JCD

JOURNAL OF COUNSELING & DEVELOPMENT

VOLUME 82 NUMBER 1 WINTER 2004

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Understanding and Treating Social Phobia

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Social phobia, a relatively obscure disorder, is receiving increased attention due to evidence suggesting that it is more prevalent and debilitative than once thought. The purpose of this article is to help counselors better understand the nature of and treatments for this disorder. Effective behavioral and pharmacological approaches are reviewed, and counseling implications are discussed to increase counselors' confidence in providing treatment to people with social phobia.

Social phobia is defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychiatric Association [APA], 1994), as "a marked and persistent fear of social or performance situations in which embarrassment may occur" (p. 411). Rapee and Heimberg (1997) suggested that social phobia can best be understood on a continuum where shyness is at one end of the spectrum (indicating mild social anxiety), social phobia is in the middle (moderate social anxiety), and avoidant personality disorder is at the other end (severe social anxiety). However, the severity of social phobia should not be underestimated because evidence suggests that it is prevalent (Kessler et al., 1994), often considered chronic (Davidson, Hughes, George, & Blazer, 1993), and can be disabling to those who suffer from it (Wittchen, Stein, & Kessler, 1999). Approximately 60% of people with social phobia experience other troubling disorders, such as depression and obsessive-compulsive disorder (Schneier, Johnson, Hornig, Liebowitz, & Weissman, 1992), and are at greater risk of experiencing suicidal ideation and suicide attempts (Davidson et al., 1993).

Furthermore, despite the fact that those with social phobia report that it significantly interferes with their lives, less than 20% seek professional help (Magee, Eaton, Wittchen, McGonagle, & Kessler, 1996; Wittchen et al., 1999), and only approximately 6% reported having used medications to treat their disorder (Schneier et al., 1992). The lack of information made available to people with social phobia about treatment options coupled with their fear of social interactions, including making contact with helping professionals, are cited as primary reasons for low treatment use.

The ramifications for those who must deal with social phobia are widespread and pervasive. When compared with people who had no psychiatric disorder, those with social phobia were less likely to marry and more likely to receive disability or welfare assistance (Schneier et al., 1992). In a study conducted by Wittchen et al. (1999), approximately one fifth of individuals with social phobia reported missing school and/or work because of their condition, and 24% reported diminished work productivity. Thus, these individuals are likely to experience a wide range of psychological, emotional, and financial consequences from being isolated and underemployed.

Because of the prevalence of social phobia and the problems associated with the disorder, this article aims to create a better understanding of this condition and explore research related to the effective counseling and pharmacological treatments. Counseling implications are then discussed to obtain a holistic perspective of how to best treat those who have social phobia.

THE NATURE OF SOCIAL PHOBIA

For people with social phobia, exposure to a feared social situation can cause extreme anxiety and even panic. Symptoms can include, but are not limited to, trembling, twitching, dizziness, rapid heart rate, feeling faint, difficulty speaking or swallowing, and sweating. Commonly feared situations include eating in public places, giving and receiving compliments, unexpectedly bumping into someone you know, making eye contact, talking with unfamiliar people, and speaking to an audience (Wilson, 1996).

The early onset age for social phobia is 16 years (Magee et al., 1996; Ost, 1987); however, adolescents and children younger than 16 can be diagnosed with this disorder. For children, the duration of social phobia must exist for more than 6 months, and their capacity for age-appropriate peer

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interactions must be confirmed before the diagnosis of social phobia can be made (APA, 1994). The *DSM-IV* suggests that social phobia should not be diagnosed in children who exhibit social inhibition with adults only (p. 414). Nonetheless, there is a link between childhood inhibition and social phobia (Hayward, Killen, Kraemer, & Taylor, 1998), and it has been speculated that children who exhibit extreme shyness around other children or adults are at risk of developing social phobia later in life (Chavira & Stein, 1999).

Social phobia can be diagnosed as one of two subtypes, nongeneralized and generalized. Although some overlap exists between the two subtypes, they differ in the pervasiveness of the problem. People with nongeneralized social phobia typically experience symptoms predominantly when in performance situations, such as meeting unfamiliar people or public speaking. For those with the generalized subtype, a larger variety of everyday social situations can cause distress (e.g., attending parties, participating in small groups, maintaining conversations).

Another consideration when working with people with social phobia is comorbidity. As mentioned earlier, a large percentage of people with social phobia have other disorders. Common comorbid disorders of social phobia include the following: specific phobias (e.g., fear of heights or flying), agoraphobia—"anxiety about being in places or situations where escape might be difficult or embarrassing" (APA, 1994, p. 200), obsessive-compulsive disorder, and panic disorder (Fong & Silien, 1999). Oftentimes, people with social phobia who also have comorbid disorders experience greater distress, including suicidal ideation (Schneier et al., 1992).

Causes of Social Phobia

Evidence indicates that genetics play a substantial role in the acquisition of anxiety disorders (Rutter et al., 1990) and social inhibition (Kagan, Snidman, Julia-Sellers, & Johnson, 1991; Tellegen et al., 1988). From years of extensive research with children and families, Mussen, Conger, and Kagan (1974) found that some children are born with hypersensitive nervous systems that cause them to have low thresholds for anxiety and fear; however, parental support and nurturance early in a child's life are important variables in determining their degree of social inhibition at later stages. The interaction between genetics and parental nurturance is evident in a study conducted by Krohne and Hock (1991). The authors found a strong correlation between mothers' and daughters' anxiety levels, and when working together to solve a problem, high trait-anxious girls' mothers displayed more restrictive and controlling problem-solving behavior. Furthering the notion that environmental antecedents contribute to the acquisition of social phobia, Ost (1987) found that over 70% of the participants in his research indicated the belief that they had developed their anxiety through conditioning and modeling. It was speculated that parental warnings and excessive instructions could be contributing variables to the acquisition of social inhibition. In addition, it was also suggested that children learn anxious behaviors from their parents' anxious responses to certain situations.

Finally, in this rapidly changing world, the Internet and automated services such as gasoline and bank teller machines are quickly reducing the need to interact with others, possibly causing people to be more isolated and socially inhibited. This idea is supported by a study conducted by Kraut et al. (1998) who followed 169 people during their first 2 years of Internet usage. Results indicated that Internet usage decreased the participants' social involvement with friends and family and increased their depression and loneliness.

Thus, the acquisition of social phobia may be the product of several different interwoven variables. Gabbard (1999) best described the relationship between genetics and environment when he stated, "the effects of genes are expressed in interaction with and in reaction to experience" (p. 4). It may well be that children inherit anxiety from their parents, who then reinforce this fear by modeling anxious behavior. Hence, it appears that genetics, the type and amount of nurturance and parental instructions received as a child, and societal trends all interact to play a role in developing and maintaining this disorder.

Cognitive Model of Social Phobia

People with social phobia are hypersensitive to the evaluations of others. The perception of negative feedback from an "audience" (e.g., rolling eyes or yawning) triggers increased anxiety in these individuals, which in turn causes physiological anxiety symptoms such as blushing or sweating (Rapee & Heimberg, 1997). Thus, a repeating cycle consisting of perceived negative evaluations and increased anxiety is common for many of these individuals when engaged in social interactions.

Three cognitive stages have been identified when people with social phobia are involved in social interactions: (a) anticipatory processing, (b) in-situation processing, and (c) postmortem (Clark & Wells, 1995; Rowa, Antony, & Swinson, 1999). The anticipatory stage is characterized by excessive worry and apprehension about an upcoming social interaction. During the in-situation processing stage, self-talk is increased and acute attention is paid to the early warning signs of anxiety. In this stage, people with social phobia are likely to take several safety precautions, such as glancing often at the nearest exit to make sure they have an escape route if their anxiety becomes overwhelming, drinking alcohol, and avoiding eye contact. As a result, due to the excessive attention paid to internal cues during the interaction, social mishaps are likely to occur (e.g., forgetting names, inappropriate laughter or excessive talking in an effort to take their mind off their discomfort). The final stage, postmortem, is characterized by scrutiny of the past interaction. For example, Wilson (1996) discussed a case in which his client faced one of his social fears but worried incessantly afterward that he had made a fool of himself. Thus, the fears of people with social phobia can be reinforced after facing situations if proper corrective attention is not paid to their self-talk after the event.

TREATMENT FOR SOCIAL PHOBIA

Several treatments seem effective in helping people with social phobia. Both behavioral therapy and pharmacological treatments have been found to be salient in alleviating the symptoms of social phobia. Research related to behavioral and pharmacological treatments are described as follows.

Behavioral Treatments

Cognitive Behavioral Therapy (CBT), Cognitive Behavioral Group Therapy (CBGT; Albano, Marten, Holt, Heimberg, & Barlow, 1995; Hayward et al., 2000; Heimberg et al., 1990; Heimberg, Salzman, Holt, & Blendell, 1993), and Exposure Therapy (ET; Feske & Chambless, 1995; Turner, Beidel, & Jacob, 1994) have repeatedly demonstrated efficacy in treating social phobia. Furthermore, several studies have found that a combination of CBT and ET is superior to using either treatment alone when treating social phobia (Butler, Cullington, Mundy, Amies, & Gelder, 1984; Mattick & Peters, 1988; Mattick, Peters, & Clarke, 1989). Finally, CBGT has been found to be more effective than Educational Support Groups (ESG; Heimberg et al., 1990; Heimberg et al., 1998; Heimberg et al., 1993).

Comparing CBGT with ESG, Heimberg et al. (1990) conducted a study to examine the efficacy of CBGT designed specifically to treat social phobia versus the efficacy of an ESG ($N = 49$). The CBGT consisted of 4 stages: (a) teaching clients how to identify and dispute irrational thoughts; (b) role-playing fearful situations; (c) cognitive restructuring before and after role-playing; and (d) assigning homework aimed at confronting feared situations, followed by self-administered cognitive restructuring. The ESG used a combination of education and support group therapy, and session content consisted of definitions of anxiety, physiological responses, communication skills, assertiveness, and perfectionism. In the final session of the 12th week, the participants were asked to complete a simulated feared social interaction called the "behavioral test." Multiple social anxiety measures, including therapists' ratings, were taken both prior to and at the conclusion of the study as well as at the 6-month follow-up.

Results indicated that both groups' symptoms were reduced; however, the CBGT participants demonstrated more substantial improvement. In addition, the CBGT group reported significantly fewer negative thoughts after the behavioral test than did the ESG. Furthermore, the results of a subsequent study aimed at determining the durability of the CBGT with the participants in this study found that treatment gains had been maintained by the CBGT group at the 5-year follow-up (Heimberg et al., 1993). On the basis of these results, it appears that education and social support, although somewhat effective, are not as effective as CBGT. This study clearly points to the importance of helping clients recognize and change irrational thoughts and face their fears, first in controlled role-play situations, and then gradually moving to more natural interactions.

A more recent study compared CBGT, phenelzine, pill-placebo, and ESG (Heimberg et al., 1998). One hundred and thirty-three participants were divided among the four groups. After 12 weeks of therapy, results indicated that CBGT and phenelzine were more effective in reducing participants' social anxiety scores than either the pill-placebo or the ESG; however, the phenelzine group was superior to CBGT on some measures.

Two studies found the combination of CBGT and exposure therapy (ET) to be ideal in treating social phobia. In the first study, Mattick and Peters (1988) divided the 51 White male participants into two treatment groups, one group received ET ($n = 26$) and the other received a combination of CBGT and ET ($n = 25$). Participants in the ET-only group repeatedly practiced submersing themselves in fearful situations (e.g., restaurants, shopping malls) until their fear had subsided. Participants in the combined group were taught cognitive restructuring strategies to challenge their irrational thoughts, after which they began engaging in fearful situations. At the 3-month follow-up, 52% of the participants in the combination group were able to complete 100% of their predetermined "hierarchy of fearful situations" compared with only 17% of the ET-only group. Furthermore, both groups demonstrated significant decreases in their avoidance of fearful situations between pre- and posttest; however, the combination group's avoidance ratings continued to decrease, between the posttreatment and the 3-month follow-up, while the ET group's avoidance ratings increased. Thus, it appears that teaching people with social phobia CBT strategies, in addition to having them engage in fearful situations, increases the likelihood that they will continue to improve once treatment is completed.

On the basis of the previous study, and the apparent superiority of a combination of CBT and ET relative to ET alone, Mattick et al. (1989) sought to determine the difference between ET ($n = 11$), CBT alone ($n = 11$), a combination of the ET and CBT (COMB; $n = 11$), and a wait-list control group (WLC; $n = 10$) in the treatment of social phobia. All of the treatment groups improved significantly more than the WLC. Similar to what was found in the previous study, both the COMB and the ET group improved significantly between pre- and posttreatment on a behavioral achievement test; however, the COMB group showed continued improvement at the 3-month follow-up, whereas the ET group decreased. The CBT alone group made only modest gains between pre- and posttreatment; however, it continued to show significant gains at the follow-up, surpassing the ET group. The results concur with those of the previous study suggesting that a combination of both CBT and ET is ideal in treating social phobia. Based on this study, it appears that CBT is a vital component in assuring continued improvement posttreatment.

A meta-analysis conducted by Feske and Chambless (1995) found CBT and ET to be equally effective in treating social phobia; however, more exposure sessions were associated with greater symptom reductions. On the contrary, it has been suggested that exposing people with social phobia to feared situations without cognitive restructuring activities can be counterproductive. According to Wilson (1996), people with social phobia tend to scrutinize themselves negatively

after social interactions; therefore, if time is not spent helping the clients identify and dispute irrational thoughts, the exposure can reinforce their negative beliefs.

In a recent review of behavioral treatments for children with anxiety disorders, CBT and CBT combined with family therapy have proven to be the most beneficial (Ollendick & King, 1998). Mendlowitz et al. (1999) examined the effects of CBGT under the following treatment conditions for children (ages 7–12) with anxiety disorders: (a) child only, (b) parent-child, and (c) parent only ($N = 62$). All three showed improved anxiety and depression scores; however, the parent-child group reported increased coping strategies as well.

Specifically related to the treatment of social phobia in children and adolescents is Hayward et al.'s (2000) study to determine the effectiveness of using a 16-week CBGT for treating female adolescents. The study consisted of three groups: a CBGT group ($n = 12$), a nontreatment social phobic group ($n = 23$), and a nonsocial phobic control group ($n = 18$) used primarily for baseline comparison. Treatment consisted of a typical CBT protocol, such as assertiveness training, social skill building, and cognitive restructuring, coupled with in vivo exposure to feared situations.

The treatment group had improved significantly more than the nontreatment group at posttreatment; however, these gains were not maintained at the 1-year follow-up. In fact, there was no significant difference in social phobia measures between the two treatment groups at the follow-up. It is interesting that there was evidence indicating that participants in the treatment group experienced less depression at the 1-year follow-up compared with the nontreatment group. Thus, the study indicated that CBGT did alleviate social phobic symptoms in the short term, but Hayward et al. (2000) suggested that booster sessions and pharmacological treatment might be needed to maintain posttreatment gains.

Barrett (1998) and Barrett, Dadds, and Rapee (1996) found that a combination of CBT and family therapy was more effective than CBT alone (participants ages 7–14 years). In fact, Barrett et al. (1996) found that 96% of the CBT-plus-family-therapy participants did not meet the criteria for social phobia at the 12-month follow-up as compared with 70% of the CBT-only group.

Family therapy comprised twelve 40-minute sessions and consisted of assisting family members to work together as a team to help the client alleviate his or her anxiety. Family members were taught how to reward courageous behavior and use "planned ignoring" to eliminate fearful behaviors. Planned ignoring involved having the parents respond empathetically to their child's first complaints about having to engage in a feared situation, but if the complaints continued, parents encouraged their child to practice the relaxation techniques taught during CBT and, finally, started to withdraw attention until the complaining subsided (Barrett et al., 1996). In addition, parents were taught how to manage their own anxiety in stressful situations. Finally, in an effort to prevent future problems, parents were taught communication and problem-solving skills and were encouraged to conduct daily discussions with their child to diffuse stressors before they began.

Pharmacological Treatment

Some of the medications found to be helpful in treating adults with social phobia include phenelzine—a monoamine oxidase inhibitor (MAOI; Gelernter et al., 1991; Heimberg et al., 1998), clonazepam—a benzodiazepine (BDZ; Davidson, Potts, et al., 1993), and paroxetine—a serotonin reuptake inhibitor (SSRI; Stein et al., 1996; Stein et al., 1998), as well as other SSRIs (e.g., Zoloft, Prozac; Van Ameringen, Mancini, Farvolden, & Oakman, 1999). In a recent review of medications used for treating social phobia, Fedoroff and Taylor (2001) found that the SSRIs and BDZs were most effective; however, concerns about the abuse and relapse potential of BDZs cause many physicians to use the SSRIs as the first line of treatment.

Stein et al. (1998) recently investigated the efficacy of paroxetine, the only SSRI that has been approved by the Federal Drug Administration to treat social phobia. In this multicentered double-blind study, 91 participants were administered paroxetine (dosage ranging between 20 and 50 mg) and 92 participants took matched-image placebos. At the end of the 12-week trial, 55% of the paroxetine group, compared with 23.9% of the placebo group, reported being *much* to *very much* improved. However, 15% of the paroxetine group terminated the study prematurely due to adverse reactions. The most common reactions were abnormal ejaculation, somnolence, and nausea. Nevertheless, Stein et al. (1998) suggested that paroxetine is an effective treatment for social phobia, especially considering that it can also treat underlying depressive symptoms and it is not known to have the abuse potential of the BDZs.

The newest BDZ, clonazepam, is receiving increased attention in treating social phobia because of its long half-life, the amount of time required for half of the medicine to leave the body, which decreases the probability that it will cause physical dependence. Davidson, Potts, et al. (1993) conducted a randomized double-blind study in which participants received either clonazepam ($n = 39$; mean dosage of 2.4 mg/day) or placebo ($n = 36$). Results from multiple social phobia measures indicated that significant reductions of social phobic symptoms were reported by 78.3% of the clonazepam group compared with only 20% of the placebo group. Thus, a significant number of participants with social phobia were helped by taking clonazepam, but Davidson, Potts, et al. (1993) cautioned that they did not know how safe and efficacious it would be to administer clonazepam for long-term use.

To address questions related to the efficacy of the long-term use of clonazepam, Connor et al. (1998) studied a group of patients with social phobia who had responded well to 6 months of clonazepam therapy. The original group of responders was divided into two groups, the discontinuation group (DT; $n = 19$) and the continuation group (CT; $n = 17$). Over the course of 5 months, the DT group's medicine was decreased .25 mg every 2 weeks until they were taking no medication. The CT group continued taking the original dose needed to reach therapeutic benefit. Results indicated that none of the CT group and 21.1% of the DT group relapsed over the course of the study; however, 27% of the

DT group experienced withdrawal symptoms. Connor et al. noted that the long-term use of clonazepam appears warranted and that only a small percentage of those in the DT group experienced relapse, suggesting that clonazepam may have some lasting benefit upon discontinuation. The authors did suggest, however, that the use of clonazepam in conjunction with CBT could have helped further reduce the relapse rate.

Two studies compared the efficacy of medication versus psychotherapy. The first study with 65 participants with social phobia was conducted by Gelernter et al. (1991) to compare the use of phenelzine, alprozolam, CBGT, and pill-placebo. Self-report and physician ratings were taken at four different times: baseline, weekly during treatment, posttreatment (at the end of the 12th week), and follow-up (after 2 months). The medications' dosages were reduced and then discontinued after the 12th week.

Results indicated that the phenelzine produced the highest responders (69%), followed by alprozolam (38%), CBGT (24%), and pill-placebo (20%). However, at follow-up, the alprozolam group showed significant relapse on discontinuation of the medication, while the CBGT and the phenelzine groups showed signs of further improvement. Thus, in this small study, phenelzine was superior in reducing social phobic symptoms compared with the CBGT; however, the continued improvement of the CBGT group at follow-up suggests that the benefits are lasting. Finally, the authors noted that the combination of phenelzine and CBGT might be ideal (Gelernter et al., 1991).

In the study by Heimberg et al. (1998), described in the Behavioral Treatment section, both medication and CBGT appeared equally effective in reducing social phobic symptoms. Seventy-five percent of the CBGT completers and 77% of the phenelzine completers were classified as responders. On the basis of the results, and in accordance with the aforementioned study, Heimberg et al. (1998) suggested that a combination of CBGT and phenelzine may be the ideal treatment for people with social phobia.

Only a few studies have examined the effects of pharmacology in treating children with social phobia. Two clinical trials found alprazolam and fluoxetine to be effective in treating children with anxiety disorders (Birmaher et al., 1994; Simeon & Ferguson, 1987). Specifically for social phobia, The Research Unit on Pediatric Psychopharmacology Anxiety Study Group (2001) examined the use of fluvoxamine for children and adolescents (ages 6–17) with social phobia. One hundred and twenty-eight children were randomly assigned to either the fluvoxamine or pill-placebo group in this double-blind study. Results indicated that 76% of the fluvoxamine group responded to the therapy versus 29% of the pill-placebo group. Despite its apparent effectiveness, questions have been raised as to the need for medicating children with social phobia, especially considering research suggesting the efficacy of CBGT (Coyle, 2001). To date, no studies have been found comparing pharmacological and behavioral interventions for children with social phobia.

