationships. They realized we have to have connection with each other in order to give support to do the work here.

Similarly, Peter discussed how he believed staff cohesion plays a role in wellness:

> My experience is that when there is a sense of cohesion, a sense of togetherness and teamwork, I think that people get along better and there's a natural well, not well, but a natural happiness that goes along with it. My experience, where I've had the most stable or happy wellness have been places that encourage staff meals or having staff getaways, or doing events that brought the staff together to enjoy one another...not to work, but just to be around one another and enjoy one another and support one another.

Participants also discussed how agency directors and supervisors directly advocate for self-care. Catherine commented about self-care and wellness:

> There is an encouragement for self-care. It is double-binded, you have to get your stuff done, but you know it is like it is Friday, let's go home. They encourage each other to work less and have fun. Other places (agencies) had more pressure to get it done. There is a consciousness of balance.

Peter also discussed positive feelings when his supervisor supported his self-care efforts, "There was one day there was an accumulation of things, a combination of feeling sick, but also in the middle of a stressful time…he said go home, have a great day. So he was in support of wellness." Peter continued, "he understood the job is not always easy and can bring on a lot of stress and he was willing to let us take care of ourselves if we needed to."

Overall, when the agency promoted the respect and value of professional counselors and encouraged counselors to have a voice and affect change, it promoted the counselors' own sense of wellness. Furthermore, sensing an investment in work relationships and promoting a work-life balance influenced the wellness of these counselors.

Individual Differences

The final theme that emerged involved the different perspectives of the participants and how that influenced their feelings of wellness. Two participants from the same agency held very different feelings about how their agencies influenced their sense of wellness. Jill felt very positive about her agency and spoke of the many financial incentives and freedoms allotted and that the agency's independent scheduling fit her. Anne also mentioned the same financial incentives, but believed that she received negative mixed messages and that her wellness was being negatively affected by the same agency. Conversely, Jill, who felt positive towards her agency, noted, "No one had to tell me to take care of myself." David also expressed that wellness is often left up to the individual; when speaking about one of his agencies he stated, "it wasn't really like it was a place of wellness. Wellness is something that happened, or self-care happened long after you left." Romie responded about her intentionality with wellness:

> Personally, what I do is many things. I exercise; I make sure I get plenty of sleep. I take time for myself when I need to. I will do yoga and meditate and do a lot of reading and I am highly spiritual. I have a wonderful home-life, a very supportive love-mate in my life. I am really in a good place.

Throughout the interviews, the participants discussed very different values in terms of their wellness. Some of the participants mentioned spiritual practice and journaling as being important in maintaining wellness. Others expressed time with family as being most important, whereas others discussed setting clear boundaries or finding meaning in their work.

Other participants discussed how wellness initiatives within their agencies often seemed inconvenient to them. When talking about a discounted gym membership that was offered, Brian viewed the offer as superficial, saying "in my experience, most of what they offer in terms of wellness is, in my experience, is somewhat superficial." He further stated, "Very few people are able to utilize the gym membership because of the hours they work and where it's located and the cost is still too high for the employees." Peter discussed the positives and negatives of a wellness initiative:

> The book was a 40 week-by-week event where you learned about wellness…physical, mental, spiritual; all these different components. The problem was they had these events that took place scattered all over the district and so for anyone to attend them, they would have to drive half an hour to 45 minutes to attend them and which if you're trying to have a good basis for wellness, then having people drive 45 minutes after a long day of work is not a good place to start for that.

However, Peter acknowledged that this may be only his view, stating:

> The planning of the events I felt could have been better. And of course, not to say other people didn't go to them and find them successful, but it was just my experience of do I go home or drive 45 minutes then attend a 2-hour meeting on nutrition. I felt like going home was more beneficial for me at that time.

These statements reveal that professional counselors may value different things related to wellness. Other counselors in Brian or Peter's agency may have appreciated the wellness initiatives.

The participants responded differently in terms of wellness values. One cannot overlook how different individuals will react to the stress of being a counselor. Knowing what type of atmosphere is the best fit for the counselor's personality and interests can factor in overall well-being. Romie commented, "It is good to know what kind of atmosphere is the best fit for you, if you love it, then that is your wellness, if you don't, then nothing you do will ever click."

Discussion

The findings in this study suggest that the environment in which the participants work may play an important role in their overall wellness. This finding is consistent with previous research that suggested agencies directly affect well-being and satisfaction of counselors (Knudsen, Ducharme, & Roman, 2006; Lloyd, King, & Chenowith, 2002; Maslach, 1982, 1986). Participants in this study discussed lack of resources as potential barriers to wellness including unsatisfactory salaries, large caseloads, heavy paperwork and lack of supervision. This finding is consistent with previous research that maintaining caseloads above 15 per week increases chances of occupational hazards (Trippany, Kress, & Wilcoxon, 2004). Additionally, counselors have reported increased salaries as directly relating to their wellness (Bell et al., 2003), and comprised a major setback for counselors in this study. Further, our findings support previous research that poor supervision, little to no peer-to-peer conversations, low salaries, heavy paperwork, lack of control over services and managed care influences are all correlated with decreased wellness and increased likelihood of burnout (Ackerly, Burnell, Holder, & Kurdek, 1998; Gaal, 2009). Clients deserve to receive the best care possible in agencies; therefore, funding sources should be aware of what counselors specifically need to function at their best. However, it is the responsibility of all counseling professionals to organize and advocate for gains such as salary increases, caseload limits, qualified supervisors, and funding for wellness activities. Advocating through joining local, state and national organizations is one way to work toward these goals, as organizations stay abreast of current legislative changes and locate opportunities to improve the counseling profession.