These studies suggest that both pharmacological and behavioral treatments are effective in treating social phobia. However, further work is needed to determine the efficacy of using both CBGT and medication. Research examining the combination of behavioral interventions and pharmacology is warranted.

IMPLICATIONS FOR COUNSELING

First, because many people with social phobia never seek treatment, it is imperative for counselors to increase the general public's awareness of this disorder. In schools, counselors should attempt to educate teachers and parents about the symptoms of social phobia and its treatment options. In addition, classroom guidance lessons could be designed to teach students coping skills for managing anxiety (e.g., relaxation techniques, positive affirmations). In the community, screenings for social phobia, much like what is done for other mental health disorders during mental health awareness week, could be conducted in local libraries and other agencies to provide outreach to this underserved population.

A substantial obstacle to receiving treatment for many people with social phobia is the discomfort they feel making contact with other individuals (Schneier et al., 1992). All efforts should be made by counselors to create an inviting and nonthreatening atmosphere. Counselors should make clients with social phobia aware that they can leave the office for a "breather" at any time during the session, if necessary, or they can lie down if their symptoms become intense. In addition, a client with social phobia is likely to experience anxiety during a session, causing him or her to pay more attention to internal feedback instead of being focused on the counselor; thus, it is important for counselors to summarize the discussed material often and to encourage their clients to write down important information and insights gleaned so they can be reviewed outside of session (Butler & Wells, 1995). Finally, traditional counselor behaviors, such as direct eye contact and sitting close to the client, especially in the first sessions, will probably cause people with social phobia much discomfort. Therefore, when working with people with social phobia, a traditional psychoanalytic approach of having the client face away from the counselor may be warranted. In fact, a client's willingness to make eye contact and face the counselor in subsequent sessions could be used as a measure of treatment success.

Second, anxiety can be a symptom of many medical conditions. Some of these conditions include diabetes, heart arrhythmia, asthma, thyroid conditions, mitral valve prolapse, hypoglycemia, pregnancy, anemia, medication withdrawal, and the effects of caffeine (Wilson, 1996). Therefore, counselors should encourage their clients to have a thorough medical examination before receiving treatment.

Third, helping clients change their irrational beliefs through cognitive restructuring and exposure to feared situations through role-play and then in-vivo exposure appears to be the behavioral treatment of choice for adults. Common components of effective CBT include educating clients about the nature of the disorder, teaching social skills, assertiveness training, cognitive restructuring, role-play, and the analysis of in-vivo exposure. One of the main components of CBT and CBGT is to help clients learn to chal-

lenge their negative self-defeating beliefs. Wilson (1996) and Masia and Schneier (1999) encouraged clients to become accustomed to using the following statements and questions when involved in feared situations: "It's OK to be nervous" "What is the worst that could happen and is that so bad?" "Are there other ways of viewing this situation?" "My speech does not have to be perfect."

Fourth, counselors should prepare clients to face feared situations. Oftentimes, this is done initially in role-play situations under the guidance of the counselor so the event can be processed immediately afterward. Once successful role-plays have been enacted, the goal is then to help clients practice during real-life situations. These assignments can be given as homework to be carried out between sessions. For example, clients may be asked to initiate three conversations with people they do not know during the week and report back in the next session.

Exposure therapy has been found to be most effective under the following conditions: (a) Clients must remain in the feared situation until they notice a significant reduction (i.e., at least 50%) of their anxiety symptoms (Butler, 1985); (b) they must refrain from using safety behaviors (e.g., checking for exits and avoiding eye contact; Wells et al., 1995); and (c) they must engage in anxiety-provoking situations often to best eliminate their fear. It is common for people with social phobia to scrutinize themselves after social interactions; therefore, if they leave an in-vivo exposure at the height of their anxiety, this will only serve to reinforce their fear. In addition, if their symptoms become so intense that they must leave a fearful situation, it is important for them to challenge the onslaught of negative self-talk, which can reduce their willingness to face the situation in the future.

Fifth, counselors should encourage their clients with social phobia to invite close family members and significant others to participate in therapy. Although couples or family counseling has not been examined specifically for adults with social phobia, evidence suggests that couples counseling is effective when working with people who have other types of anxiety disorders (Barlow, O'Brien, & Last, 1984; Cerny, Barlow, Craske, & Himadi, 1987). Including significant others in therapy reduces the chance that the significant other will ignore the problem of the partner who has social phobia or will push him or her excessively into uncomfortable situations (Barlow et al., 1984). In addition, significant others' lifestyles will be affected by the problems experienced by their partners who have social phobia. Anecdotal evidence suggests that those who live with people with anxiety disorders commonly experience feelings of anger, resentment, and confusion. Thus, efforts should be made to educate and support significant others.

It is clear that combining CBGT and family therapy is effective when working with children and adolescents with social phobia. Counselors should provide parents and guardians with education and support to help their children develop coping skills. In addition, because of the strong genetic link between parent and child anxiety, the assessment and treatment of parents' anxiety is important as well.

Sixth, it is important for counselors to become familiar with the medicines commonly used to treat social phobia and their side effects. As mentioned earlier, the SSRIs are typically the first line of treatment. However, these medicines can take up to 4 weeks to take effect, and several clinical trials indicated that only 50% to 60% of the participants improved, leaving another 40% to 50% that were not helped. Common side effects of SSRIs include headache, abdominal discomfort, nausea, and insomnia (Birmaher et al., 1994; The Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001).

Finally, two sources are recommended for those who seek additional information about social phobia. On the Internet, the Social Anxiety Institute (www.socialanxietyinstitute.org) is a good site to learn more about social phobia, and those who are interested can register to receive a confidential newsletter that is edited by mental health professionals and contains information about current treatment options and allows members to share their coping strategies. An excellent source for counselors is the book *Social Phobia: Diagnosis, Assessment, and Treatment* edited by Heimberg, Liebowitz, Hope, and Schneier (1995). This book contains chapters written by the foremost researchers of social phobia.

CONCLUSION

Social phobia is a serious condition that can be disabling. It is often comorbid with other disorders, causing a significant deterioration in the quality of life of those who have this condition. Fortunately, both behavioral and pharmacological treatments have proven effective in treating this condition; nevertheless, further research is needed to examine the efficacy of using a combination of pharmacology with CBGT. Furthermore, longitudinal studies are needed to determine if the treatment of children and adolescents with social phobia produces lasting effects or if it thwarts some of the more severe symptoms that they may experience later in their lives. At the very least, based on the favorable treatment results, it is important for counselors who work with children and adolescents to identify and treat those who exhibit symptoms of social phobia. Finally, counselors need to increase the general publics' awareness of this disorder and to adjust their counseling styles to best meet the needs of those who have social phobia.

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Developing and Nurturing Excellence in African American Male Adolescents

Deryl F. Bailey and Pamela O. Paisley

High dropout rates and poor academic performance are too often characteristic of the educational experience for African American male adolescents. In response to this dilemma, enrichment initiatives targeting young Black men have been developed. This article provides an in-depth description of Project: Gentlemen on the Move, a program designed to develop and nurture academic and social excellence in African American male adolescents. Recommendations for school counselors are provided.

Across the nation, scores of African American male adolescents can be observed wandering the halls of public schools, alienated from the educational process, searching for the making of their American dream. Their absence is often conspicuous in upper-level academic and gifted classes, while their presence is readily apparent in remedial classes. They outnumber White male adolescents on suspension and expulsion lists (Bailey, 1996; Center for the Study of Social Policy, 1990; "Federal Report," 1999; Ford, Grantham, & Bailey, 1999; Lee, 1992; Skiba, Michael, Nardo, & Peterson, 2000; Trescott, 1990). They can be found on street corners and in shopping malls, often the objects of fear and contempt. On any given day, their legal troubles clog the calendars of the juvenile justice system. Many never have the opportunity to celebrate their 18th birthdays because of arguments over material objects, such as athletic shoes, resulting in violent deaths. They often walk away from their education, their hopes, and their dreams because they do not see the educational and social systems as places for them to achieve. Rather, these systems are perceived as institutions that collectively label them without affording them the opportunity to realize their potential as individuals (Narine, 1992).

The poor academic and social performance of African American male adolescents has been linked to the lack of role models, low self-esteem, hopelessness, productivity dysfunction, and low expectations by the school, communities, and society at-large (Gardner, 1985; Kunjufu, 1984; Lee, 1996; Lee & Bailey, 1997; Lee & Lindsey, 1985; Majors, 1986; Majors & Billson, 1992; Morgan, 1980). Many educators, researchers, and community leaders often discuss the poor performance of male African Americans at professional meetings but, with the exception of a few, are at a loss when it comes to assisting them in recognizing and moving toward their optimal potential.

The purpose of this article is twofold. First, it explores the current experience of African American male adolescents while considering those factors that might contribute to different outcomes. Second, a detailed description of one initiative designed to have an impact, Project: Gentlemen on the Move, is also provided. This program was developed in response to the needs of African American male adolescents, yet it has the potential to be used, if adapted appropriately, with a variety of groups from different ethnic and cultural backgrounds.

THE CURRENT EXPERIENCE OF AFRICAN AMERICAN MALE ADOLESCENTS

As noted in the introduction, the current experience of African American male adolescents provides numerous areas for concern. This idea seems to be confirmed by the existing educational achievement gap between male African Americans and their White counterparts as well as the continual overrepresentation of male African Americans in the juvenile justice system (Bailey, 1999; The Education Trust, 1996,1998). As a result, too many African American male adolescents become a part of a growing number of negative social and academic statistics.

Within U.S. Society

Socially, the number of African American male adolescents involved at one level or another in the juvenile justice system remains at a critical level. It has been reported that 1 out of every 4 male African Americans is in jail or under court supervision and that there are more African American men in their 20s under court control than are enrolled in college (Bass & Coleman, 1997; Green & Wright, 1992; Mauer, 1990). Data from the 1995 Federal Bureau of Investigation (FBI) report "Crime in the United States" (FBI, 1996; Sickmund, Snyder, & Poe-Yamagata, 1997) indicate that "black adolescents represented 15% of the juvenile population in

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1995 yet were involved in 28% of all juvenile arrests" (Sickmund et al., 1997, p. 17). Although they represent only 15% of the juvenile population, African American adolescents constituted 43% of the juvenile populations in public facilities and 34% in private custody facilities (Bailey, 1999; FBI, 1996; Sickmund et al., 1997). It is clear that African American male adolescents are overrepresented in juvenile criminal statistics. This makes it difficult for them to be involved in their community in positive ways, perpetuating a negative self-image and disrespect for authority (Lee & Bailey, 1997).

Within the Educational System

Within the educational system, statistics reveal that minority and poor populations continue to be underserved. These students are less likely to be found in rigorous courses geared to college-bound students and are more likely to be taught by out-of-field teachers (The Education Trust, 1998). In fact, across the board, schools that are made up of predominately minority and/or poor populations have a smaller number of qualified teachers and fewer resources for instruction. African American male adolescents do not escape the implications of these statistics. Their potential for achievement and for a variety of postsecondary options becomes limited.

Although African Americans represent only 17% of the total school population, they account for 32% of suspensions and 30% of all expulsions (Skiba et al., 2000). This overrepresentation increases in cases where administrators rely on suspensions and expulsions as their primary form of punishment. In addition, African American male adolescents are placed in remedial or special education classes at a rate 3 times higher than that for their White counterparts (Advancement Project/Civil Rights Project, 2000; Allen-Meares, 1999; Lee, 1996; Trescott, 1990); conversely, only 8.4% are identified and enrolled in gifted and talented classes (Ford et al., 1999; George, 1993; Trescott, 1990). Furthermore, the African American male student has only a 1 in 12 chance of graduating from college, but a 1 in 4 chance of becoming a dropout statistic from high school (Trescott, 1990). Relative to college enrollment, male African Americans only account for 3.5% of the total college and university enrollment in the United States (U.S. Bureau of the Census, 1998).

FACTORS CONTRIBUTING TO MORE POSITIVE OUTCOMES

The best chance of changing these negative social and educational trends for African American male adolescents lies within the school environment and will require innovative strategies if the trend is to be reversed. Many educators, community leaders, and even some school systems believe that enrichment initiatives geared toward the special needs of African American male youth could reverse the present trend toward failure within the educational system as well as society (Ascher, 1991; Johnson, 1990). Depending on the racial breakdown of the student population, these enrichment initiatives over the past decade have resulted in significant changes to the curriculum and school mission or in the addition of special after-school programs.

Successful Interventions

A number of school districts made attempts to dedicate entire schools to a focus on the challenge of developing curriculum and programs to meet the needs of African American male youth. For example, a citizen's task force in Milwaukee endorsed a plan to implement a specific curriculum for African American male youth after seeing a study that yielded grim statistics in their school district. Specifically, African American male youth constituted half of the suspensions, dropped out at a rate of 14.4%, and had fewer than 20% of their population with a C average or better. In 1990, the Milwaukee school district designated an elementary school and a middle school as African Immersion Schools, becoming the first public school district to approve such a plan. Supporters of the African Immersion Schools hope to counteract the low achievement of African American male youth in the Milwaukee school district by stressing the accomplishments and achievements of African American people (Leake & Leake, 1992). Using the first letter of famous African Americans' names to teach the alphabet and studying the slave trade by integrating history, writing, and math skills are two examples of strategies from the program's Afrocentric approach (Johnson, 1990).

In predominantly White schools, enrichment programs scheduled for after school, weekends, and in the summer embrace African American male youth. These programs also use empowerment strategies such as studying African and/or African American history, participating in activities designed to build positive self-identity, and spending time with adult African American mentors (Ascher, 1991; Bridges, 1986). For example, Fulton Academics and Athletics Magnet, an elementary school in San Diego, initiated a pilot project to enhance the achievement of African American male youth for their district. The program incorporates both in class and "pull-out" classes (where students are allowed to leave class for a certain period of time to participate in the program) focusing on famous African Americans and highlights of the African American culture. In addition, the program depends on the support of adult African American mentors, counseling, and tutorial sessions (Ascher, 1991). On the secondary level, the High Achievement, Wisdom, and Knowledge (HAWK) Project developed by Grant Union High School in Sacramento uses a combination of two pullout classes and two after-school classes each month to achieve the program's goals. Those goals include the development of a positive identity through the study of African rituals and African and/or African American history. Program directors believe that the development of a positive identity acts as a preventive measure against drug usage, gang involvement, and poor academic performance. In addition, the program incorporates a community service project with senior citizens to increase responsibility to the community. After one semester in the program, 55% of the participants improved their grade point averages and the percentage of students performing below their ability level dropped from 82% to 33% (Ascher, 1991).

Yet another example, Project 2000, was founded and continues to be directed by Spencer Holland, an African Ameri-

can educational psychologist. Project 2000 is a nonprofit organization that provides continual educational and financial support to inner-city African American male adolescents who live in Washington, DC. Program participants are called "scholars," and they participate in after-school study halls, Saturday academies, community service, and peer mentorships (Foster, 1996).

Current literature regarding enrichment initiatives for African American male adolescents, while very sparse, reveals several common program components. These include African and/or African American history and culture, use of mentors and/or role models, rites of passage, community service, individual and group counseling, educational enrichment activities, collaborations with businesses and institutions of higher learning, recreational activities, and family involvement (Ascher, 1991; Lee & Bailey, 1997; Leonard, Lee, & Kiselica, 1999). In addition, building a positive self-identity through cultural awareness, cultivating a sense of purpose and confidence, developing a healthy balance between individualization and a sense of belonging, and an open door to career possibilities all represent commonalities of successful programs (Hare & Hare, 1985; Lee, 1994; Mincy, 1994).

Proposed Approach

Although many programs available to African American male youth incorporate many of the common components to some degree, two central factors seem to be missing in their overall design. First, enrichment initiatives need to be developmental and comprehensive in their approach because they are dealing with African American male adolescents (Bailey, 1998; Lee & Bailey, 1997). Enrichment initiatives should be "developmental" in that program directors should consider where each member is compared with where they should be psychosocially and academically. Program activities might include opportunities for members to bridge any existing developmental gaps and lay the foundation to prevent future gaps.

In addition, enrichment initiatives should be "comprehensive" in that planned activities consider the full range of aspects of the adolescent's life. Single-focus approaches have limited chances for success, whereas multifaceted interventions offer much more promise. For example, an outline of the enrichment initiative might include (a) contact with teachers; (b) community service projects that provide a quality service to the community; (c) opportunities for participants to interact, learn and share experiences with adolescents from other cultures; (d) intentional instruction on what it means to be African American and male in this society; and (e) personal and business etiquette training and leadership opportunities for all participants. Many of the above components/goals may be implied or assumed as part of the program's agenda, but those involved with managing the initiative cannot afford to leave these items to happenstance because adolescent development is critical to a healthy transition to adulthood.

Finally, most enrichment initiatives lack empirical data that document and support their success as well as lessons learned. Evaluations that collect both qualitative and quantitative data can provide thorough documentation that can inform further program development. In addition, quality and thorough evaluation procedures can meet documentation requirements of donors, as well as contribute to establishing creditability in the professional community.

"PROJECT: GENTLEMEN ON THE MOVE": A DEVELOPMENTAL AND COMPREHENSIVE APPROACH

The mission of Project: Gentlemen on the Move (PGOTM) is to develop and nurture excellence in African American male adolescents academically and socially (Bailey, 2001). This program mirrors the mission of many other programs created for male African Americans and incorporates many common components previously mentioned. As suggested earlier, PGOTM is both developmental and comprehensive in nature, components not explicitly focused on in other programs. Developmentally, this model (a) identifies where each member is socially and academically, (b) compares this information with where they should be (based on age and academic ability level), and (c) then provides them with the skills they will need to reach their full potential. This is referred to as the "transformation." The transformation is defined as a positive change or modification in the social and academic performance of PGOTM members; therefore, the transformation is unique to each student. For some, these transformations will begin to manifest shortly after they join the group, and, for others, they will emerge in stages over varying periods of time.

Second, PGOTM is comprehensive in that it takes a holistic approach to the empowerment and transformation of African American male adolescents by addressing multiple aspects of their lives. The program intentionally and directly deals with issues that members are confronted with on a daily basis (i.e., how to appropriately respond to prejudice/racism in school and the community, how to combat peer pressure, etc.). PGOTM members participate in community service projects as a way to develop leadership skills and unity among its members, while providing a service to members of their communities and establishing a sense of ownership and responsibility for the well-being of the community at-large. PGOTM also provides avenues (i.e., dances, community service projects, and forums) for its members to interact with other groups of students who are normally outside of their circle of friends. The intent is to remove the social barriers that exist between them and their peers from different cultures. PGOTM also enlists the support and assistance of the families. Parents are provided with a variety of opportunities to engage in the activities of the program. One such opportunity is the Parents of Gentlemen on the Move network (POGOTM). Parents are required to attend monthly meetings where they discuss issues regarding their son's academic and social performance. In addition, workshops are held to assist parents with negotiating the educational system on their son's behalf. Parents also serve as advisory board members offering suggestions to program staff

for the improvement of the overall program. This parent involvement represents one of the guiding assumptions of PGOTM.

Assumptions

Embedded in the mission of PGOTM is a set of basic assumptions regarding young people. These assumptions are as follows: (a) African American parents want their children to succeed and will participate if opportunities are provided; (b) all are capable of learning; (c) all know right from wrong but may not know or understand the consequences for their behaviors; (c) all young people want to do what is right; (d) all are at-risk; (e) all deserve a quality education; (f) all have a right to fail, if they so choose (however, it is critical that the consequences for this choice are made clear along with the opportunities for personal growth); (g) all young people are worthy of forgiveness from others and themselves; (h) all are worthy of love, nurturing, guidance, support, and meaningful opportunities; and (i) stereotypes of male African Americans can only be changed by providing positive views of male African Americans. These assumptions serve as the foundation and driving force for the PGOTM model.

Program Background

PGOTM was created in a high school in western North Carolina in the fall of 1989. Concerns regarding the poor academic and social performance of some African American male students were the impetus for the creation of this project. With the approval of the building principal (i.e., the high school principal), a meeting was held with African American male students interested in attending.

This meeting proved to be both encouraging and discouraging. The group, composed of approximately 50 African American male students ranging from those who constantly found themselves in trouble to those who were considered to be "ideal students," met for 2 hours. After a brief explanation as to why they had been summoned and assurance that everything they said would be kept in confidence, the students were given the opportunity to express their feelings regarding their academic performance and overall school experiences. They reported feeling isolated, mistreated, and disrespected; they believed some teachers and administrators were prejudiced and, in some instances, racist. After 1 hour of allowing them to vent, they were asked what they thought they could to do to change experiences at the school. The answer was a unanimous "nothing." "Nobody wants to listen to us . . . nobody cares." It was at this time that the idea of PGOTM was introduced to them. Several meetings were held over the next few weeks to establish group rules, goals, and to determine which students were seriously interested in participating. The following rules and expectations were explained:

1. Obey all school rules and policies. If there were rules or policies that we as a group believed to be unfair, then the group would develop a plan and challenge them (the rules) in an appropriate manner.
2. Respect yourself and others (with a strong emphasis on respecting young women).
3. Attend weekly meetings.
4. Abide by the group rules.

In addition to the rules set by the program, group members were encouraged to add to the aforementioned set of rules. After some discussion, they decided that instead of adding more rules, they wanted to have some input into the consequences for violations to these rules. As a result, the following consequences were agreed on:

1. Members found in violation of a group rule(s) would receive a warning.
2. A second violation would result in a second and final warning.
3. A third violation would result in suspension from the group and all group activities. After a period of one (1) semester, suspended members could apply to be reinstated. If the suspended member maintained satisfactory academic and social performance while on suspension, active members would vote on his reinstatement. A majority vote would be needed for reinstatement.

Membership

The membership roster varied from semester to semester as members dropped out of the program or school; transferred; were committed to juvenile detention centers; graduated; or, as in one case, fell victim to homicide. Although membership fluctuated, 15 committed students became the core of the program. The academic performance of these students ranged from below average to above average in academic courses. Socially, some members were considered ideal students, meaning they never disrupted class, skipped class or school, or were never considered troublemakers. Others were all of the above. In terms of family background, members came from low-income and middle-class families. For the most part, members were raised in two-parent homes, although a few were raised in single-parent homes or lived with aging grandparents or other relatives (aunts, uncles, and in one case an older sister). The education level of parents varied; some were well educated (college degrees and in some cases graduate degrees), whereas others had a high school education. All had dreams of their sons, grandsons, and brothers becoming good students and productive citizens rather than a dropout or homicide statistic, and all were very supportive of their participation in the program.

Expectations of Members

Although it is important that the rules are strictly adhered to, it is also important that the program director is sensitive to the variety of factors (family situations, after-school employment obligations, and extracurricular activities) that may cause individual members to miss group meetings or occasionally violate a school policy. However, these factors

should not be to be used as excuses for their behavior. Members should always be encouraged and expected to accept the consequences for their behavior. Members of PGOTM are expected to

1. Attend school everyday—members are constantly reminded, "If you're not in school, you can't learn."
2. Be prepared for class everyday—they are constantly reminded that coming to class is only part of their responsibility, and being unprepared for class would be considered "disrespectful to the teacher and fellow students." For members who feel that a particular class is not important to them or their future, members are reminded that they have a responsibility to their classmates and to the group to treat each class as if it is their future.
3. Show respect for school personnel (this includes teachers, administrators, counselors, cafeteria and janitorial staff, etc.)—showing respect for all is what being a "gentleman" is all about.
4. Never accept being "average"—students are encouraged to never accept "being average" as their best. In the past, some teachers, administrators, and even parents challenged this philosophy. Their rationale was that "some students are just average and will never be able perform beyond this." Acknowledging that some students are average, the group leader consistently pointed out that "being average" was not the goal of the program. The goal for PGOTM members was to become "the best" they could be. PGOTM strongly believes that if you expect students to be average, they will become just that—average. However, if you expect students to be the best, and assist them in doing so, they will inevitably become just that—the best. With this said, it was and is important to determine, with each group member, what his "best" was. A visual picture of what this would look like is developed with an emphasis on behavior.

Requirements for Membership

Requirements for membership are simple. First and foremost, students must be willing to improve on who they are, and they must be interested in and willing to work toward presenting the community with positive images of African American male youths by enhancing their own academic and social performance. Included in social performance is a willingness to participate in community service projects. Next, referrals are accepted from teachers, administrators, parents, community members, and PGOTM members themselves. In addition, students who are interested in participating can request membership simply by attending a program meeting and completing the necessary paperwork. Included in this paperwork are parental consent forms. In essence, anyone wanting to join can do so simply by making his interest known and making a commitment to himself, his family, and the program.

Outcomes From Participants

At the end of 5 years, approximately 300 male African Americans had been on the PGOTM roster at one point or another. Many of these students went on to enjoy success in their personal lives: Two are now playing in the National Football League (NFL), 1 is a senior pre-med student, 1 is a teaching fellow, another is a computer software engineer with the U.S. Department of Defense, 1 is a member of the U.S. Navy, and another is a senior majoring in fashion design. Although many of the former PGOTM members fell through the cracks, it is obvious that many are doing well. Results from one study revealed that students who participated in the program on a regular basis obtained higher grade point averages (GPAs) than did students who were referred to the program but chose not to participate (Bailey, 1995).

One question left to be answered is To what extent did PGOTM affect the lives of the young men who participated for more than one semester? As a partial response to this question, former members and parents were interviewed. When asked "How did Project: Gentlemen on the Move influence you or your son academically and socially?" the interviewees gave the following responses:

Student 1: I am a self-proclaimed lazy person and I do need a swift kick in the butt every once in a while and PGOTM and Mr. B provide that . . . on several occasions matter-a-fact [laughing]. The program just pushed me and Mr. B just pushed me to take harder classes 'cause I just kind of skated through some to the easier, lower level classes. He pushed me to take those [upper level classes] and I did well. [He] also pushed me to apply for this scholarship and that scholarship. . . . Never limit yourself . . . that's one thing I learned . . . that's the biggest thing I learned through PGOTM is to never limit yourself. You can do anything you want to do and at the time I did not realize it . . . it wasn't in my realm to believe I could go to certain schools, get certain things, and do certain things and PGOTM gave me that push.

Student 2: PGOTM affected me by making me a leader and I really do consider myself a leader because I look at the things that PGOTM and Mr. B gave to me and I have in turn used that to give back. I [participate in the] Guilford County Lunch Buddy Program (LBP). . . . I [have] lunch with my little buddy . . . the requirement is once a week, but I try to meet with him twice a week and we just go over some things that may be bothering him, academically or socially, at home or at school. On February 5th I [will] start my tutor training so I can also go into the schools and help with the after school-tutoring program. I think my leadership skills are unsurpassed . . . I mean Mr. B was definitely a leader for me no matter what my problems were he was always there to help or give me advice and I think this is something we definitely lack today . . .

Parent 1: . . . during my son's freshman and early sophomore year, he did enough to get by. He did okay . . . but after working with [PGOTM], he seemed to take his academics to another level. He seemed to really want to do better . . . he started taking more honors and AP courses. I think a lot of that probably came about because of being in PGOTM.

Parent 2: I think my son benefited from PGOTM because he is a very quiet, bashful child and it helped him to be a little more assertive. It helped him academically, too . . . to try a little harder, to push a little further.

Parent 3: [T]he program gave each of them an incentive by being around one another . . . they were like a support to one another . . . they built friendships . . . you knew you had someone you could go to and talk to, that you were all part of the same program with the same goals and objectives in mind.

It is apparent from both student members and parents that PGOTM had a positive impact on the academic performance and social development of its members.

Critical Components

The program consists of four components: (a) attention to process, (b) focus on identified areas of content, (c) support through individual and group counseling, and (d) specifically designed activities to achieve the goals of the program. Although each component serves an important role, it is the intermingling of these four components that creates a system in which the effectiveness of one component is important to the effectiveness of the next and is critical to the overall success of the program.

The *process component* includes elements such as recruitment and referral, selection, invitation, and monitoring. The *content component* involves skill development and the integration of new information pertinent to program participants' academic and social growth. Academic topics include a study of African, African American, and family histories, health-related issues, and tips on enhancing academic excellence. Topics promoting social development include the improvement of self-efficacy, personal and business etiquette training, the importance of giving back to the community, and appreciation and acceptance of individual differences. This last element of the social topics focuses on respect for self, elders, women, and culturally different individuals. Opportunities to be exposed to traditional African American culture as well as interactions with individuals from other cultures are considered crucial. Both the academic and social topics are covered during mini-workshops held weekly and are referred to as Saturday Learning Institutes (SLI).

The third component is the *support component*. Within this component, group members are involved in individual and group counseling sessions. These sessions enable group members to establish short-term and long-term academic and social goals. Other areas of support include structured study sessions held during the first 2 hours of the SLI and intense exam preparation, known as the exam lock-in (held at the end of each semester). The exam lock-in is held the weekend prior to the end-of-semester exams, and participation is mandatory. Members who earn an overall exam average of 93 or above earn the privilege to be Project: Gentlemen on the Move Scholars for the upcoming semester. Give Me A Reason: An Academic Incentive Program represents another part of the support component. This program provides a variety of rewards for academic progress and excellence, such as money, tee shirts, travel, dining, and tickets for sporting and cultural events.

Finally, the *activity component* includes field trips, college visitations, special event opportunities, and community service projects. Past community service projects have included community-wide Easter egg hunts for youngsters in grades K–5, an annual 5k road race called the "Project: Gentlemen on the Move Race Against Drugs," and a 1-day basketball clinic for elementary and middle school students. The first three activities (field trips, college visitations, special event opportunities) help to broaden members' worldviews. The remaining activities provide avenues for developing leadership skills and a positive work ethic while fulfilling an identified need within the community. During the summer, group members are invited to participate in the Project: Gentlemen on the Move Summer Academy; this 1-week academy focuses on leadership development and self-improvement for group members.

A VISION FOR NEXT STEPS

When adolescents are provided with adequate direction, support, and opportunities, they are better able to overcome many of the academic and social challenges that often hinder their development. This is especially true for African American male adolescents. Over the past 12 years, PGOTM has been well received by schools and communities. Although many participants continue to view their academic and social challenges as barriers, others have been able to accept the challenges for what they are, devise a plan of action, and move forward. The vision for PGOTM is that it will someday become widely used to assist adolescents of all cultural and ethnic backgrounds to realize their capacity to excel academically as well as socially. It has been well documented that adolescents from a variety of non-White backgrounds are underachieving and are in need of assistance (The Education Trust, 1996, 1998; Gandara & Maxwell-Jolly, 1999; Lee, 1994). If implemented, monitored, and supported appropriately, programs such as PGOTM can provide the necessary assistance for many adolescents who find themselves labeled as "an endangered species" or "hopeless."

After 12 years of operating PGOTM in three different southeastern high schools, three barriers to the vision of PGOTM's future have emerged. First and foremost, dedicated adults are needed to implement and operate the program. Working with adolescents demands time, high levels of energy, unending patience, and determination. Running such a program is much like coaching a team, and success means total commitment from the coach. Sadly enough, because no monetary rewards are involved, few have accepted the challenge in the past 12 years. Programs like PGOTM need individuals with vision and a heart dedicated to the advocacy of young people. Currently, a manual for PGOTM is being developed as well as plans for adult leadership training. Both the manual and the leadership training could assist in the establishment of new programs.

Second, operating an effective PGOTM chapter (a cohort of 25–30 young men) will require adequate funding, approximately $50,000 per year. During fiscal year 2000, the average national cost to house a youth in a Regional Youth Detention Center was $41,245 and $56,940 for a state-operated Youth Detention Center. For an intermediate residential treatment placement, the cost ranged from $47,450 to $74,825, and for an intensive residential placement, the cost ranged from $100,375 to $166,800 (G. Jackson, personal communication, October 1, 2001). The lowest of these costs could very

easily support one PGOTM cohort. However, it is important to note that the amount of funding will vary depending on the structure of the program (i.e., ability of parents to contribute, total number of participants, number of paid tutors, etc.). The community, local businesses, churches, school districts, and other funding agencies must understand the importance of such an investment. Providing funding for programs, such as PGOTM, that promote positive development, prevent delinquent behavior, and encourage academic success has to be considered a step in the right direction. Finally, both quantitative and qualitative research are needed to determine the strengths and weaknesses of PGOTM. This research could provide critical information to strengthen programming efforts while providing documentation required by public and private funding agencies.

RECOMMENDATIONS FOR COUNSELORS

Counselors are in a key position to assist students in their quest for excellence. The following recommendations are a place to start but are not meant to be an exhaustive list of actions school counselors can take to assist African American male adolescents. Counselors interested in supporting or implementing programs such as PGOTM must first develop an awareness of African American culture and its influence on the academic and psychosocial development of African American male adolescents. School counselors must also simultaneously acknowledge their personal biases related to the targeted population (i.e., personal beliefs and attitudes based on negative stereotypes). Counselors must be able and willing to develop meaningful rapport with male African Americans within the school environment. This rapport will assist them in identifying the individual needs of each student.

In addition, counselors must be able to identify positive male African Americans in the community who could serve as potential leaders for the program or as mentors after the program has been implemented. Next, counselors should identify existing programs designed for the empowerment of African American male adolescents; become familiar with the goals, objectives, and membership criteria; and create a system that matches students to existing programs. School counselors could easily assist program directors with academic information as well as updated progress reports; consequently, the counselor could act as a liaison between the program director and the faculty and parents. If the program director is not employed by the school system, the counselor could act as the "point person" for the program and arrange parent–teacher conferences, organizing community round table discussions on the positive development of African American male adolescents within their school community and conducting professional development workshops for teachers that focus on finding solutions to the factors that hinder academic success for this population.

Finally, counselors should be willing to serve as true advocates for African American male adolescents in the school and in the community. For female African American counselors who are interested in implementing such a program, it is imperative that they are willing to identify African American men from the community to serve as program directors. These individuals must be willing and able to invest significant amounts of time and energy into the success of the program.

Based on the ethnicity and gender of the counselor, his or her role will vary in the success of programs such PGOTM. However, everyone has a critical role to play (director, support person, academic volunteer, school and community advocator, resource locator, etc.). Identifying that role and committing to it is the first step in ensuring the success of programs targeting African American male adolescents.

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The Developmental Origins and Treatment Needs of Female Adolescents With Depression

Richard J. Hazler and Elizabeth A. Mellin

Rates of female to male depression rapidly soar during adolescence to a 2:1 ratio despite fairly equal rates throughout childhood. The literature suggests that changes in social development, social role expectations, and/or biology may play significant roles, but research considering these factors is scarce and inconsistent. This review considers how current information about these factors can help develop more culturally and client-appropriate treatment approaches and guide recommendations for the next steps in research.

What could lead a middle class female adolescent in the prime of health with her whole future blooming ahead, to tell the counselor, "Everything good in me died in junior high" (Pipher, 1994, p. 21)? Unfortunately, the feelings of this individual are not isolated but are instead reflective of the emotional problems faced by too many young women in our society and around the world (Culbertson, 1997; Pipher, 1994; Sands, 1998). The fact is that female adolescents face emotional, academic, and social problems more often and more extensively than male adolescents at this critical age (Nolen-Hoeksema & Girgus, 1994). What has been lacking in the counseling profession is an appropriately strong commitment to research on the unique difficulties female adolescents face and the identification of techniques designed to meet their specific needs (Culbertson, 1997).

Despite evidence of significant gender differences in the emergence of depression during adolescence, there is a lack of empirical attention given to understanding why these differences emerge and how those differences might influence treatment. Research indicates that throughout childhood and preadolescence, depression rates between the sexes tend to be fairly equal, but at about the age of 14, female adolescents begin experiencing depressive disorders at twice the rate of male adolescents (Sands, 1998). One out of every 4 girls is likely to experience moderate to severe symptoms of depression (Leiman & Scott Collins, 1999).

The onset of major depressive disorders (MDD) appears most likely between the ages of 13 and 19 (Birmaher, Ryan, & Williamson, 1996), and for young women the probability of developing this disorder continues to increase with age (Sands, 1998). These findings take on additional significance in light of research indicating that depression may have more extreme consequences for adolescents than for adults (Schraedley, Gotlib, & Hayward, 1999).

The combination of depression and suicidal ideation represents a dangerous relationship because depression is the most common diagnosis reported among adolescents who commit suicide (Kutcher & Marton, 1996). This relationship deserves specific attention when it is also recognized that suicide rates among adolescents have been increasing to the point where it is the third leading cause of death among 15- to 24-year-olds (Modrcin-McCarthy & Dalton, 1996). Female adolescents with MDD have a striking 12-fold increase in suicide risk and are twice as likely as their male peers to attempt suicide (Stanard, 2000).

Suicide ideation among female adolescents has been linked to increased anxiety, stress, depression, and loss of self-esteem related to negative interpersonal relationships with peers (Owens, Slee, & Shute, 2000). These are among the same characteristics seen in female adolescents who are entering junior high school (Eder, 1985). Many changes in female adolescents' peer relations typically occur at this time and friendships often revolve around popularity and sexuality in contrast to previously shared childhood interests with male peers including sports, music, academics, and other areas (Pipher, 1994). This shift in the social milieu of young women seems to be especially stressful in light of consistent research that has found self-esteem among female adolescents to be closely tied to their success in interpersonal relationships (Eder, 1985). Despite evidence supporting an increase of internalizing problems such as depression and anxiety at this age for female adolescents, empirical investigations in this area are lacking. In comparison to studies

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that have examined the nature of peer relations among young men, few investigations address peer relations among young women at this critical stage of development (Bell-Dolan, Foster, & Christopher, 1995).

Counselors working with individuals diagnosed with depressive disorders often see the anxiety, stress, and suicidal ideation common among female adolescents. Despite significantly higher rates of depression among female adolescents, little is known about symptomatology, etiological factors, course, and associated difficulties specific to this population. Counselors are therefore left with inadequate information on how to help young women in need. Additional empirical attention must be given to this area in order to better understand the nature of these problems among female adolescents and to help develop treatment techniques more specific to their needs.

Prior research on female adolescents has concentrated on symptoms of depression (Schraedley et al., 1999) and access to mental health treatment among female adolescents (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995). There are numerous references in the literature indicating inadequacy in this research and a lack of knowledge about adolescent female depression and treatment models (Cuffe et al., 1995; Culbertson, 1997; Leiman & Scott Collins, 1999; Nolen-Hoeksema & Girgus, 1994; Sands, 1998; Schraedley et al., 1999). Much more work is clearly needed if counselors are to accurately identify depressive symptomatology specific to young girls and offer mental health treatment easily accessible to this population.

There are a number of hypotheses regarding reasons for the increase in gender differences for depression in adolescence (Nolen-Hoeksema & Girgus, 1994) as well as treatments that may prove more efficacious for this population (Sands, 1998). Empirical attention, however, has not systematically focused on these hypotheses, and there is a lack of solid understanding about why these gender differences surface or how counselors can best help female adolescents in need. Currently the trend in counseling is to adapt approaches for the treatment of adults with depression to adolescents (Mueller & Orvaschel, 1997), and there is no treatment approach specific to female adolescents that has been empirically investigated.

Perhaps the state of research and practice with adolescent females is best summarized in the report of The Commission on Women's Health (1999) that called for greatly expanded efforts in the areas of prevention, detection, and treatment of depression and related psychological problems. The significance of the threat these problems pose to both the immediate well-being of girls and the future of these emerging women and society in general seems clear.

Increasing numbers of female adolescents showing up at hospitals and counselors' offices with symptoms ranging from mild depression to major depressive disorder make it imperative that counselors have as thorough an understanding as possible of this disorder as it is experienced in female adolescents. The unique developmental, biological, social, and psychological etiology of this disorder provides the basis from which to develop treatment, whether it emerges as the primary symptom or as a related one in a dual diagnosis. This article provides a review of the recently increasing information regarding etiology and treatment of the disorder and also identifies the inconsistencies and gaps in knowledge facing counselors and researchers as they seek to better serve clients.

SYMPTOMS

It has only been within the last few decades that mental health professionals have begun to recognize that depressive disorders can and do occur among children and adolescents. The result of this belated recognition is a tremendous gap in the literature available on the nature of adolescent depression compared with similar literature on adults (Mufson, Weissman, Moreau, & Garfinkel, 1999). The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision *(DSM–IV–TR;* American Psychiatric Association, 2000), also reflects this gap in knowledge in its absence of discussion or identification of the unique clinical features of depression among young people. Counselors adhering to the clinical features of depression offered for adults in the *DSM–IV–TR* may therefore be misguided in their interpretations of the clinical symptoms of depressed adolescents. This concern is particularly recognized by mental health practitioners and researchers experienced in adolescent depression who have observed unique clinical symptoms of adolescent and female adolescent depression (Birmaher, Ryan, & Williamson, 1996; Birmaher, Ryan, Williamson, Brent, et al., 1996; Modrcin-McCarthy & Dalton, 1996; Moreau, 1996; Mufson & Moreau, 1997; Sands, 1998; Stanard, 2000). Without a solid understanding of these unique symptoms, many mental health counselors may be missing critical signs of depression exhibited by their adolescent clients.

There are specific clinical symptoms that differentiate the experience of depression in adolescents from that of adults (Birmaher, Ryan, & Williamson, 1996). These differences are often reflected in significant impairments in interpersonal relationships and academic functioning (Birmaher, Ryan, Williamson, Brent, et al., 1996). Perhaps most noted by mental health counselors are the extremes of helplessness, despair, lack of pleasure, hypersomia, and changes in weight as compared with adults (Birmaher, Ryan, & Williamson, 1996). Depression among adolescents is observable as reports of excessive boredom, substance abuse, family problems, insubordination, symptoms of conduct disorder, and eating disorders (Moreau, 1996; Stanard, 2000). The combination of these symptoms makes suicide a particular concern for adolescents who tend to complete suicides more often than adults (Birmaher, Ryan, & Williamson, 1996). What can make these factors more confusing for counselors is that stages of depression are often followed by stages of improved functioning, which reflect the more episodic nature of adolescent depressive disorders (Mufson & Moreau, 1997).