The finding in this study that occupational hazards influenced counselors' wellness is consistent with previous literature (Skovholt, 2001; Stebnicki, 2007). Additionally, participants in this study discussed the importance of supervision and processing time in order to work through such hazards. This finding reinforces the importance of supportive environments where counselors can obtain peer support and adequate supervision. Consequently, counselors' wellness may be increased when agencies have consistent treatment-team meetings and supervision sessions, where counselors have an opportunity to process their work with others and obtain consultation. Additionally, supervisors should have appropriate training in supervision to ensure that a quality supervision experience occurs.

Participants in this study expressed that the culture of the agency influenced their sense of wellness. Factors that positively influenced them included feeling valued by administrators, feeling that they had a voice, being respected and feeling cohesion with coworkers. Agencies may assist in counselor wellness by developing employee committees that provide a forum for counselors to express concerns and provide recommendations to the agency. This may help to foster a sense of value among the counselors when their perspectives are heard. Additionally, employee committees may serve to organize wellness activities and professional development opportunities for the staff, encourage peer support and cohesion, and organize advocacy efforts.

Implications for Professional Counselors

The findings in this study suggest that one's wellness is very personal and is heavily influenced by personally salient values. In this study, the participants mentioned different wellness values. Individually, counselors can develop holistic wellness plans and gain self-knowledge concerning what aids them in performing at their best, while considering the realities of their work environment and resources that are available to them. Counselor educators can model wellness activities and highlight the resilience that stems from a comprehensive wellness plan so new professionals are prepared to attend to wellness when they enter the field. Counselor educators also should educate counselor trainees as to the realities of agency work (e.g., caseloads, paperwork, difficult clients) so they can prepare themselves mentally to enter the system. Counselors and clinical directors can vocalize ways to enhance the well-being of the atmosphere in the agencies by advocating for reasonable caseloads and encouraging wellness days for the staff (e.g., days where the entire staff rejuvenates together through team building or other enjoyable workshops or activities). Given that funding is often mentioned as a factor that influences wellness, agencies and individual counselors may benefit from learning how to

secure various types of grants to assist with resources (e.g., additional staff, technology, wellness initiatives). Additionally, agencies may benefit from developing ad-hoc committees that will evaluate processes and procedures (e.g., paperwork, documentation) to potentially reduce workloads and ensure that counselors' time is used efficiently. Finally, counselors should be proactive in seeking out further training in wellness, self-care and burnout prevention through conferences (e.g., ACA, AMHCA) or other professional development opportunities, and should advocate that their agencies provide these types of trainings.

Limitations and Future Research

Despite the depth and richness of information obtained in this exploratory study, there are multiple limitations. First, we did not spend prolonged time in the field in order to gather further data about wellness practices through observation or document analysis. Future researchers may benefit from direct observations of wellness practices in the natural setting. Additionally, we only utilized one source of data for interpretation (i.e., interview/focus group) which may have affected the depth of information obtained. Finally, although generalizability is not a major goal of qualitative research, readers should be mindful that the findings may not be representative of other counselors in different settings.

Future researchers could explore wellness experiences of more diverse racial/ethnic groups and those at various income levels. Additional studies may include more prolonged engagement in the field by the researcher in order to make observations about wellness practices as well as multiple data sources (e.g., observations, questionnaires, reflective journals). Other studies may include agencies that are currently implementing specific wellness practices in order to evaluate their effect on counselor wellness. Finally, future researchers may benefit from identifying particular agencies that maintain effective wellness practices and exploring them through in-depth analysis.

Conclusion

Counselor wellness is an important aspect of ensuring effective and ethical services to clients (ACA, 2010; NBCC, 2005). The findings in this study provide some initial information about the various aspects of wellness that may be influenced by professional counselors' work environment. Although agencies may not be able to immediately change all aspects of the work environment (e.g., salary, caseloads, work hours), other aspects such as agency culture and adequate supervision are easier to address. Counselors and clinical directors may benefit from evaluating their current wellness practices through staff questionnaires, focus groups, or needs' assessments. Attending to professional counselors' wellness needs may help to improve the morale in the agency, help counselors avoid burnout, and ensure more quality care for clients.

References

Ackerly, G. D., Burnell, J., Holder, D. C., & Kurdek, L.A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice, 19*, 624–631.

American Counseling Association. (2005). *ACA code of ethics.* Alexandria, VA: Author. American Mental Health Counselors Association. (2010). *AMHCA code of ethics.* Author.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Services*, *84*, 463–470.