Several symptoms of adolescent depression are particularly specific to the female experience of this disorder. Eating disorders, dissatisfaction with one's body, and weight

loss are the most directly observable common symptoms for the female population (Sands, 1998). These often appear as either obsession with physical appearance or total lack of interest in physical appearance (Modrcin-McCarthy & Dalton, 1996). The common theme between these two opposite concerns is the extreme behaviors that produce physically observable results.

The physical characteristics of adolescent depression are all accompanied by other specific symptoms. Reports of migraine and other types of chronic headaches can be indicative of depression among young women and may well be attached to escalating levels of worry and self-criticism (Sands, 1998). High levels of self-destructive behavior, such as sexual promiscuity and running away from home, are frequently associated symptoms (Modrcin-McCarthy & Dalton, 1996), as are increased levels of anger resulting from personal violence such as physical and sexual abuse, rape, self-mutilation, or suicide attempts (Sands, 1998).

The clinical symptoms of female adolescent depression can appear primarily through physical changes or complaints, and young girls with depression may not present with an obvious depressive affect. The clinical features of adult depression provided in the *DSM–IV–TR* fail to identify many of these unique symptoms such as destructive behavior, intense anger, unhealthy eating patterns, and a variety of other somatic complaints. The result can be that counselors using *DSM–IV–TR* guidelines may miss the depression diagnosis and instead conceptualize the symptoms as indicating an oppositional defiant, a conduct, and/or an eating disorder.

Symptoms of female adolescent depression appear to also have a connection to common struggles associated with the developmental challenges of adolescence. Attempts to establish autonomy during this time can be closely related to symptoms of intense anxiety and worry commonly associated with depression in young girls. The close connection between these developmental obstacles and symptoms of depression among female adolescents is not surprising because their common struggles are often compounded by the intensity of emotion with which they experience events in their lives. Developing a solid understanding of the connections between symptoms of depression and the normal developmental struggles of female adolescents is necessary for the implementation of appropriate and effective prevention, identification, and treatment models for young girls.

DEVELOPMENTAL FACTORS

The quote opening this article emphasized the research-backed recognition that female adolescents have a marked increase in depression compared with their childhood and even preadolescent years (Nolen-Hoeksema & Girgus, 1994). The middle school or junior high years mark a distinct increase in stress and depression in the development of female adolescents. The literature reflects differing information about the degree to which this situation is due to changes in social development (Pipher, 1994), social role expectations (Sands, 1998), and biological changes (Moreau, 1996). The most likely scenario is that all of these factors play important roles and that they combine in an unlimited number of situational and individual variations to create the complex and unique individual in need of assistance from a counselor, parent, friend, or perhaps even a good book.

Social Development

The social development tasks of early adolescence can be uniquely stressful for young women. Navigating the underlying social milieu of female friendships, exploring one's sexuality, and establishing autonomy from parents are all new developmental transitions taking place at this time. It has been hypothesized that stresses from the developmental transitions during this period are related to increases in depression among female adolescents (Pipher, 1994). Research has also noted significant drops in self-esteem related to various social development factors and a shift in focus from a desire to achieve to a preoccupation with being well liked by other young girls (Eder, 1985). In the midst of all these challenges, female adolescents are also fighting to establish or maintain a sense of self because a majority of the ideas and interests they previously identified with are no longer readily accepted by their peers (Pipher, 1994).

Pipher (1994) indicated that female friendships at this age tend to focus on popularity and sexuality rather than individual interests and achievement, whereas male relationships do not change nearly as much. A young girl whose sense of self once revolved around her talents as a musician may compromise this involvement in light of pressure to conform to new interests of peers, such as establishing popularity and becoming more attractive. Establishing a sense of connection or belonging with female peers seems to be both a particularly difficult and an important developmental task.

The pressure for girls to be successful in interpersonal relationships is often considerable in light of consistent research indicating that girls base a large portion of their self-esteem on the success of relationships with others (Eder, 1985). Friendships at this age are often severed and formed around newly established groups or cliques, which vary in level of popularity. Group memberships are often not stable because girls are frequently "kicked out" for not conforming to the group's often unspoken rules or because girls travel back and forth between groups trying to find one that accepts them and with whom they are comfortable. Establishing and maintaining friendships with female peers throughout adolescence can therefore create a confusing and anxiety-provoking living environment.

The last decade has seen researchers begin to emphasize an empirical examination of the underlying social milieus of adolescent female friendships and how they relate to the psychological well-being of young girls (Bell-Dolan et al., 1995; Eder, 1985; Evans & Eder, 1993; Henrich, Blatt, Kuperminc, Zohar, & Leadbeater, 2001; Owens et al., 2000). The results of each of these studies underscore the importance that young girls place on their connectedness to female and more popular peers. These studies also indicate strong relationships between negative interactions with female

peers and symptoms of stress, anxiety, and/or depression. The unique stresses relating to social development experienced by female adolescents may therefore play a major role in the emergence of gender differences in depression during this time.

Social Role Expectations

The available literature on female adolescent depression discusses the possibility of social role expectations as being a factor in the etiology of their depression (Moreau, 1996; Nolen-Hoeksema & Girgus, 1994; Pipher, 1994; Sands, 1998). Young girls coming into adolescence often find increased pressures on them from peers, parents, teachers, and society as a whole to become more "feminine." Specific changes in personality and behavior often occur at this age in order to meet these pressures.

It is during adolescence that girls tend to give up their interests in sports, music, arts, or other areas to take on the challenges of being popular and pretty (Pipher, 1994). The pressures on them to make such changes at this age are significant. Media images and commercials challenge female adolescents to look their best, which often means looking similar to others. Parents often begin to compliment daughters on their weight and looks. Female friends isolate them from groups or spread rumors about their sexual orientation for not taking interest in liking boys and putting on makeup. Those who do not readily accept these gender-typed roles are frequently rejected by peers and are at higher risk for psychological difficulties (Nolen-Hoeksema & Girgus, 1994).

It is during adolescence that girls often become aware of stereotypes associated with women, which in the United States can include being modest or passive; feeling incompetent; blaming oneself; and placing the quest to be beautiful, married, and feminine above all other concerns (Sands, 1998). Evidence of absorbing these traits is found in research indicating that female adolescents view their relationships with others (especially boys) as being threatened by their personal competence (Nolen-Hoeksema & Girgus, 1994). Many female social role expectations in this country are synonymous with traits of depression, with a result that youthful personality traits may be seen as signs of depression in many female adolescents.

Biological Changes

Biological changes, hormones, and the development of secondary sex characteristics associated with puberty appear to be additional factors in the increased rates of depression among girls during adolescence (Culbertson, 1997; Moreau, 1996). Some of the female/male differences beginning at this age include the 2-year gap in the start of pubertal experiences (girls begin earlier), the significant gains in lean muscle and skeletal mass for boys as opposed to the significant gain in body fat for girls, and the significant increase in estrogen and progesterone hormones for girls that boys do not experience (Nolen-Hoeksema & Girgus, 1994). The differences in types of hormone secretions between male and female adolescents have also been suggested as a potential factor in the gender differences in rates of depression among adolescents (Moreau, 1996).

Arguments for the role of hormones in the onset of depression in female adolescents suggest that dysregulation of the estrogen and progesterone hormones leads to depression, and because boys do not experience a surge of these hormones during puberty, they are less vulnerable to depression during this time (Nolen-Hoeksema & Girgus, 1994). Relationships between steroids, birth control, premenstrual syndrome, and their connections to depressive mood may further the argument for the potential role of hormones in depression among young girls (Moreau, 1996). Preliminary investigations of the relationship between depression in adolescent girls and hormones, however, have not consistently found correlations between the two (Nolen-Hoeksema & Girgus, 1994).

Nolen-Hoeksema and Girgus (1994) indicated that secondary sex characteristics have also been suggested as potential factors in the differing rates of depression among male and female adolescents. Although both boys and girls develop secondary sex characteristics at puberty, research indicates that girls are more likely to be dissatisfied with their bodies starting at this time. This finding is important because further research studies have suggested that body dissatisfaction leads to more depressive symptoms in girls than in boys. Arguments that biological changes, hormones, and secondary sex characteristics play a larger role in explaining the gender differences in rates of depression during adolescence are weakened, however, because of insufficient empirical research in this area.

Stressors related to changes in educational structure, unique challenges of social development, social role expectations, and biological differences have all been indicated in the literature as possible factors in the onset of higher rates of depression among girls in adolescence. Although there have been no empirical studies concluding that any of these factors are solely responsible, the most likely model is that a combination of these factors leads to a unique set of problems and characteristics that put female adolescents at higher risk for experiencing depression. Understanding these unique problems and characteristics, however, does provide insight into conceptualizations about key therapeutic issues specific to female adolescents struggling with depression.

SPECIFIC PROBLEMS NEEDING ATTENTION

A group of factors emerges from the gender-related conditions that influence development of depression in female adolescents. Counselors should take note of these factors to establish a direction for their attempts to apply less generic and more client and culturally supportive treatment techniques. Counselors may use differing theoretical approaches to handle the therapeutic issues outlined in the following sections, but whatever theoretical model and techniques are used, they should be implemented with the issues uniquely related to the female adolescent clearly in mind.

Belonging

When working with female adolescents who are depressed, a critical therapeutic issue is the extent to which they experience a sense of belonging with peers. Sense of belonging

refers to the internal experience of feeling that one is personally included as an important part of one's environment (Hagerty & Patusky, 1995). The negative interactions, conflict with peers, and rejection from peer groups associated with depressive symptomatology in female adolescents (Owens et al., 2000) interfere with the connectedness of interpersonal relationships, which are far more critical to girls' sense of self than they are to boys' (Eder, 1985; Nada Raja, McGee, & Stanton, 1992). These needs are particularly salient in the development of girls during this adolescent period when they are seeking a sense of self and a sense of belonging with peers.

Specific research focusing on the association between a sense of belonging and depression in female adolescents has only recently begun to be empirically examined, but there is support for emphasizing the sense of belonging when working with young girls who are depressed (Hagerty & Williams, 1999). The strong relationship between female self-esteem and relationships with peers should direct counselors to explore adolescents' experience of friendships, sense of belonging with peers, and how these issues may be contributing to current difficulties and the sense of self. Helping young girls identify feelings they have about themselves in relation to current friendships, friendships they would like to have, and conflicts with peers should help clarify the extent to which connectedness to peers is affecting current problems and the sense of self.

Cognitive-behavioral treatment approaches are commonly used for treating adolescent depression (Harrington, Whittaker, & Shoebridge, 1998) and related cognitive distortions that can accompany anxieties about friendships. Cognitive distortions, such as "I will be the biggest nerd in the whole school if she doesn't invite me to her party," are regularly heard when working with adolescent girls, and successfully challenging the validity of these may alleviate some anxiety and help them to see their situation from a more productive perspective. Journal writing that facilitates dialogue with female adolescents about their thought processes may be useful in helping them uncover connections between their thoughts and current depressives symptomatology. Teaching relaxation and coping skills are other cognitive-behavioral approaches that may also be key in helping to ease anxieties and raise self-esteem. If they are able to experience the success of effectively coping with and gaining a more productive view of their friendships, young women should be able to develop more confidence in their ability to tackle other problems in life.

Social Isolation

The internal sense of belonging is closely related to the more external events that produce social isolation. These are the negative interactions and conflicts with peers that are common among female adolescents and that often lead to a form of ostracism from peers. Female adolescents routinely encounter current forms of negative interactions known as *relational aggression*, which are characterized by behaviors such as spreading fabricated rumors about someone and threatening to exclude or excluding someone from a social group (Brown, Way, & Duff, 1999). These relational forms of aggression involve more social isolation than the direct forms of aggression common to male adolescents (Olweus, 1991). One study found that adolescent girls were particularly isolated from peers because of appearance, gender-typed role, or psychological maturity that was unacceptable to peers and that the additional failure to conform to the accepted norm only exacerbated their isolation (Evans & Eder, 1993). The impact of relational aggression on female adolescents can be seen as higher rates of depression in comparison with peers who had not been victimized (Crick & Grotpeter, 1995).

As is the case with other factors related to female adolescent depression, the research focusing on the link between social isolation and depression among female adolescents is not extensive; yet, given the nature of conflicts among girls at this age, social isolation is likely to be another key therapeutic issue. Young girls who are depressed may benefit from exploring possible connections between their depression and conflicting feelings about interactions with other female peers, typical exchanges with girls, and feelings about divisions within and among peer groups. Teaching girls how to interact assertively with peers may also help girls become less vulnerable to being socially isolated by relational aggression, because those who are most vulnerable to relational aggression typically lack assertiveness skills (Owens et al., 2000).

Interpersonal treatment approaches, originally designed for adults with depression, have now been modified to meet the specific needs and concerns of adolescents (Mufson & Moreau, 1997) and their social isolation issues. Modeling, teaching, and practicing social skills may be successful interpersonal techniques for counselors working with socially isolated young girls who are depressed. Role-plays and homework assignments that help female adolescents transfer new social approaches to other environments should support the development of the skills and self-confidence they need to begin to form new connections with peers.

Neediness

The strong desire to belong and the specific threat of social isolation for adolescent girls create greater fear of the loneliness that can accompany threats of ostracism from peers. These fears are heightened by the tendency to be hypersensitive to looks, actions, or words that may indicate someone does not like them. Such a combination of factors often leads to neediness that has been described as "feelings of loneliness and insecurity as well as a marked vulnerability to nonspecific experiences of loss, rejection, and abandonment" (Henrich et al., 2001, p. 50) and "intense fears and concerns about loss and rejection in general" (Henrich et al., 2001, p. 53). This neediness, accompanied by the threat of social isolation from peers who do not accept them, is intimidating for many young girls. They can become terrified of doing anything that may not be acceptable to their peers or might seek ways to gain acceptance that even they recognize as unhealthy in other

situations. Their need for acceptance from other female peers is often so significant that any threat of rejection has a tremendous impact on their moods.

Recently researchers have found a specific connection between intensity of depression and the level of neediness of female adolescents (Henrich et al., 2001). The degree of neediness is therefore likely to be another key therapeutic issue for working with female adolescents who are depressed. The level of neediness should therefore be considered along with the fears about loss and rejection in order to understand and deal with the differences in client reactions to treatment.

Counselors can help female adolescents identify and explore their fears and the possibilities of what will happen should those fears become reality. Many adults try to help female adolescents overcome these fears by suggesting that they will never come to fruition or that, if they do, it will not be the end of the world for them. The result can be a devaluing of these fears that makes it even more critical for counselors to accept and empathize with the intensity of these needs and fears that are a real part of the female adolescent experience. Girls may also benefit from critically examining what they will do if they are indeed rejected by their peers or if they lose someone in their lives. Identifying, exploring, and practicing coping methods are helpful in reducing the associated stress and anxiety that often accompany such fears.

Feminist treatment approaches have been used in the treatment of female adolescent depression (Sands, 1998) to help clients identify and differentiate societal prescribed gender role behaviors from clinical manifestations of depression. Discussing the positive and negative impact and the changes the female adolescent would like to make to gender-specific messages from peers about young women are treatment techniques that may be useful. These techniques could help female adolescents clarify what it is they need from peers and what they can provide for themselves.

Biological and Medication Issues

Mental health professionals and the public often emphasize the biological aspects of depression that can be treated with medication. Biological markers for depression in adults have been identified and antidepressants have provided many adults with significant relief from depressive symptomatology, but studies have not found similar biological correlates in adolescents who are depressed (Mueller & Ovraschel, 1997). The potential therapeutic effects of antidepressants on adolescents have been explored, but poor research design and the failure to demonstrate efficacy have been cited as significant limitations to these studies (Mufson et al., 1999). The relative failure of psychopharmacological treatments for adolescent depression, in light of significant success rates for adults, has been attributed to developmental differences in the central nervous system, hormones, and the biological correlates that distinguish adolescent from adult depression (Mueller & Orvaschel, 1997).

Psychiatrists typically only attempt psychopharmacological treatment for adolescent depression when other psychological interventions have failed because such treatments have not proved to be particularly efficacious (Moreau, 1996). Counselors working with young girls who are depressed should remain cognizant of the strong hormonal fluctuations that occur at this age. Helping female adolescents compare their depressive symptomatology with biological changes may highlight the role of their hormones in intensifying symptoms of depression. If connections are made between biological changes and increases in depressive symptoms, counselors may want to help young girls identify and explore different avenues for coping with these changes such as getting more rest, making changes in diet, or taking some time out for relaxing activities.

Further biological investigations into the etiology of depression for female adolescents are needed. These investigations could highlight different biological markers or contributors to adolescent depression, which may result in the development of psychopharmacological treatments that might complement psychological interventions. Additional research should result in much needed information that can assist counselors in the development of more responsible and sound treatments for female adolescents.

NEXT STEPS IN RESEARCH AND PRACTICE

Despite evidence of significantly higher rates of depression among girls during adolescence, an appropriately solid line of research investigating this situation from a developmental perspective is lacking (Culbertson, 1997). The available literature offers some common themes while also revealing conflicting opinions on what may be responsible for the weaknesses in this area of research. The current situation, however, is that little research has focused on investigating possible relationships between unique developmental factors and female adolescent depression. Empirical investigations addressing the unique treatment needs of adolescents are also lacking (Mufson et al., 1994). These gaps in the research create difficulty for counselors who seek to understand the experience of depression in young girls and develop modalities to best meet the needs of these particular clients. A reorganized commitment to research is needed to sort through the inconsistencies and gaps of knowledge regarding prevention, detection, and treatment of depression and other related mental health issues for female adolescents.

Understanding what variables contribute to the onset of significant gender differences in depression during adolescence needs to be the first research step toward better prevention, detection, and treatment of this disorder among young girls. Investigations on the developmental aspects of these factors are needed to acquire valuable information about the etiology and experience of depression for female adolescents. Information on biological contributions to female adolescent depression has been inconsistent, and additional studies could help clarify these discrepancies. Future research should also investigate the social challenges experienced at this age to delineate what role they may be playing in the onset of depression for female adolescents. Studies with a larger number of participants that examine developmental, biological, and

social variables in combination are also needed. Qualitative investigations with female adolescents may prove useful in understanding the experience of depression from their perspective without limiting their responses through inflexible survey formats or rigid instrumentation. The combination of such investigations will likely lead to other significant variables not yet considered by researchers.

Research should also focus on developing treatment techniques that best meet the unique needs of young girls struggling with depression. Investigations of this type should include the help of practitioners in the field who often have a keen sense of this population's clinical needs. Much of the current literature emphasizes clinical knowledge and theory, which lend themselves to research into both the etiology of teenage depression and the impact of specific therapeutic techniques. The vast body of experience these human resources possess needs to be effectively used.

Given the significant rates of depression among female adolescents and the threat it poses to their immediate well-being and future, a solid commitment to research in this area seems clearly warranted. Counselors working with young girls need to better understand the different variables that contribute to their depression and how to best meet their unique treatment needs. This review has highlighted several areas in need of empirical attention as well as some key clinical issues, which may be of value to counselors and young girls attempting to navigate the depression experience together.

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Help-Seeking and Counseling Within a Traditional Male Gender Role: An Examination From a Multicultural Perspective

John McCarthy and Ebony L. Holliday

A traditional male gender role reflects an affirmation of masculine identity associated with such qualities as success and self-reliance. This gender role is examined from a diversity perspective in counseling, because it may affect many men's help-seeking attitudes and behaviors. Suggestions from the literature are reviewed from the standpoint of the Multicultural Counseling Competencies (P. Arredondo et al., 1996). The counseling profession would benefit from greater sensitivity in aiding men endorsing this role.

Criticizing the current practice of counseling and psychotherapy for the limitations based in its Eurocentric construction, Ivey (1993) maintained that the counseling system must be modified to better serve various clientele. His contention was that the "values and beliefs of such cultures as African-American, Asian-American, Latina/os, and Native American Indians, and those of women can change and enrich our practice in a reconstructed view of the helping process" (Ivey, 1993, p. 225). Without change, he maintained that counseling psychology will disappear.

The creation of the Multicultural Counseling Competencies (Arredondo et al., 1996) by the Professional Standards and Certification Committee of the Association for Multicultural Counseling and Development of the American Counseling Association is one vital way that the counseling profession has responded to the need for cultural sensitivity, consideration, and ability on the part of professionals within it. The Competencies are geared toward work with racial and ethnic groups, and the introduction to the Competencies makes a clear differentiation between "multicultural" and "diversity." The latter includes the culture of "gender," and it is in this spirit that we apply points from the Competencies to counseling within a traditional male gender role. As discussed by Pleck (1976, 1981) and in David and Brannon (1976), this male gender role reflects an affirmation or validation of masculine identity around qualities such as success, self-reliance, and aggressiveness, among others.

This article summarizes the literature on counseling men in a manner that is meant to be both gender-consistent and gender-sensitive. One primary challenge in this discussion is that a segment of the literature speaks of men in broad terms; no other cultural descriptors are added. On the other hand, a portion of the literature is truly more specific and examines subcultures within masculinity and male identity (Levant, 1996, 1997; Philpot, Brooks, Lusterman, & Nutt, 1997; Wade, 1998) or other cultures, including racial background and ethnicity (Bell, 1996; Lazur & Majors, 1995; Thorn & Sarata, 1998), sexual orientation (Schwartzberg & Rosenberg, 1998), age (Simon, 1996), and socioeconomic status (Jolliff & Horne, 1996), all of which can have significant influence on men's multicultural identity as well as their positions of power in society.

No doubt these cultures, and others, offer varying influences on men's identity, thoughts, and actions. In this article, it is not our intention to imply that all men are traditional or that all men should be counseled in the same manner. Just as a book chapter on counseling Asian Americans, for instance, would not suggest that all individuals of Asian American descent be approached the same way in counseling, we would certainly not claim that all traditional men be seen identically by counselors. Such a statement would negate or minimize the influence of other cultures of a person. (Throughout this article, *traditional men* refers to men of a traditional male gender role.) Rather, our approach is to examine the culture of traditional masculinity alone and how this personal aspect may affect a client in his help-seeking process and counseling.

As a result, it is easy to assume that in speaking of men a segment of the literature is inherently addressing individuals of European American descent who are of middle- to upper-middle-class socioeconomic backgrounds and are heterosexual. This is also a group that has traditionally held substantial economic, political, and educational power in American society, a fact that the Competencies also acknowledge (Arredondo et al., 1996). The experiences, social

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statuses, and worldviews of men in these cultures are often vastly different from those of men of other corresponding cultures (e.g., men of lower socioeconomic status, men of African American descent, men whose sexual orientations are gay). That is, the psychology of men can cross multiple cultures. Therefore it is important to note that men can be seen as both dominant and nondominant as well as oppressors and oppressed. Furthermore, because some of the literature fails to involve other cultures and subcultures in its discussion of men, it is assumed that it is addressing men who adopt dominant norms and traditional ideologies of masculinity.

In addressing the counseling needs of adult male clients, it is noteworthy that the current mental health system, created predominantly by men, has not examined its services to them more thoroughly. Brooks and Good (2001) discussed the necessity to treat gender (and more specifically, men) as a unique culture to be understood. With more men seeking psychological help than previously (Betcher & Pollack, 1993; Freiberg & Sleek, 1999), the need to address this issue has become imperative. Jolliff and Horne (1996) pointed out an interesting paradox: In examining the low usage of mental health services by individuals "who ethnically and culturally differ from European ancestry" (p. 56), the counseling service is often blamed. However, when it comes to the similar low usage of mental health services by men, the tendency has been to criticize them for not being open to such services instead of examining how the mental health system can become more relevant to them. Historically, as Scher, Stevens, Good, and Eichenfield (1987) noted, "psychotherapy is a feminine endeavor practiced by men, usually on women" (p. 28), and Greatrex (1997) believed that many of the "rules of treatment" concerning issues such as missed appointments, payment, and termination were also created by men (p. 270).

First, a brief review of the research on men's approach to help seeking is offered to enhance professionals' understanding of the mind-set brought into counseling sessions by clients. Second, suggestions rendered by the literature are outlined, and connections to the Competencies are drawn. Finally conclusions on the counseling of men are offered. Again, it must be noted at the outset that the generalizations used throughout this article in no way imply that all men are alike. After all, "there is no single male experience" (Philpot et al., 1997, p. 98). Rather, the cultures and socialization influence many men in their development and perception of the world.

ATTITUDE TOWARD HELP-SEEKING AND HELP-SEEKING BEHAVIOR

The attitude toward help-seeking and actual help-seeking behavior can be a central aspect of the change process, particularly when understanding the mind-set that people have regarding counseling. Research (Fischer & Farina, 1995; Fischer & Turner, 1970; Fischer, Winer, & Abramowitz, 1983) has been devoted to these topics over the past three decades. Although, in general, professional help is usually not sought for psychological concerns (Tijhuis, Peters, & Foets, 1990; Wills, 1983), women tend to use the mental health system more often than men. About two thirds of all clients seeking psychological services are women. Furthermore, it has been estimated that 1 in 3 women seek help from a mental health professional at some point in their lives, whereas only 1 in 7 men do the same (Collier, 1982). Robertson (2001) also found that women sought counseling at higher rates than men, although men had similar if not higher rates of distress than women. This gender difference is even evident among counselors themselves, because female professionals attend counseling at significantly higher rates than their male colleagues (Neukrug & Williams, 1993).

Researchers have attempted to explain this discrepancy in a variety of ways. One theory points to male gender role socialization, about which Robertson (2001) further explained, "Traditional counseling requires men to set aside much of their masculine socialization simply to get through the door and ask for help" (p. 148). All in all, it seems that not only do some men struggle to find counseling and/or psychotherapy effective, but they also have difficulty in even initiating the help-seeking process.

The challenges for mental health professionals are clear and often start with the issue of negative social messages that many men, both traditional and nontraditional, receive for seeking help in the first place. O'Neil's (1981) survey of the literature prompted a set of propositions about the "masculine mystique," one of which suggested that men's seeking help and support signified weakness, vulnerability, and potential incompetence.

Good, Dell, and Mintz (1989) proposed that adherence to the traditional male gender role may be a source of hesitation in using mental health services and, subsequently, found a significant relationship between elements of the male gender role and men's help-seeking attitudes and behaviors. The authors concluded, "As men's values regarding the male role became less traditional, their views of psychological help seeking became more positive" (p. 299).

Masculine role conflict, as discussed by Good and Sherrod (2001), referred to the amount of strain that men encounter in their attempts to live up to the standards set by society. This distress experienced by men may lead to restriction of emotion and other problematic behavior. Robertson and Fitzgerald's (1992) work reiterated the negative correlation between traditional masculine attitudes and the willingness to seek help. Men scoring high on gender role conflict indicated that they had more negative views of psychological help-seeking after watching an emotion-focused videotape than other men high in gender role conflict who watched a cognition-focused videotape (Wisch, Mahalik, Hayes, & Nutt, 1995).

Furthermore, Robertson (2001) commented on various research that connected male socialization with a reluctance to seek psychological help. He speculated that, in a traditional counseling environment, men may be less independent, less successful, and less in control. It then seems reasonable to conclude that rather than trying to change the individual to fit the environment, it might be more effective to alter the environment to fit the person. According to Roberston,

> If counseling does not require men to set aside their sense of independence, their comfort with goals, tasks, and activities, or their preference of developing an understanding of a situation, then the idea of seeking help may be more appealing. (p. 156)

Finally, male gender role conflict has been found to be related to men's experience of depression (Good & Wood, 1995). Although many studies have found higher rates of depression for women compared with men, Cochran (2001) argued to the contrary. He referenced studies in which rates of depression for men were found to be at least equal to rates for women, and some studies in which the rates of depression for men actually exceeded those for women. Depression in men could be underdiagnosed because of "our culturally derived definitions of depression" (Cochran, 2001, p. 232). Furthermore, according to Good and Sherrod (2001), men may experience depression in ways that may not be in line with the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association, 1994). Cochran (2001) added to this idea, as he noted that the "male experience of depression" can often include "alcohol- and drug-related comorbidity, behaviors characterized as compulsive and antisocial, and increases in interpersonal conflict such as anger, withdrawal, and defensive assertions of autonomy" (p. 233).

The age of men may be another factor in their choice of the helper. In their survey of the public's knowledge about mental health professionals, Murstein and Fontaine (1993) discovered that younger men were more comfortable than younger women with psychiatrists and the clergy, whereas older women were more comfortable than older men with psychiatric nurses, marriage counselors, and psychologists. One possibility arising from this finding is that, when seeking assistance, younger men feel more at ease with what are considered more "masculine" helping professions (Murstein & Fontaine, 1993). In this case, men may be averse to the current helping structure.

Borrowing from Holland's (1985) career counseling theory of a person–environment fit, Skovholt (1993) maintained that counseling is an "S (Social)-type activity" (p. 8). Many more traditional men, however, are of a predominantly "R (Realistic)-type" (p. 9; technical, mechanical interests) who would not fit as well with the counseling system. His conclusion is one that does not bode well for the match between men and the current system: "Many males are of a personality type that may make traditional counseling/therapy an aversive rather than a supportive process" (p. 9). Regarding those individuals, however, who do seek counseling, the literature offers some recommendations to professionals on how to best work with traditional men.

THE COUNSELING PROCESS: SUGGESTIONS FOR TREATMENT

Several ideas and suggestions for working with men whose masculinity is traditional are offered in the literature. The following section summarizes a number of them along various themes.

Use Role Induction

This idea has clear connections to the process by which clients are prepared to enter and undertake counseling (Beutler & Clarkin, 1990; Beutler & Harwood, 1995). The Competencies maintain that culturally skilled counselors are able to identify the role that gender, among other cultures, has played in personality formation. In his article on reluctant men, Shay (1996) encouraged professionals to be sociologists first by getting a clearer picture of male culture, then to become an anthropologist by immersing themselves in the world of the male. Serving "as an ambassador" from the world of counseling, professionals offer a gradual and safe invitation to counseling and therapy through communication and exposure (pp. 511–512). If clearer expectations are provided on entering the counseling culture, fewer misunderstandings may take place, thereby enhancing continuance and decreasing premature termination. With traditional men who are highly resistant, a part of the "hard sell" of the therapeutic process may also involve a direct challenge to their defenses and resistances and offering longer term predictions about them (Brooks, 1998, p. 73).

Interpersonal theory is another approach that may be considered in counseling men. Hills, Carlstrom, and Evanow (2001) defined this orientation as a behavioral guide to "the very predicable actions and reactions among people" (p. 132). When the Interpersonal Circle is used to conceptualize interactional behaviors of traditional men, they are commonly described as presenting interpersonal relationship traits from the dominant and hostile quadrant. Such individuals can be characterized as rigid in their actions with others, reserved with their emotions, and reluctant to seek help from other individuals. This has clear implications for the success of a professional helping relationship with men (Mahalik, 2001b). Robertson (2001) suggested that, when working with college men, counseling professionals should acknowledge their clients' decision to seek help as a strength rather than regarding this as a personal defeat. This may assist in decreasing shame, embarrassment, and/or hesitancy that men may experience as a result of seeking help (Courtenay, 2001).

Understand One's Stereotypes and How They May Enter Into Counseling

The Competencies are specific in addressing stereotyping, as the guidelines prompt culturally skilled counselors to understand how their cultural heritage influences their perceptions and the counseling process. According to the Competencies, "Culturally skilled counselors possess knowledge and understanding about how . . . stereotyping . . . affect[s] them personally and in their work" (Arredondo et al., 1996, p. 59). This is not to suggest that mental health practitioners should believe that troubled men are incapable of harming others, but rather the Competencies encourage clinicians to be cognizant of unfounded negative beliefs that may interfere with treatment.

Such stereotyping mentioned in the Competencies may include perceptions centered on differences in communication. The clinical experiences of Nahon and Lander (1992) serve as a primary example in which professionals examined their biases, listened to male clients, and, as a result, experienced rewards in their work. In their group counseling program for men who had recently experienced a marital separation, the

female clinicians found that initial interventions failed. The men expressed resentment and resistance, and the authors came to the realization that they had "fallen prey to a possible 'feminization' or at least 'personalization' of the gender role reevaluation process" (p. 409), meaning that their original treatment design was inconsistent with the traditional male culture. A redesigning of one component that included group brainstorming was much more successful, and, according to the authors, more consistent with male thinking patterns. With the use of different strategies, premature termination rates dropped below 10%.

Counseling and therapy groups specifically for men have proven to be quite beneficial for men. The group atmosphere allows men to improve on their communication skills by presenting opportunities for them to share with others and also assists them in establishing emotional connections with others (Robertson, 2001). These types of groups are based on the unique type of support and encouragement that men can offer one another (Rabinowitz, 2001).

Consider Positive and Negative Perceptions of Cultural Groups

Considering the positive and negative perceptions that people have of cultural groups is also relevant to the section within the Competencies on the need for counselors to be aware of both positive and negative emotional reactions toward other cultural groups. As Arredondo et al. (1996) pointed out, "They [culturally skilled counselors] are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion" (p. 62).

One way to change the negative perception that mental health professionals have of men would be to eradicate the pathology model professionals sometimes use to describe male clients. Once again, this is not to say that practitioners should ignore the violence and harm that some men do. Kelly and Hall (1992) encouraged the adoption of a positive, developmental framework in counseling men, including the assumptions that men are in need of developing dormant strengths and abilities and that counselors must affirm men's assets.

Their masculinity itself provides men with several important and valuable strengths both in and out of counseling sessions, many of which may not be validated by professionals. Levant and Kopecky (1995) outlined such qualities, which include showing love to others through favors and gifts; enduring difficulties for the sake of loved ones; and putting aside one's own needs in providing for others. One way for counselors to uncover such strengths is through empathy, particularly with traditional male clients, for it may be difficult for these men to comprehend or honor their assets (Brooks, 1998).

What We Call It and How We Do It Matters

Offering effective cross-cultural counseling and psychotherapy implies that culturally consistent and sensitive interventions are being used. In the case of work with men, one must particularly bear in mind that names and labels can affect perceptions. As a result, perhaps the descriptors of "counseling" and "psychotherapy" should be modified. Robertson and Fitzgerald (1992) suggested that simply by changing the name of services, men with more masculine attitudes may take advantage of them more freely. Rather than "personal counseling," they suggested "classes," "workshops," and "seminars" as potential name substitutes.

In choosing the proper modality with reluctant men, the ideal setting is one that maximizes comfort and minimizes shame and exposure (Shay, 1996). Brooks (1998) suggested the following "sequence of change": (a) a positive initial therapeutic experience with a clinician in which hope is offered regarding the client's challenges; (b) a segment exposing the man to other men, often through involvement in a men's group, weekend retreats/conferences for men, or reading books on men's issues; (c) marital or family therapy, which can enhance men's interpersonal functioning in relationships; and (d) social activism so that men may "join efforts to change cultural institutions that restrict men's lives, or that harm women and children" (pp. 76–77). With men who experience gender role strain and who show rigid defenses, therapists may assist them in identifying and confronting the resulting anxiety and help them to develop appropriate coping skills (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998).

One of Shay's (1996) treatment principles—"Forget that you're doing therapy" (p. 508)—contends that a professional should understand that a man may enter therapy for any reason but to enter therapy; that is, they may have alternative goals. With an individual who is legally mandated to see a counselor, a male client may want to appease the court system or placate a partner but not explore issues. In such cases, Shay suggested that professionals might try too hard in the counseling process, a tendency that is counterproductive. By taking less conventional approaches, the therapeutic alliance is sometimes forged in a more concrete manner from the start. In asking professionals to think back to previous encounters with reluctant men, he wondered, "Isn't it true that you've often spoken in great detail about the nature of their business interactions, about the movies they've seen, about the sporting events they watch" (p. 508), a route by which men are encouraged to be more open and offer more about themselves.

Fit the Strategy

Clearly, no intervention is guaranteed to work for every client of a single culture. In offering possible strategies in gender-sensitive therapy, the only invariable items are a sufficient knowledge base and an understanding of the socialization of the genders (Philpot et al., 1997). In choosing strategies for men, consider how the change-enhancing component fits with the male culture. Yet, before delivering the intervention, it is important for professionals to assess whether "the male dialect" is being spoken by the client. Shay (1996) claimed that this dialect is not one that fits the typical counseling session, for "[it] is typically not the emotion-speak or the insight-speak that we [psychotherapists] tend to specialize in" (p. 507). Shapiro (2001) commented that many times therapists "fail to speak the same language as [their] male clients" (p. 404).

He further suggested that careful attention needs to be given to the indirect communication of male clients.

Much has been written on *alexithymia* (Levant, 1998; Mooney, 1998; Potash, 1998), the literal meaning of which is "the inability to put emotions into words" (Levant, 1998, p. 35), and its effect on the male emotion socialization process as well as the therapeutic process. Levant (1998) outlined a five-step treatment process for this, suggesting that it may work best for those men who are motivated to comply with treatment. In addition, Mahalik (2001a) identified cognitive therapy as being beneficial for those men experiencing alexithymia because "its focus on the importance of thoughts is likely to feel more congruent for men who conform to traditional gender roles regarding emotional expression" (p. 544).

Heesacker and Prichard (1992) suggested the use of biblio-, audio-, and videotherapy and encouraged listening to stories—things they admitted they were admonished for in their own training—as they relate to mythical themes. Bibliotherapy has been found to be a helpful tool to assist in educating men about various issues related to gender (Johnson, 2001). Moreover, other suggestions by Johnson include telling stories, using journals, and relating to metaphors.

Furthermore, closer attention should be paid to silence, because some men may need to "brood" before verbalizing emotions. Finally, Heesacker and Prichard (1992) encouraged men to "observe their actions . . . as a way of being in touch with their emotions" instead of counselors "shaming" men about their actions (p. 286). According to the authors, this process turns into a collaboration through which therapists can help clients to uncover the meanings of and the various emotions rooted in their actions. Brooks (1998) viewed silence as more appropriate in the middle stages of therapy, because it can be an aid in confrontation with traditional men. Silence, according to him, signifies that the responsibility for psychotherapeutic work is the client's, not the therapist's.

CONCLUSION

Several points raised by the recent literature are strikingly consistent with the Competencies (Arredondo et al., 1996). The profession is committed to understanding how counselors' perceptions of various cultures affect the conceptualization of presenting problems as well as subsequent treatment of clients. Furthermore, although the Competencies claim that "culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups" (Arredondo et al., 1996, p. 66), it would behoove counselors to do the same for other cultures, including the gender of masculinity. Researchers may also consider more studies in this area.

As counselors become increasingly sensitive to multicultural considerations, the culture of genders must be included for the male segment of the population to be better served. With traditional men being socialized to be independent, it not surprising that they have sought the services of mental health professionals less often than women do. In treating men, recent writers have emphasized the need for counselors' flexibility (Nahon & Lander, 1992) and gender sensitivity (Brooks & Good, 2001) as well as the importance of learning from their male clients in the counseling process. Furthermore, recognizing and applying strengths that men bring to counseling can be integral. Finally, using various techniques that fit the cultures of traditional men should also be considered.

By understanding traditional men as well as male socialization and its effects on the help-seeking behavior and attitudes of men, our profession can better meet the needs of traditional men. The relatively recent increased interest in men's issues has occured in part because of using "a new lens to examine men's lives" (Skovholt, 1993, p. 1), and the call has come from some mental health professionals to empirically investigate the ideas of treatment of traditional men (Freiberg & Sleek, 1999). Admittedly, the study of men and masculinity is in its early stages, as Pollack and Levant (1998) have reminded professionals. As the field develops further, the mental health system will no doubt benefit from looking at its understanding of men's help seeking and treatment from a cross-cultural and multicultural perspective as well as from its influence in the transformation of traditional men.

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Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors

Robyn L. Trippany, Victoria E. White Kress, and S. Allen Wilcoxon

Counselors in all settings work with clients who are survivors of trauma. Vicarious trauma, or counselors developing trauma reactions secondary to exposure to clients' traumatic experiences, is not uncommon. The purpose of this article is to describe vicarious trauma and summarize the recent research literature related to this construct. The Constructivist Self-Development Theory (CSDT) is applied to vicarious trauma, and the implications CSDT has for counselors in preventing and managing vicarious trauma are explored.

Counselors in virtually all settings work with clients who are survivors of trauma. Trauma can generally be defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 2000). Client traumas frequently encountered in clinical practice include childhood sexual abuse; physical or sexual assault; natural disasters, such as earthquakes or tornadoes; domestic violence; and school and work-related violence (James & Gilliland, 2001). Many American counselors have recently been faced with a new population of traumatized clients secondary to the recent terrorist attacks on the United States. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Clients' reactions to traumas are typically intense fear, helplessness, or horror. As a result of the trauma, the person may experience severe anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 2000).

Counselors' reactions to client traumas have historically been characterized as forms of either burnout or countertransference (Figley, 1995). More recently, the term *vicarious trauma* (VT; McCann & Pearlman, 1990) has been used to describe counselors' trauma reactions that are secondary to their exposure to clients' traumatic experiences. The construct of VT provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors' VT reactions.