Cain, D. J. (2001). Defining characteristics, history, and evolution of humanistic psychotherapies. In D. J. Cain & J. Seeman (Eds.), Humanistic psychotherapies: Handbook of research and practice (pp. 3–54). Washington, DC: American Psychological Association.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five traditions* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2008). Emotional exhaustion and turnover intention in human service occupations: The protective role of coworker support. *Sociological Spectrum, 28*, 81–104. doi:10.1016/j.jsat.2006.04.003

Figley, C. R. (2002). *Treating compassion fatigue.* New York, NY: Routledge.

Gaal, N. (2009). Comparing burnout levels experienced by therapists working in a mental health organization versus therapists working in private practice. (Doctoral dissertation). Retrieved from ProQuest. (3360424)

Glesne, C. (2006). *Becoming qualitative researchers* (3rd ed.). Boston, MA: Pearson Education.

Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2006). Counselor emotional exhaustion and turnover intention in therapeutic communities. *Journal of Substance Abuse Treatment, 31*(2), 173–180. doi:10.1016/j.jsat.2006.04.003

Lambie, G., & Young, M. E. (2007). Wellness in school and mental health systems: Organizational influences. *Journal of Humanistic Counseling, Education and Development, 46,* 98–113.

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education and Development, 46,* 21–34.

Lawson, G., & Venart, B. (2005). Preventing counselor impairment: Vulnerability, wellness, and resilience. In G. R. Walz & R. K. Yep (Eds.), *VISTAS: Compelling perspectives on counseling 2005* (pp. 243–246). Alexandria, VA: American Counseling Association.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health, 11*, 255–265. doi; 10.1080/09638230020023642

Maslach, C. (1982/2003). *Burnout: The cost of caring.* Cambridge, MA: Malor Books.

Maslach, C. (1986). Burnout research in the social services: A critique. *Journal of Social Service Research*, 10, 95–105.

Maslach, C., Leiter, M.P., & Schaufeli, W.B. (2008). Measuring burnout. In Cooper, C.L., Cartwright, S. (Eds), *The Oxford handbook of organizational wellbeing* (pp. 86–108). Oxford: Oxford University Press.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131–149. doi: 10.1007/BF00975140

Muhr, T. (2004). ATLAS.ti 5.0 (Version 5:). Berlin, Germany: ATLAS.ti Scientific Software Development GmbH. Available from http://www. Atlasti.com/

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78,* 251–266. Retrieved from http://aca.metapress.com/link.asp?id=pxpkullf5qnetnax.

National Board for Certified Counselors (2005). *NBCC code of ethics*. Greensboro, NC: Author.

Pines, A., & Maslach, P. (1978) Characteristics of staff burnout in mental health settings. *Hospital and Community Psychiatry*, *29*, 233–237.

Rupert, P., & Morgan, D. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, 36*, 544–550. doi: 10.1037/0735-7028.36.5.544

Shapiro, S., Brown, K., & Biegel, G. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training, *Training and Education in Professional Psychology, 1*, 105–115. doi: 10.1037/1931-3918.1.2.105

Skovholt, T. M. (2001). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals.* Boston, MA: Allyn & Bacon.

Stebnicki, M. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation, 10,* 317–338. doi:10.1080/15487760701680570

Stokes, G., Henley, N. & Herget, C. (2006), Creating a culture of wellness in workplaces. *North Carolina Medical Journal, 67*, 446–448.

Teddlie, C., & Fen, Yu (2007). Mixed methods sampling: A typology of examples. *Journal of Mixed Methods Research, 1*, 77–100. doi: 10.1177/2345678906292430

Trippany, R. Kress, V., & Wilcoxon, S. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82,* 31–37.

Vredenburgh, L., Dale , C., Alfred, F., & Stein, L. B.(1999). Burnout in counseling psychologists: Type of practice setting and pertinent demographics. *Counselling Psychology Quarterly, 12*, 293–302. doi: 10.1080/09515079908254099

Witmer, M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Counseling, Education, & Development, 34*, 141–156.

Appendix

Participant Demographics

Name (pseudonyms were assigned)	Type of Facility	Gender	Age	Race	Experience in Field	Interview Method
Anne	Palliative Care Facility	Female	37	Caucasian	11 Years	Individual
Jill	Palliative Care Facility	Female	40	Caucasian	2 Years	Individual
Helen	Clinical Director for Domestic Violence Shelter and Community Counseling Center	Female	45	Caucasian	13 Years	Individual
Romie	Clinical Director of an Adolescent Residential unit	Female	53	Caucasian	20 Years	Individual
Fatin	University Counselor	Female	27	Caucasian/ Middle Eastern	1 Year	Focus Group
Catherine	University Counselor	Female	28	Caucasian	9 Months	Focus Group
Sarita	University Counselor	Female	33	East Indian	1 Year	Focus Group
David	Behavioral Hospital	Male	29	Latino	3 Years	Individual
Peter	Inpatient & Residential	Male	28	Caucasian	3 Years	Individual
Brian	Adolescent Residential	Male	38	Caucasian	13 Years	Individual

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