VT has been referred to as involving "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995b, p. 152). These changes involve disruptions in the cognitive schemas of counselors' identity, memory system, and belief system. VT has been conceptualized as being exacerbated by, and perhaps even rooted in, the open engagement of empathy, or the connection, with the client that is inherent in counseling relationships (Pearlman & Saakvitne, 1995b). VT reflects exposure of counselors to clients' traumatic material and encompasses the subsequent cognitive disruptions experienced by counselors (Figley, 1995; McCann & Pearlman, 1990). These repeated exposures to clients' traumatic experiences could cause a shift in the way that trauma counselors perceive themselves, others, and the world. These shifts in the cognitive schemas of counselors can have devastating effects on their personal and professional lives. By listening to explicit details of clients' traumatic experiences during counseling sessions, counselors become witness to the traumatic realties that many clients experience (Pearlman & Mac Ian, 1995), and this exposure can lead to a transformation within the psychological functioning of counselors.

This article describes VT and how it differs from counselor burnout and countertransference. In addition, this article applies the Constructivist Self-Development Theory (CSDT) to VT, and discusses the implications CSDT has for preventing and managing counselor VT.

VT, BURNOUT, AND COUNTERTRANSFERENCE

Previously, in the professional literature, the term VT was not used; such trauma was referred to as being either a form of burnout or a countertransference reaction (Figley, 1995; McCann & Pearlman, 1990). Recently, differences among the concepts of burnout, countertransference, and VT have been identified. There are several significant differences between burnout and VT. Burnout is described more as a result of the general psychological stress of working with difficult clients

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(Figley, 1995) versus VT, which is seen as a traumatic reaction to specific client-presented information. Also, vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout may occur in persons in any profession (McCann & Pearlman, 1990). VT and burnout also differ in that burnout is related to a feeling of being overloaded secondary to client problems of chronicity and complexity, whereas VT reactions are related to specific client traumatic experiences. Thus, it is not the difficult population with which the counselor works, but rather the traumatic history of a traumatized population that contributes to VT. Burnout also progresses gradually as a result of emotional exhaustion, whereas VT often has a sudden and abrupt onset of symptoms that may not be detectable at an earlier stage. Finally, on a personal level, burnout does not lead to the changes in trust, feelings of control, issues of intimacy, esteem needs, safety concerns, and intrusive imagery that are foundational to VT (Rosenbloom, Pratt, & Pearlman, 1995). It is important to note that many counselors working with traumatized populations experience general burnout as well as VT.

Despite these contrasts, VT and burnout share similar characteristics. Both VT and burnout may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, and interpersonal problems. In addition, both VT and burnout are responsible for a decrease in concern and esteem for clients, which often leads to a decline in the quality of client care (Raquepaw & Miller, 1989).

Like the construct of burnout, countertransference is also distinct from VT. Countertransference refers to a counselor's emotional reaction to a client as a result of the counselor's personal life experiences (Figley, 1995). VT, however, is a direct reaction to traumatic client material and is not a reaction to past personal life experiences. The differences between countertransference and VT are not always distinct. Although VT may involve countertransference issues (e.g., the counselor being a trauma survivor), VT is not inherent in, nor does it equate to, countertransference (Figley, 1995). An additional difference between countertransference and VT is that countertransference is specific to the counselors' experiences during or around counseling sessions, whereas VT effects transcend the session, thus affecting all aspects of counselors' lives.

Countertransference and VT, although distinct in conceptualization, are related to one another. As a counselor experiences increasing levels of VT, the related disruptions in cognitive schemas become part of the counselor's unconscious personal material that may then result in countertransference reactions toward the client (Saakvitne & Pearlman, 1996). These differences among VT, countertransference, and burnout indicate that VT is a unique construct that is worthy of consideration apart from the concepts of burnout and countertransference. The management and prevention of burnout reactions and countertransference have been addressed in the literature (James & Gilliland, 2001), yet these issues are rarely addressed with regard to VT. Despite VT's apparent importance and uniqueness, there is a paucity of research and literature exploring ways in which counselors working with traumatized clients can prevent VT reactions from developing.

VT AND CSDT

As previously stated, VT has a unique progression. One theory that can be used to explain this progression is the CSDT (McCann & Pearlman, 1992; Pearlman & Saakvitne, 1995a). The premise of this theory is that individuals construct their realities through the development of cognitive schemas or perceptions, which facilitate their understanding of surrounding life experiences. CSDT supports the notion that changes in these cognitive schemas, or the perceived realities of counselors, occur as a result of interactions among clients' stories and counselors' personal characteristics (Saakvitne & Pearlman, 1996). In this self-development process, counselors are active in creating and structuring their individual perceptions and realities. CSDT "emphasizes the adaptive function of individual behavior and beliefs, and the individual's style of affect management" (Pearlman & Saakvitne, 1995a, p. 56), thus indicating that counselors' VT reactions to client-presented traumas are normal and adaptive.

CSDT further purports that human cognitive adaptation occurs in the context of interpersonal, intrapsychic, familial, cultural, and social frameworks. According to CSDT, counselor VT experiences are normal counselor adaptations to recurrent client-presented traumatic material. Essentially, CSDT proposes that irrational perceptions develop as self-protection against these emotionally traumatic experiences. In addition, CSDT suggests that the effects of these changes in counselors' cognitive schemas are pervasive (i.e., have the potential to affect every area of the counselor's life) and cumulative (i.e., potentially permanent because each traumatized client the counselor encounters reinforces these changes in cognitive schemas; McCann & Pearlman, 1990).

According to CSDT, there are five components of the self and how the self and one's perceptions of reality are developed: (a) frame of reference; (b) self-capacities; (c) ego resources; (d) psychological needs; and (e) cognitive schemas, memory, and perception (Pearlman & Saakvitne, 1995a). These CSDT components reflect the areas in which counselors' distorted beliefs and VT reactions occur. Saakvitne and Pearlman (1996) proposed that the interpersonal components of CSDT (i.e., frame of reference, self-capacities, ego resources, psychological needs, and memory system) are the most vulnerable to symptomatic adaptation (e.g., disruptions in previous belief systems as a result of clients' trauma material) in the emergence of VT in counselors.

In discussing the first component of CSDT, frame of reference, McCann and Pearlman (1990) wrote that "a meaningful frame of reference for experience is a fundamental human need" (p. 141). The frame of reference is generally defined as an individual's framework, or context, for understanding and viewing the self and the world (Pearlman & Saakvitne, 1995b).

The frame of reference encompasses one's identity, worldview, and belief system and is the foundation for viewing and understanding the world and self. It also involves cognitive processing of causality and attribution. Any disruptions in an established frame of reference can create disorientation for the counselor and potential difficulties in the therapeutic relationship. For example, in attempting to understand a client's pain, counselors discussing a traumatic event may conclude that the victim was actually to blame, an outcome that will likely revictimize the client. Such an outcome might be the result of the counselor's frame of reference not accommodating the possibility of a blameless victim.

Self-capacities, the second component of CSDT, are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p. 64). These self-capacities allow individuals to manage emotions, sustain positive feelings about themselves, and maintain relationships with others. Self-capacities are susceptible to disruptions when a counselor experiences VT and may result in counselors experiencing a loss of identity, interpersonal difficulties, difficulty controlling negative emotions or avoiding exposure to media that conveys the suffering of others, or feelings of being unable to meet the needs of significant others in their lives. The inability to tolerate negative emotions could have pronounced implications for counselors attempting to serve trauma survivors.

The third component of CSDT, ego resources, allows individuals to meet their psychological needs and relate to others interpersonally (Pearlman & Saakvitne, 1995a). Some of these resources include (a) ability to conceive consequences, (b) ability to set boundaries, and (c) ability to self-protect. Disruptions affecting these ego resources may promote symptoms such as perfectionism and overextension at work. Counselors may also experience an inability to be empathic with clients, a condition that poses a variety of practical and ethical dilemmas, particularly for services to trauma survivors.

The fourth and fifth components of CSDT are psychological needs and cognitive schemas. These include safety needs, trust needs, esteem needs, intimacy needs, and control needs. These needs reflect basic psychological needs of individuals, as well as how individuals process information related to these needs in developing their cognitive schemas about themselves and others (Pearlman & Saakvitne, 1995a). As discussed in this article, these psychological needs can be very helpful in understanding VT and how to prevent VT in counselors. A discussion of each of these aspects and their relationship to VT is reflected in the following sections.

Safety Needs

A sense of security is basic to safety needs. Counselors experiencing VT may feel there is no safe haven to protect them from real or imagined threats to personal safety. According to Pearlman (1995), higher levels of fearfulness, vulnerability, and concern may be ways in which this disruption in safety needs is manifested. Counselors experiencing VT may be overly cautious regarding their children or may feel an overwhelming need to take a self-defense course, install a home alarm system, or carry mace or a rape whistle for protection. The following segment of an interview with a counselor experiencing VT, after working with a sexual trauma survivor, illustrates this point with vivid clarity:

> I suddenly find myself more critical of the quality of locks in my home and replace them with better ones. The car door is always locked when I am driving. I am more careful with whom I speak in public. I find myself wondering why that guy is walking toward me and clutch my keys ready to strike out if I have to. I question the motives of others much more readily and never assume they mean no harm to me. (Astin, 1997, p. 106)

Trust Needs

According to CSDT, trust needs include self-trust and other trust. Trust needs reflect an individual's ability to trust her or his own perceptions and beliefs, as well as to trust others' ability to meet his or her emotional, psychological, and physical needs; in other words, trust needs refer to a form of attachment or a "healthy dependency" (Pearlman & Saakvitne, 1995a, p. 71). All people, according to CSDT, have a natural need to trust themselves and others.

A counselor's inherent trust needs make him or her vulnerable to VT. In other words, the exposure to repeated client trauma shakes the trusting foundations upon which the counselor's world rests. For example, a counselor may have a caseload of clients who were recently exposed to a terrorist act by a minority group and, hence, may have his or her trusting foundation shaken and may become suspicious of all minority group members. This suspiciousness may even transcend previously trustworthy relationships with minority group members. In addition, counselors experiencing VT are vulnerable to self-doubt and inhibited self-trust, often prompting them to question their ability to judge and intervene effectively with clients. Such trust difficulties frequently promote negative effects in relation to esteem needs.

Esteem Needs

The need for esteem is characterized by value for self and value for others (Pearlman, 1995). Counselors experiencing VT may feel inadequate and question their own abilities to help someone. Esteem for others can be compromised as counselors are faced with the ability of people to be cruel and for the world to be unfair.

Intimacy Needs

Intimacy needs are defined as "the need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995a, p. 62). Pearlman (1995) described consequences of disruptions in this area as feelings of emptiness when alone, difficulty enjoying time alone, an intense need to fill alone time, and avoidance and withdrawal from others. VT may cause a counselor to push away or become increasingly dependent on significant persons in his or her life.

Control Needs

Control needs are related to self-management; when schemas are disrupted regarding sense of control, the resulting beliefs and behaviors may be helplessness and/or overcontrol in other areas. "These beliefs lead to distress as we [counselors] question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world" (Pearlman & Saakvitne, 1995a, p. 292).

The memory system of each individual is basic to his or her perception of life. Pearlman and Saakvitne (1995a) identified five aspects of the memory system: (a) verbal memory (cognitive narrative), (b) imagery (pictures stored in the mind), (c) affect (emotions experienced), (d) bodily memory (physical sensations), and (e) interpersonal memory (resulting dynamics in current interpersonal relationships). With traumatic experiences, each aspect of memory can represent a fragment of a traumatic event. Without therapeutic integration of these aspects, the fragments interfere with one's awareness and perception. Therefore, through empathic engagement with the client, the counselor is vulnerable to experiencing VT and intrusion from clients' descriptions of memories.

These recollections can remain with the counselor long after the therapy session has ended, even to the point of introducing thoughts and images that involve the counselor having nightmares of being raped. Astin (1997) wrote that she would imagine a rapist coming toward her—much as the rapist had approached the victimized client. The author suggested that intrusive images are associated with normal perceptual processing for traumatic events but, due to the painful emotions involved, resist assimilation into memory as simple events to become actual mental representations. To combat these intrusive thoughts and images, the counselor may turn to numbing, avoidance, and denial. However, avoidance and numbing provide only temporary relief. Astin further suggested that these intrusive images need to be examined, rather than suppressed or overshadowed, to make them less painful and intrusive for the counselor.

PROFESSIONAL AND PERSONAL CONSEQUENCES OF VT

Constructivist self-development theory and recent research suggest that the experience of VT is significant for counselors on both a personal and professional level. A concern for the personal functioning of trauma counselors is the increased awareness of the reality and occurrence of traumatic events. This reality makes counselors more aware of their vulnerability. Safety and security are threatened when counselors become cognizant of the frequency of trauma, often resulting in a loss of feeling in control as a result of hearing clients' stories in which the control was taken from them. In addition, the helplessness of a counselor to change past trauma can challenge, or even shatter, the counselor's identity (Pearlman & Saakvitne, 1995b).

VT can also affect how counselors relate to their friends and family. Counselors affected by VT may be less emotionally accessible due to a decrease in access to emotions (Saakvitne & Pearlman, 1996). Intimacy with partners may become difficult as guilt and intrusive thoughts related to a client's abuse become present when engaging in intimacy. Counselors may also experience overwhelming grief, which may create a sense of alienation from others (Herman, 1992). Herman reported that counselors who worked with survivors of the Nazi Holocaust reported feeling "engulfed in anguish" or "sinking into despair" (p. 144). Finally, the counselor may experience changes in esteem for self and others (Saakvitne & Pearlman, 1996).

The impact of VT on counselors, if unacknowledged, can present ethical concerns (Saakvitne & Pearlman, 1996). The potential for clinical error and therapeutic impasse increases as the vulnerability that counselors experience increases. The disruptions in cognitive schemas may lead to counselors compromising therapeutic boundaries (e.g., forgotten appointments, unreturned phone calls, inappropriate contact, abandonment, and sexual or emotional abuse of clients). Counselors may feel anger toward their clients when they have not complied with some idealized response to therapy (Herman, 1992). Counselors may begin doubting their skill and knowledge and potentially lose focus on clients' strengths and resources (Herman, 1992). In addition, counselors may avoid discussion of traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the client's abuse or pushing to identify or confront perpetrators before the client is ready (Munroe, 1995).

Other hazards the client may be subjected to when the counselor is experiencing VT include irritability of the counselor, decreased ability to attend to external stimuli, misdiagnosis, and "rescuing" by the counselor (Munroe, 1995). In addition, the client may attempt to protect the counselor, which may create an ethical bind based on exploitation of the client. Any of these effects can be damaging to the client. Therefore, addressing the occurrence of VT is imperative for counselors.

IMPLICATIONS FOR COUNSELORS: PREVENTING VT

CSDT as applied to VT has numerous implications for counselors who work with traumatized clients and are thus at risk for VT. Being aware of the risk of VT and applying the CSDT model to one's experiences may prevent VT. More specifically, counselors can apply the CSDT model to their own experiences, thus preventing negative professional and personal consequences and encouraging self-care. The following sections describe ways that counselors can engage in the prevention of VT through self-care.

Caseload

Counselors who work primarily with trauma survivors experience a greater measure of VT than counselors with a general caseload who may see only a few trauma survivors (Brady, Guy, Poelstra, & Brokaw, 1997; Chrestman, 1995; Cunningham, 1999; Kassan-Adams, 1995; Pearlman & Mac Ian, 1993; Schauben & Frazier, 1995). Trippany, Wilcoxon, and Satcher (2003) found that sexual trauma counselors who reported

an average of 14 to 15 clients per week did not have statistically significant experiences of VT. This finding suggests that the management of counselors' caseloads through limiting the number of trauma clients per week may minimize the potential vicarious effects of working with traumatized clients. This implication is consistent with the research of Hellman, Morrison, and Abramowitz (1987), who reported that counselors indicated less work-related stress with a moderate number of clients on a weekly caseload than with a higher number of regularly scheduled clients.

Peer Supervision

Peer supervision groups serve as important resources for trauma counselors (Catherall, 1995). Sharing experiences of VT with other trauma counselors offers social support and normalization of VT experiences. This normalization lessens the impact of VT, which in turn amends cognitive distortions and helps counselors maintain objectivity. Other benefits include reconnecting with others and sharing potential coping resources (Catherall, 1995). Pearlman and Mac Ian (1993) found that 85% of trauma counselors reported discussion with colleagues as their most common method of dealing with VT. Peer supervision methods are helpful in providing trauma counselors with validation and support, in providing them with the opportunity to share new information related to therapeutic work, and in allowing them to vent their feelings (Oliveri & Waterman, 1993). Talking to colleagues about their experience in responding to trauma offers trauma workers support in dealing with aftereffects (Dyregrov & Mitchell, 1996). Peer supervision has also been found to decrease feelings of isolation and increase counselor objectivity, empathy, and compassion (Lyon, 1993).

Peer supervision offers several benefits to trauma counselors. First, consultation with colleagues provides an opportunity for counselors to examine their perspective, thus aiding in decreasing cognitive disruptions. Peer supervision also gives counselors an opportunity to debrief and express reactions regarding client stories (Catherall, 1995). Whereas limits of confidentiality prevent counselors from being able to debrief with support systems, peer supervision serves as a medium for counselors to debrief in an ethical manner. Furthermore, supervision helps alleviate issues of countertransference and traumatic reactions (Rosenbloom et al., 1995). "It is important for caregivers to have a variety of peer support resources to allow easy access to share with others the burden of bearing witness to traumatic events" (Yassen, 1995, p. 194). Discussion of therapeutic successes in formal peer supervision helps to reaffirm a counselor's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b).

Agency Responsibility

Agencies that employ counselors who provide services to clients with traumatic histories have a responsibility to help their clinicians decrease the effects or occurrence of VT (Pearlman & Saakvitne, 1995b). Formal measures of informed consent regarding risks of providing trauma counseling services can be used as a standard employment procedure when considering new counselors. In addition, professional development resources should be available for trauma counselors, including (a) opportunities for supervision, (b) consultation, (c) staffing, and (d) continuing education. Pearlman and Saakvitne (1995b) further suggested that provision of employee benefits could decrease the impact of VT, including (a) insurance for personal counseling, (b) paid vacations, and (c) limiting the number of trauma survivors on the counselor's caseload. In addition, Chrestman (1995) found empirical evidence suggesting that increased income correlated positively with a decrease in symptoms of psychological distress. Thus, pay raises may help trauma counselors acknowledge success as a counselor.

Education and Training

Training focused on "traumatology" is vital for trauma counselors and can decrease the impact of VT (Pearlman & Saakvitne, 1995b). In a study by Follette, Polusny, and Milbeck (1994), 96% of mental health professionals reported that education regarding sexual abuse was imperative to effective coping with difficult client cases. Chrestman (1995) also found empirical evidence that supported use of additional training to decrease the symptomatology of posttraumatic stress disorder in counselors working with trauma clients. Furthermore, Alpert and Paulson (1990) suggested that graduate programs for mental health professionals need to incorporate training regarding the impact of clients' childhood trauma and its effects on VT.

Personal Coping Mechanisms

The impact of VT can be decreased when counselors maintain a balance of work, play, and rest (Pearlman, 1995). This balance includes socializing with friends and family, being involved in creative activities, and being physically active. Participation in the aforementioned activities may aid in preserving a sense of personal identity. Because of their restorative nature, rest and leisure activities (e.g., taking vacations) are important in decreasing the effects of VT (Pearlman, 1995). Moreover, VT may affect counselors' ability to trust others; therefore, a strong social support network can help to prevent VT and may also help soothe VT reactions. In addition, participation in activities that increase counselors' personal tolerance level, including journaling, personal counseling, meditation, and obtaining emotional support from significant others, allows reconnection to emotions.

Spirituality

The damage of vicarious traumatization is often related to the counselor's sense of spirituality (Pearlman & Saakvitne, 1995a). The VT experience results in a loss of a sense of meaning and often fractures cognitive schemas and counselors' worldview. Without a sense of meaning, counselors may become cynical, nihilistic, withdrawn, emotionally numb,

hopeless, and outraged (Herman, 1992; Pearlman & Saakvitne, 1995a). "The defenses employed to protect oneself from knowledge of people's capacity for cruelty . . . have their own costs" (Pearlman & Saakvitne, 1995a, p. 288). These defenses, produced from changes in cognitive schemas regarding one's view of the world (i.e., the world is good; people are good), create a reorganization in the counselor's spirituality. As a result, the counselor may experience sorrow, confusion, and despair.

Research indicates that counselors with a "larger sense of meaning and connection" (Pearlman & Saakvitne, 1995b, p. 161) are less likely to experience VT. In a survey of trauma counselors, 44% reported that spirituality provided an effective coping mechanism in dealing with the effects of their work (Pearlman & Mac Ian, 1993). Finding meaning can help trauma counselors alleviate the impact of VT. Astin (1997) reported that working with rape victims has made her more aware of the potential for harm, thus making her more prudent. She wrote, "My rape clients have given me a gift without knowing it . . . I don't live in a fantasy world and I take active steps to reduce risk and vulnerability" (Astin, 1997, p. 107). In addition, Wittine (1995) suggested that counselors with a strong sense of spirituality are more likely to accept existential realities and their inability to change the occurrence of these realities. Wittine further suggested that counselors' acceptance of these existential realities allows them to be more present with their clients.

More specifically, counselors who are at risk for developing VT can use whatever source brings them a sense of spirituality. Organized religions, meditation, and volunteer work are just a few examples of activities that may facilitate a sense of spirituality. Ultimately, it is up to the individual counselor to determine how he or she will choose to develop his or her sense of spirituality.

CONCLUSION

Vicarious traumatization is a significant concern for counselors providing services to traumatized clients. Counselors' cognizance of potential changes in their beliefs about self, others, and the world may have a preventative function regarding VT. This awareness can aid counselors in protecting themselves against the consequential effects of helping those with traumatic histories. An awareness of personal reactions to VT may allow counselors to implement self-care strategies to ameliorate such effects, thus minimizing potential ethical and interpersonal difficulties.

In addition, it is important that supervisors and administrators overseeing counselors working with trauma survivors consider the impact that VT may have on counselors and take an active preventative role. Supervisors have a responsibility to use their knowledge about VT to prevent counselor VT and to facilitate counselor mental health through providing a supportive and VT-preventative environment. Encouraging peer support groups, educating counselors on the impact of client traumas on counselors, diversifying counselor caseloads, encouraging counselor respite and relaxation, and encouraging counselors' sense of spirituality and wellness are several means of providing support for at-risk counselors. Professional counselors have many strengths and resources that are used to help traumatized clients—applying these resources to themselves, as a means of preventing VT, will surely facilitate their own wellness.

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Solution-Focused Counseling and Motivational Interviewing: A Consideration of Confluence

Todd F. Lewis and Cynthia J. Osborn

Solution-focused counseling (SFC) and motivational interviewing (MI) have gained recognition over the past 2 decades. A review of the features of these counseling approaches is provided, as well as an examination of the similarities and differences on several dimensions of counseling. Attention is given to empirical research, and it is proposed that SFC and MI be considered concurrently, which appears consistent with calls in the literature for theoretical integration. A case study is included.

Over the past two decades, two counseling styles, solution-focused counseling (SFC) and motivational interviewing (MI), have gained recognition and increased in popularity. The appeal of these styles is that they offer a respectful approach to counseling and regard the cultivation and utilization of client resources (i.e., strengths, abilities, intrinsic motivation) as the keys to positive change. The tenets of SFC and MI are primarily rooted in person-centered counseling and might be considered reactions to, or the antitheses of, problem-focused types of therapy. They represent, therefore, paradigmatic shifts in how clients are conceptualized, the counseling process, the counselor's role, and client participation in counseling.

Although MI and SFC have emerged from different origins, they share many similarities. The focus of this article is to examine perspectives shared by SFC and MI, as well as to note what we consider to be some key differences. In keeping with Polansky's (1986) call for parsimony in theoretical formulations, and following the example of recent contributors to this journal who have each compared two related therapeutic approaches (viz., responsive therapy and motivational interviewing; Gerber & Basham, 1999; Adlerian therapy and solution-focused brief therapy; Watts & Pietrzak, 2000), we suggest a counseling posture wherein SFC and MI are appropriately intertwined and intentionally practiced in coexistence. Such confluence appears appropriate and consistent with numerous recommendations for theoretical integration (e.g., Norcross & Goldfried, 1992; Prochaska & Norcross, 1999).

UNIQUE FEATURES

SFC

SFC is an evolving counseling approach conceived and developed by de Shazer and colleagues (de Shazer, 1985, 1988, 1991; de Shazer et al., 1986; Molnar & de Shazer, 1987; Walter & Peller, 1992) in the early 1980s at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. It is often referred to as *solution-focused brief therapy* (i.e., a form of brief or short-term psychotherapy) in light of its emergence from the brief strategic therapy movement (Watzlawick, Weakland, & Fisch, 1974).

The solution-focused approach to counseling is considered an alternative to the problem-focused approaches that have prevailed in mental health clinical practice. Although its roots are in the work of hypnotherapist Milton Erickson and family systems theory, as well as in poststructural/postmodern or constructivist ideology (de Shazer, 1991, 1994; de Shazer & Berg, 1992), solution-focused counseling began taking shape as a reaction to the problem-resolving model espoused by therapists at the Mental Research Institute (MRI) in Palo Alto, California (Shoham, Rohrbaugh, & Patterson, 1995). Its impetus, therefore, was disenchantment with what was viewed as an interest in understanding how and why problems persist. A nonpathological, salutary, strengths- or competency-based approach to helping people was more attractive and appealing, one that Prochaska and Norcross (1999) regarded as "refreshing" (p. 440).

The foundation of SFC is the counselor's confidence in the client's ability to make positive changes in his or her life by accessing and using inner resources and strengths. The client is not provided with a blanket prescription for problem resolution nor, for that matter, told by the counselor that he or she needs to change (I. K. Berg, personal communication, November 30, 1995). Rather, the client often directs the therapeutic process (Berg & Miller, 1992) by voicing his or her preferences (Walter & Peller, 2000) and by determining the goals and outcome of therapy (de Shazer, 1990). In this regard, SFC has been characterized as "client-

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determined" (Berg & Miller, 1992, p. 7). Solutions are constructed by identifying and capitalizing on nonproblem occasions or "exceptions" to the presenting problem (de Shazer, 1988), rather than exploring and dissecting the problem. The client's strengths and competencies are fostered and then funneled toward the implementation of realistic and achievable behavioral objectives.

G. Miller (2001) regarded solution-focused brief therapy as "a radically new institutional discourse because it is based on different assumptions about social reality, new practical concerns about the therapy process, and new strategies for changing clients' lives" (p. 75). Primary assumptions include the notion that solutions are constructed rather than that problems are solved (Berg, 1995; De Jong & Berg, 1998; Gingerich & Eisengart, 2000; G. Miller, 1997), implying, in part, that knowing a lot about the problem may not be necessary to formulating a solution (de Shazer, 1988). Indeed, G. Miller and de Shazer (1998) stated that problems may be "unconnected" and even "irrelevant to the change process" (p. 370). In addition, a small change in one area can lead to greater or more expansive changes in other areas (referred to as the "ripple effect"; see Berg & Miller, 1992), often made possible by identifying "problem irregularit[ies]" (S. D. Miller, 1992, p. 2), or occasions when the problem is not a problem (past or present) or times when the client has taken, or can envision taking, a break or vacation from the problem. The "miracle question" is a primary method used for capturing these exception times, wherein the client is encouraged to imagine a time in the future when the current difficulty does not exist. Finally, counselor–client cooperation is key to the practice of counseling (Berg & Miller, 1992), with the counselor assuming the role of student and the client viewed as the teacher, a "notion that challenges the prevailing idea that the therapist dispenses wisdom and brings about cures" (McGarty, 1985, p. 149). SFC, therefore, reflects a humanistic, respectful, egalitarian approach to working with clients who are encouraged to make use of available resources and are trusted to know and make decisions about what is best for them.

MI

MI is a counseling style that emanated from the addictions field as an alternative to more traditional methods of counseling intervention, which tend to use direct persuasion and confrontation (Rollnick, Butler, & Stott, 1997). It generally adopts a brief intervention format, using critical elements that serve as catalysts for motivation and change. Indeed, W. R. Miller and Sanchez (1994) identified six critical elements as the "active ingredients" (referred to as the acronym FRAMES) necessary for successful brief interventions, which provide the background for MI: providing direct *F*eedback, emphasizing the client's personal *R*esponsibility for change, offering *A*dvice, providing a *M*enu of alternative treatment options, demonstrating *E*mpathy, and reinforcing the client's hope and optimism (i.e., *S*elf-efficacy). As with SFC, MI is not considered a theory; rather, MI is more a style or philosophy of how to strengthen client motivation to change and reduce ambivalence (Walitzer, Kimberly, Derman, & Conners, 1999). Ultimately, MI counselors help clients to cultivate their intrinsic motivational capacities (Walitzer et al., 1999) and "build commitment to reach a decision to change" (W. R. Miller & Rollnick, 1991, p. x).

In MI, the process of facilitating and enhancing intrinsic motivation and reducing resistance is guided by several principles: avoiding argumentation, rolling with resistance, expressing empathy, developing discrepancies, and supporting self-efficacy. Because arguing with clients tends to evoke resistance, opposition, and defensiveness, MI practitioners avoid harsh confrontations, accusations, and labeling (W. R. Miller & Rollnick, 1991, 2002). They instead "roll with resistance" by acknowledging that reluctance to change a firmly entrenched behavior is natural and understandable (W. R. Miller & Rollnick, 1991). An essential and defining characteristic of MI is expressing empathy (W. R. Miller & Rollnick, 1991, 2002), which, according to William Miller (personal communication, December 8, 1999), ranks as one of the most important components of MI. This therapeutic milieu not only lowers resistance but also encourages client self-motivational statements (W. R. Miller & Rollnick, 1991) or client *change talk* (W. R. Miller & Rollnick, 2002), that is, client speech affirming his or her decision to change or consider change.

MI uses confrontation in the sense of creating and amplifying discrepancies between present behaviors and client values. The goal is to bring to the client's awareness discrepancies within the client by clarifying goals and values and exploring consequences of present behaviors that appear to conflict with these goals and values (W. R. Miller & Rollnick, 1991). As a client becomes aware that change is needed, MI practitioners seek to help strengthen what Bandura (1977) termed *self-efficacy*, or the client's perception of his or her ability to change and manage obstacles on the path to change. MI emphasizes that many clients become aware of the need for change; however, they may also have limited confidence and hope that they can make a successful alteration in behavior. MI counselors bolster this confidence and hope, which is a step beyond simply recognizing the need for change.

SFC-MI SIMILARITIES

Nonpathological, Salutatory Focus

Because both SFC and MI emerged in response to and in contrast with prevailing medical/disease and problem-focused models, they can be said to represent nonpathological and salutary or health-promoting therapeutic ventures. An interest in and a curiosity about client abilities, strengths, and competencies characterize both SF and MI counselors. "Excavating," "dissecting," and even "excising" client liabilities, problems, and "character defects" (as mentioned in the 12 Steps of Alcoholics Anonymous) or deficiencies are not the primary concern.

An example of MI's nonpathological vein is its avoidance and, indeed, intolerance of diagnoses or labels, regarding such

practice as dehumanizing. In contrast to traditional substance abuse treatment approaches, MI eschews "branding clients with names" (W. R. Miller, 1999, p. 11), such as "alcoholic," "addict," or "in denial." Furthermore, it is assumed that the client does want to be healthy and desires positive change, viewing such a desire as inherent (Lewis & Carlson, 2000a). Positive reframing, therefore, is encouraged so that what was once considered a deterrent to change (e.g., the compulsivity of addiction) can be considered an asset (e.g., the persistence of recovery), such as the consideration of a client's "multiple sobrieties" as opposed to his or her "multiple relapses."

Similarly, SFC maintains an emphasis on mental health (Berg & Miller, 1992), presupposing that positive change is possible and preferring a preoccupation with exceptions or nonproblem occasions. Care must be taken, however, that there not be a rush to formulate solutions or that only "solution talk" be permitted. These are characteristics of the solution-forced therapist described by Nylund and Corsiglia (1994) and echo concerns that SFC neglects problem elicitation (Kuehl, 1995) and clarification (Fraser, 1995, 1999), as well as client history and broader assessment (Stalker, Levene, & Coady, 1999), which may contribute to a tendency to adopt an either/or view of solutions (Walter & Peller, 1994). The nonpathological and salutary focus of both SFC and MI, therefore, does not (and should not) regard health as the simple opposite of disease (see Antonovsky, 1987) or imply that difficulties or problems are to be eliminated. Rather, both counseling approaches place more emphasis on what is working well for the client, rather than what is not (Berg & Miller, 1992), and help the client get back "on track" (Walter & Peller, 1994) and maintain the benefits of change, which may represent increasing the length of time between relapses and adopting a harm reduction approach (W. R. Miller, 1999).

Multiple Perspectives

With varying degrees of emphasis, MI and SFC reflect a social constructionist, postmodern influence. In contrast with modernist philosophy, which stresses the existence of a single, tangible social reality, postmodern philosophy argues the existence of multiple, intangible social realities (Gergen, 1991). As a component of the postmodern perspective, social constructionist thinking contends that the languages we use largely shape our social realities (Guterman, 1996). That is, social realities are coconstructed by the choice of words we use to communicate in conversation. The social constructionist influence is apparent in SFC, which emphasizes the coconstruction of multiple "possibilities" rather than one. Indeed, the SF practitioner strives to coconstruct with clients alternative attitudes, different ways of perceiving, and solutions to presenting concerns (Walter & Peller, 1992).

MI reveals elements of constructivistic thinking, evident in the recommendation that counselors generate with clients a "menu" of alternative interventions or options (W. R. Miller, 1999). Thus, the client is not persuaded to adopt a sole suggestion provided by the counselor, but is invited to consider several alternatives that emerged through counselor–client discussions. This precludes the possibility of the client becoming mentally fixed on one option and, instead, allows the client to consider the problem through multiple perspectives.

Anchored in Change

MI is closely aligned with the stages of change model (DiClemente & Velasquez, 2002; Prochaska, DiClemente, & Norcross, 1992). This model suggests that all clients progress through a series of identifiable stages in the counseling process: precontemplation, contemplation, determination, action, maintenance, and relapse. According to MI, a critical component in the counseling process is to match counselor interventions with whatever stage of change the client is experiencing. Counseling strategies that are stage specific reduce therapeutic resistance and simultaneously increase intrinsic motivation (W. R. Miller & Rollnick, 1991). This makes MI a particularly useful approach for "challenging clients" who present with little or no motivation to change (i.e., those who are precontemplative or contemplative about change), even though there is an assumption that clients do want to make positive change. Rather than assuming that all clients are "ready for action," MI recognizes that many clients may initially be ambivalent about changing. This counseling approach provides a perspective that facilitates movement through the change process.

SFC is also anchored in positive change, with a consistent emphasis on what the client will be doing (changing) to reach a solution and how he or she will be doing it (Walter & Peller, 1992). Change occurs through action because action is the process through which changes in thinking and behavior come about (Walter & Peller, 1992). Indeed, SFC can be thought of as "solutioning therapy" or "goaling therapy" (Walter & Peller, 1992), implying the idea that positive change is not a static event, but an action-based, process-oriented phenomenon. This appears consistent with MI's focus on the stages of change model, where change is not fixed indefinitely but evolves and progresses through client action (motivation). Similar to MI's matching of interventions with a particular stage of change, SFC assumes that change is more likely to occur when counselors cooperate to match each client's style of engagement and adjust tasks to fit the client's mode of operation (Walter & Peller, 1992). Whereas MI and SFC adopt somewhat different procedures for encouraging change in clients, both operate with a persistent focus on the capabilities clients have to evoke positive change in their lives.

Reframing "Resistance"

Traditionally, resistance has been perceived as something that lies within the client. If therapeutic progress is not made or an impasse is reached, blame is placed on the client who is said to be "lazy," "unmotivated," or "resistant." MI and SFC offer a much different perspective on resistance, how it manifests in counseling, and counselor strategies to address it. From the MI viewpoint, counselor style is a powerful determinant of resistance and change (W. R. Miller,

1999; W. R. Miller & Rollnick, 1991, 2002). Thus, resistance is greatly affected by interpersonal interactions between the client and the counselor. In other words, resistance is not viewed as something exclusively "in" the client; rather, it is a relational phenomenon that lies within the counselor–client relationship (W. R. Miller & Rollnick, 1991, 2002). Unlike traditional views of resistance, MI encourages counselors to reflect on how their interactional style may contribute to resistance in the therapeutic milieu.

From the MI perspective, the counselor's response to resistance can largely determine the client's subsequent willingness to engage in the counseling process (W. R. Miller & Rollnick, 1991). As noted previously, rather than striving to "break down" resistance, MI counselors "roll" with resistance by reflecting statements and feelings, offering new perspectives (but not imposing these on clients), and demonstrating empathy (W. R. Miller, 1999). Clients are in an auspicious position to discover their self-healing capabilities (see Bohart & Tallman, 1999) when placed in an environment that is nonjudgmental and avoids argumentation.

In a humorous look at resistance, therapists at the BFTC made a "declaration of the death of resistance" and even held a funeral to grieve its loss (O'Hanlon & Weiner-Davis, 1989, p. 21). Consistent with the MI view, SFC disputes the fundamental belief of most contemporary therapies that clients really do not want to change and that their resistances must be "attacked" (O'Hanlon & Weiner-Davis, 1989). Such approaches, according to the SFC perspective, promulgate an adversarial us-versus-them strategy that takes the focus away from solutions (O'Hanlon & Weiner-Davis, 1989).

SF counselors believe that clients do want to change, and if a client neglects to follow a counselor's suggestion, it is simply a sign that the counselor and client are not on the same page (O'Hanlon & Weiner-Davis, 1989; Walter & Peller, 1992). Rather than "breaking down" client resistance through confrontation, SF counselors seek to understand a client's idiosyncratic way of cooperation and interact with the client in a manner consistent with this. According to SFC, focusing on client resistance is a "blind alley" that counselors should avoid (O'Hanlon & Weiner-Davis, 1989). Similar to the MI perspective, SFC holds that, too often, resistance is a convenient label counselors give to clients when an impasse has been reached. Labeling clients, incongruent with both MI and SFC, precludes the development of solutions and working with the client as a partner.

Cooperation Is Key

William R. Miller (personal communication, December 8, 1999) commented that traditional U.S. treatment (especially in the addictions field) has been extremely authoritarian and described it as the "I know best, you're impaired, listen to me" mentality. From his perspective, this paternalistic emphasis directly prescribes action (usually only one action—the therapist's), promotes aggressive "confrontation of denial," and institutes moralistic blaming when changes do not occur. According to W. R. Miller, there are still plenty of programs that adopt this philosophy, despite the widespread belief that such treatment does not exist. MI avoids this emphasis on a confrontational style, promoting instead a gentle persuasive style in which cooperation is a key element for successful counseling (W. R. Miller & Rollnick, 1991, 2002).

MI stresses client personal responsibility and self-determination for change (W. R. Miller & Rollnick, 1991; Smyth, 1996) and promotes working cooperatively and democratically with the client to generate alternative solutions to behavioral problems. Several principles of MI, including avoiding argumentation, rolling with resistance, and expressing empathy, suggest that the client is not perceived as an opponent to be defeated but as an important ally who offers a critical perspective in counseling (W. R. Miller & Rollnick, 1991, 2002). This is similar to regarding the client as the "teacher" and "expert" in SFC (Berg & Miller, 1992), underscoring the commitment that both approaches have toward cooperation instead of confrontation.

In SFC, cooperation is strengthened by focusing observations on what clients are already doing to reach their goals. Because resistance is no longer in the clinician's perceptual field, a positive atmosphere is established in which the counselor and client are genuine with each other (O'Hanlon & Weiner-Davis, 1989). Disagreements are incorporated into the counseling process as a way to further promote client–counselor cooperation (Walter & Peller, 1992).

SF counselors assume that clients hold critical beliefs on how change takes place relative to their goals (Walter & Peller, 1992). Therefore, it is up to the counselor to cooperate with these views, while facilitating a process in which clients are invited to consider new possibilities, differences, and solutions (Walter & Peller, 1992). According to Walter and Peller (1992), two principles of cooperation are "pacing" and "inviting." Pacing involves matching the client's tone, affect, and words, so as to demonstrate understanding and acceptance. This is analogous to MI's emphasis on expressing empathy. Inviting involves using questions to gently ask the client to consider or explore new meanings and possibilities. Although using different vernacular, MI also makes use of inviting questions, which are designed to evoke self-motivational statements (statements affirming the client's commitment to change; W. R. Miller, 1999). Cooperation, from the perspectives of MI and SFC, allows clients to feel supported, which facilitates openness toward future possibilities and new directions.

Use of Client Strengths and Resources

MI and SFC use client strengths and resources in ways to promote positive change. MI promotes self-efficacy by conveying the message "you have the ability" and "you can change." This is similar to the SF counselor's role in giving positive feedback in the form of statements of encouragement, compliments, and affirmations (Walter & Peller, 1992). MI counselors may also bolster self-efficacy by discussing previous client success stories, strategies that have been suc-

cessful for the client in the past, and client strengths in general, strategies that are also used in SFC.

As noted earlier, both MI and SFC stress that the responsibility for change lies with the client, not the counselor; both approaches will not allow clients to place the onus of change on the counselor. Implicit is that clients have within themselves the capacity to consider new or different meanings, coconstruct solution-focused realities, and generate sufficient intrinsic motivation to change.

Temporal Sensitivity

Both SFC and MI can be considered time-sensitive approaches, with their respective ties to brief therapy and to brief interventions in the area of addictions counseling. Temporal sensitivity implies that time is valued and respected in counseling because it is not unlimited and counselors make the best use of their time with clients, working efficiently and judiciously. The approach to counseling that both SF and MI practitioners take can be likened to that of theologian Henri Nouwen's therapist who, according to Nouwen (1976) "gave me much time and attention but did not allow me to waste a minute" (p. 15). In this manner, SF and MI counselors can be said to use time wisely, keeping themselves and their clients focused, without the impression of being rushed.

Whereas SFC is not regarded today as an exclusively short-term or time-limited approach, MI is. Hoyt (1990), who has written extensively on brief therapies and SFC, views time not so much as a commodity but more as a perspective. In this way, SFC can be used in not-so-brief formats, such as with recovering, alcohol-dependent, single-parent mothers (Juhnke & Coker, 1997) and persons with thought disorders (Hagen & Mitchell, 2001). MI, on the other hand, "was designed from the outset to be a brief intervention and is normally delivered in two to four outpatient sessions" (W. R. Miller, 1999, p. 55). Extensive research on brief interventions and MI (often one and the same) regard the temporal limitation of therapeutic activity as the operative variable.

SFC–MI DIFFERENCES

Social Construction Through Language

Both SFC and MI speak to the importance of therapeutic collaboration and the intentional use of nonjudgmental, respectful, and engaging language with clients. These exemplify humanistic counseling practices. SFC, however, emanates from and is shaped by poststructuralist, postmodern, or constructivistic/social constructionistic thought, which not only regards the consideration of multiple perspectives but also views the construction of reality as the product of human interaction through language. In this sense, the act of counseling is a process of "languaging" (Maturana & Varela, as cited in Walter & Peller, 2000), wherein counselors resemble "linguistic detectives" (Efran & Cook, 2000, p. 140) and practice as "conversational facilitators of clients' solution-building" (G. Miller, 2001, p. 75) and "curious conversationalists" (G. Miller, 2001, p. 80). Indeed, de Shazer and Berg (1992) have proposed that language *is* reality.

It is evident in our observation of several SF practitioners (e.g., Insoo Kim Berg, Scott D. Miller, and Linda Metcalf) that effort is made not only to adopt the language of their clients but also to mutually consider and experiment with new ways of thinking and talking about the client's experiences and aspirations. No assumptions are made about what would be best or even most helpful for the client. Rather, the SF counselor assumes a "not-knowing" stance (Anderson & Goolishian, 1991), using questions to "wonder out loud" with the client about what might be helpful. Solutions take their shape, therefore, in the moment, during the client–counselor exchange, wherein both are considering, pondering, experimenting with, formulating, and contributing to a possible scenario or reality that the client can identify with and views as helpful. Indeed, "solutions emerge from dialogues" (Prochaska & Norcross, 1999, p. 444). A goal of counseling may simply be to help the client begin shifting his or her language from talking about problems to talking about solutions (Nichols & Schwartz, 2001). In this manner, SFC exemplifies Anderson's (1997) conceptualization of therapy: "a language system and a linguistic event in which people are engaged in a collaborative relationship and conversation—a mutual endeavor toward possibility" (p. 2).

Although MI mentions the importance of using language that does not convey judgment (e.g., client who is "in denial" or "resistant"), and presents strategies that involve the counselor's use of inflection and positioning of words (e.g., "double-sided reflection" and "agreement with a twist"), the client–counselor verbal exchange is not necessarily viewed (as is SFC) as a new reality "under construction." In this way, MI may exemplify a phenomenological approach (i.e., counselor attempts to view life from the client's perspective and identify goals from that vantage point) more so than SFC (which seeks to formulate a new reality, a new perspective, mutually constructed by the client and counselor). This is evident in the prominent use of reflective statements in MI, whereas SFC makes use of a variety of questions (e.g., exception, coping, scaling questions) intended to generate possible solutions and convey that counseling is a collaborative venture, an exercise in "mutual puzzling" (see Anderson & Goolishian, 1991).

Concept of Change

MI uses a well-defined model of change—the stages of change model (DiClemente & Velasquez, 2002; Prochaska, 1999), which proposes that individuals pass through stages in the course of solving a problem. This model of change aids MI counselors in conceptualizing the level of client motivation and implementing stage-appropriate motivational interventions. Enhancing commitment to change requires MI counselors to be sensitive to levels of ambivalence and resistance, which manifest differently depending on what stage of change a client is presenting. From the MI perspective, change is a process that occurs as clients resolve ambivalence while moving

through the stages of change (i.e., from precontemplation to maintenance), and simultaneously cultivating greater levels of intrinsic motivation to alter behavior.

Recall that SFC assumes that resistance does not exist and that clients genuinely want something from counseling and do want to change (Walter & Peller, 1992). As such, SFC does not follow a clearly defined model of change or concentrate on a client's progression through systematic stages of change. It does, however, offer strategies that facilitate new possibilities and changes in perspective (G. Miller, 1997). For example, the use of "scaling questions" and the "miracle question" serve to encourage clients to imagine what change and success might look like in the future. Scaling questions imply movement or change along a linear continuum, as when a counselor asks a client what changes would occur if he or she were at a "7" as opposed to a "5" (say, on a scale where "10" was considered "all the confidence in the world" and "0" was presented as "no confidence at all"). Scaling questions are often used as assessments of presession change (Lawson, 1994). If clients indicate movement in a positive direction on the scale, counselors inquire as to how the client was able to make changes and encourage him or her to do more of what is working. Clients who are asked the miracle question are encouraged to clarify concrete changes imagined after the miracle has taken place.

Counselor Focus and Goals

Both SFC and MI view positive client change as possible. Methods adopted for realizing such change, however, differ. To begin with, MI emphasizes the importance of assessment, particularly attending to the stage of change a client is manifesting and his or her readiness for change, apparent discrepancies, and the level of resistance in the counseling session. Although scaling questions and inquiries about "pretreatment change" (Beyebach, Morejon, Palenzuela, & Rodriguez-Arias, 1996; Lawson, 1994; Weiner-Davis, de Shazer, & Gingerich, 1987) used in SFC can be said to be a form of assessment, it is not the difficulty or complaint that is being evaluated (a practice criticized by some; Fraser, 1995, 1999; Kuehl, 1995; Stalker et al., 1999); rather, the focus is on identifying possible exceptions (i.e., instances in which the client has successfully dealt with a problem) so the client can generate solutions. Furthermore, a primary focus and strategy in MI is to identify and amplify client discrepancies (e.g., between current and ideal behavior, or between values and current behavior) in an effort to fuel client's commitment to initiating change. In contrast, what is identified and amplified in SFC are exceptions to the problem so that the client can do more of "what's working."

To address resistance, MI is confrontational in the sense that it adopts a gentle, strategic, and persuasive style designed to increase a client's awareness of a need for change (W. R. Miller & Rollnick, 1991, 2002). This characterizes the directive approach of MI, which can also include advice giving (or idea offering) with certain guidelines. Once a client becomes sufficiently motivated to change, MI's focus shifts to strengthening the client's commitment to changing behavior (W. R. Miller & Rollnick, 1991, 2002). These foci and strategies assist MI practitioners in accomplishing their ultimate goal: facilitating a client's intrinsic motivation to consider and implement changes in behavior.

SFC counselors emphasize honoring the client's preferences for change (Walter & Peller, 2000), which implies that clients are capable of doing what they need to do to get what they want (Walter & Peller, 1992). This is slightly different from a focus on enhancing intrinsic motivation. In SFC, attention is focused on coconstructing goals and solutions (G. Miller, 1997), directed by client preferences (client as expert), with the counselor maintaining an "eye for exceptions."

Temporal Focus

MI is primarily a present-focused style of counseling, evident in the prominent use of reflective statements. This is not to say that MI practitioners eschew any discussion of future actions; however, the thrust of MI is addressing the client's current stage of change and facilitating the enhancement of intrinsic motivation in the here-and-now. SFC, on the other hand, tends to be present- and future-oriented. The emphasis on the future materializes through the previously discussed scaling, miracle, and hypothetical questions, which encourage the client to think about what a solution might look like in the future and what he or she will be doing differently when the problem is solved.

Reflectivity

We have already mentioned SFC's exemplification of postmodern or social constructionistic thought, which has as its premise the consideration and creation of multiple realities (because there is no one absolute reality) through the process of "languaging." Inherent in this philosophy is the need for active reflection, wherein individuals take time to intentionally consider or ponder the meaning or implications of a particular experience, event, or course of action from a variety of perspectives. Because realities are always "under construction," careful and disciplined reflection guides the formation of a new reality or perspective and, indeed, allows them to take shape.

SFC makes intentional use of reflection, viewing the therapeutic exchange as a disciplined exercise in mutual reflection, without a predetermined goal, destination, or end result in mind. In this manner, it is not only the counselor who engages in reflection; he or she models and encourages the client to do so also. This reflective activity takes place in the moment, during the counseling session itself, not only outside of the session (e.g., when the client may be encouraged to journal). The SF counselor demonstrates a reflective approach when he or she assumes a "not-knowing" position, poses questions to the client about possible variations of the current perspective or experience, and "wonders aloud" with the client about relevant and feasible solutions. In addition, many SF counselors have adopted the routine of taking a break near the end of a session to consult with a colleague or to gather his or her own thoughts privately in order to "pack-

age" and then provide helpful feedback and recommendations to the client at the close of the session (Lewis & Carlson, 2000b). Creating this physical distance and space promotes careful reflection.

MI might also be thought of as an exercise in reflection, firmly based on and influenced by a person-centered or Rogerian theoretical perspective. It appears, however, that such activity is primarily the responsibility of, and is carried out by, the MI counselor through the use of empathic, reflective statements. Cultivating client–counselor mutual and deliberate reflection does not appear to be a goal or the purpose of MI, as it is in SFC. Rather, because MI is goal oriented, MI counselors assume an intentionally directive approach (W. R. Miller & Rollnick, 2002), encouraging movement toward an outcome amenable to the client. Reflection in MI, therefore, (a) is intended to communicate counselor empathy; (b) promotes client–counselor collaboration and hence, reduces resistance; and (c) allows the counselor to formulate a strategy toward change that is acceptable and attractive to the client.

RESEARCH FINDINGS AND DIRECTIONS

Research on SFC

SFC has been criticized for its lack of an empirical research base (Eckert, 1993; Fish, 1995, 1997; S. D. Miller, 1994; Shoham et al., 1995; Stalker et al., 1999) despite its more than 20 years of practice. Most of the studies reporting the effectiveness of SFC have been promulgated by its founders, clinicians at the BFTC in Milwaukee, Wisconsin, and students of the BFTC training center. These reports are "substantiated solely by reference to 'subjective clinical experience'" (S. D. Miller, 1994, p. 21) and are often presented in anecdotal form.

Two studies reporting favorable outcomes (viz., length of treatment, and achievement and maintenance of client goals) of solution-focused brief therapy (SFBT) have frequently been cited in the SFBT literature (see Kiser & Nunnally, 1990). These studies, however, were conducted at the BFTC by Center staff, were based on "poorly designed" methodology, and have not been published (D. Kiser, personal communication, January 11, 1996). Claims of its utility and efficacy, therefore, are purely theoretical and have not been subjected to sound empirical testing (Fish, 1997; Shoham et al., 1995).

Although existing outcome research is less than adequate and must be interpreted cautiously (Fish, 1997; McKeel, 1996), Gingerich and Eisengart (2000) reviewed 15 outcome studies of SFBT, five of which were determined to have met established standards for empirically supported psychological treatments. Two of these studies reported significant outcomes favoring a solution-focused approach: return to work for patients with orthopedic injuries, in comparison to a standard rehab program (Cockburn, Thomas, & Cockburn, 1997); and less recidivism for prisoners involved in an SFBT treatment group, compared with a control group, up to 16 months after release (Lindforss & Magnusson, 1997). Efforts are underway, therefore, to demonstrate efficacious outcomes of a solution-focused approach, addressing what has been acknowledged as a "shortcoming" of SFC (Lewis & Carlson, 2000b). These efforts, however, do not compare with, and trail far behind, the consistent rigorous investigations of the effects of a MI approach.

Research on MI

MI has a larger empirical research base than SFC and, of the research conducted by both counseling approaches, MI has incorporated more methodologically sound investigations that purport its clinical effectiveness. The strength of many of these investigations involves the use of randomized controlled trials (of which a few are mentioned as follows; see Burke, Arkowitz, & Dunn, 2002, for a review of 26 controlled clinical trials using MI), which serve to bolster internal validity and control for extraneous factors that can compromise findings.

In a study that compared MI principles and methods with a confrontational counseling approach among problem drinkers, W. R. Miller, Benefield, and Tonigan (1993) found that therapist behaviors associated with the term *confrontational* were found to predict poorer outcomes for problem drinkers. Successful therapeutic styles were those that evoked positive motivational responses from clients without engendering resistance. Bien, Miller, and Boroughs (1993) found similar findings in a study comparing motivational interviewing with a control condition among 32 individuals experiencing alcohol problems. Participants who engaged in the MI treatment condition reported consuming fewer standard drinks, lower peak blood alcohol levels (BALs), and a higher percentage of days abstinent than did control participants at 3-month follow-up. Similar findings supporting the effectiveness of brief motivational interventions were reported by W. R. Miller (1996).

Rollnick et al. (1997) outlined a program to help smokers make decisions regarding their health status and behavior. This three-phase intervention implemented several MI elements such as brainstorming solutions (offering menu), bringing out discrepancies between what the client likes and dislikes about his or her current behavior, and questions to assess self-efficacy. In a qualitative examination of this program, these researchers reported satisfaction from both clinician and client perspectives. For example, several clinicians stated that the emphases on client responsibility, rapport building, and active client decision making were admirable components. Clients seemed to believe they were doing something positive for themselves, instead of being the recipient of a lecture.

More recently, Borsari and Carey (2000) conducted a randomized controlled trial comparing a one-session motivational intervention with a no-treatment control among binge-drinking college students. Although the length of follow-up was relatively short (6 weeks), Borsari and Carey found that students who engaged in the MI treatment condition consumed fewer drinks per week and had fewer binge drinking episodes in the month after treatment.

The efficaciousness of MI has been examined among participants with more severe addiction problems. For example, Stotts, Schmitz, Rhoades, and Grabowski (2001) evaluated brief MI within the context of an outpatient cocaine-detoxification program. One hundred and five participants were randomly assigned to MI treatment or a detoxification-only condition. Results suggested that MI participants had fewer positive urine samples and were more likely to increase their behavioral coping repertoires compared with the detoxification-only participants.

The application and effectiveness of MI has been established in other areas besides substance-related issues. For example, W. R. Miller (1996) reported that MI strategies have been applied successfully to HIV–risk behavior, sexual offenses, diabetes, pain management, and cardiovascular rehabilitation. Bellack and DiClemente (1999) proposed a comprehensive treatment for patients with schizophrenia and substance abuse, focusing on MI to assist clients in goal setting and reducing the use of substances. An investigation by W. R. Miller, Meyers, and Tonigan (1999) provided support for a counseling program designed to help concerned significant others encourage their loved ones to enter treatment. The authors commented that this program, based on the principles of MI, "is substantially more effective than the two more commonly practiced approaches in engaging initially unmotivated problem drinkers in treatment" (p. 695).

STYLE INTEGRATION

Considerations of commonalities and the coexistence of therapies are to be expected with more than 400 models of psychotherapy now available (Corsini & Wedding, 2000; Prochaska & Norcross, 1999). Chief among these is the expanse of literature on what is referred to as "theoretical integration" (Norcross & Goldfried, 1992; Prochaska & Norcross, 1999), based on and driven by the notion of common factors (Lambert, 1992). From this perspective, factors *across* therapies contributing to positive outcomes are emphasized, rather than attempts at isolating the unique contributions of a *particular* therapeutic approach. Additional examples of an integrative milieu in psychotherapy and counseling today include W. R. Miller and Hester's (1995) informed eclecticism in the addictions and Gergen's (2000) reference to creative confluence wherein schools of therapy are connected by the significance of human meaning.

With both SFC and MI advocating for the consideration of multiple perspectives, with SFC being promoted as adaptable to (or compatible with) other approaches (Guterman, 1996), and furthermore, with MI itself informed and guided by a transtheoretical theory of counseling and psychotherapy (see Prochaska, 1999), a consideration of the coexistence and confluence of both counseling styles appears appropriate and consistent with themes inherent in both approaches. What follows represents our preliminary attempt to understand and articulate SFC and MI from an integrative and a both/and perspective in the hope of promoting the strengths of a synergistic emergence. This is followed by a case study demonstrating the possible application of an integrative perspective.

Honoring Client Stories

What is paramount to us in the confluence of SFC and MI is a respectful and humanistic therapeutic posture that values and, indeed, honors (even relishes in) the unique stories and experiences of clients. Counselors remain curious about and intrigued by the client's idiosyncratic perspectives and preferences. Although the tributaries of such a respectful stance originate from different sources (SFC from a constructivistic/social constructionistic philosophy, and MI from Rogerian therapy), the resulting integration reflects a cohesive and adamant appreciation for and use of client constructions and presentations. That is, clients are regarded as the experts about or the authorities on their experiences. This means that the counselor invites and welcomes the client's unique contributions to therapeutic interactions and conversations and adjusts to the client's proclivities. SF and MI counselors are therefore the students of their clients' preferences, adjusting their stance to "fit" with or accommodate and adapt to the client's needs.

Motivation as a Client Resource

Client motivation in MI can be likened to client preference in SFC. Both refer to client resources and strengths that are identified and amplified in the course of therapeutic encounters. What is critical is that the client's intrinsic intentions and preferences are recognized (e.g., client's image of being reunited with his or her children, client's eagerness to fulfill the requirement of counseling) and incorporated into counseling interactions and tasks. This includes the client's ambivalence about change, for this taps into the client's source of energy or energy reserves (e.g., client mental and emotional investment in the consideration of several possibilities, which may have resulted in a feeling of "stuckness") and makes room for the possibility of client engagement and cooperation.

Such recognition and arousal of intrinsic motivation in constituents is regarded as a necessary characteristic of effective leaders (Kouzes & Posner, 1995). Kouzes and Posner stated that "Reliance upon external incentives and pressures doesn't liberate people to perform their best, and it constrains leaders from ever learning why people *want* to excel" (p. 41). Identifying and appreciating what propels the client to either filibuster or consider change opens the door for more collaborative dialogue and encourages client aspirations of something different and rewarding.

Change in Relation

The process of identifying and cultivating client intrinsic motivation or preferences takes place within a relationship, and it is in this therapeutic relational and conversational process that change occurs or emerges. Indeed, both SFC and MI exemplify one of the prominent common factors—

the therapeutic relationship—credited with being responsible for approximately 30% of positive client change (Lambert, 1992).

From an integrated SFC and MI perspective, however, change is not something that happens only to the client or that is limited to the client. That is, movement in counseling is not confined to client performance or status, as if the client directs or is solely responsible for such movement and change. Rather, when considered in the light of SFC and MI confluence, change is understood in terms of conversational or relational movements or fluctuations over time, illustrating the systemic, holistic, dynamic or interactional, and recursive nature of counseling and the counseling process. Indeed, SFC speaks of three types of client–therapist relationships (customer, complainant, and visitor; Berg & Miller, 1992) and not three types of clients. Although MI refers to stages of change based on client presentations, it is understood that change is an interactive phenomenon, reflecting both client and counselor contributions, and recent discussions (e.g., Prochaska, 2000) have focused on the therapeutic relationship at each stage. The integration of SFC and MI, therefore, suggests a reconceptualization of therapeutic change as relational and communal (i.e., the relationship as not only the agent of change, but also the subject of change).

Case Study: Integration in Action

I (first author) had a unique opportunity to work in a community counseling agency that strongly endorses SFC and MI. Although a confluence of SFC and MI was not emphasized throughout the agency, I was encouraged in supervision to apply the combined strengths of SFC and MI.

Mark D. was a 39-year-old White man, employed as an auto mechanic at a local auto shop. Mark had been court-ordered to attend counseling due to a third driving-under-the-influence (DUI) offense. Two 50-minute sessions were devoted to assessing the extent of Mark's substance use, attitudes toward use, and associated consequences. Mark's assessment results indicated possible alcohol dependence, and, while providing him feedback from the assessment, I noted a moderate to strong amount of frustration. "I don't see why I have to go through all of this," Mark said. "Can't we just get on with the counseling and be done?" I concluded that Mark appeared to be in the precontemplative stage regarding his drinking behaviors.

Throughout Mark's counseling, I maintained a posture of curiosity and intrigue and established rapport by listening empathically to Mark's "story." Honoring Mark's perspective and showing genuine interest in his construction of reality seemed to open space for reflection and consideration of alternative ideas. Mark seemed a bit surprised when I stated, "I'm really curious to learn, from your perspective, what happened when you received your third DUI. . . . Tell me what that experience was like for you?" As the resistance between Mark and me lessened, Mark was more willing to offer his perspective on his drinking behavior, its impact on himself and others, and recent legal troubles. Believing that his story was *heard*, Mark began to acknowledge the possibility that drinking had caused a strain on his marriage, his relationship with his two children, and his job.

Building on Mark's awareness of problems related to drinking, I assisted Mark in exploring and amplifying his strengths and resources that he could draw on to accomplish counseling and personal goals. I explored previous times when Mark overcame difficult circumstances in his life (i.e., exceptions). Remembering and reliving these experiences bolstered Mark's self-efficacy as he began to develop the intrinsic drive to change his behavior. By this time, Mark had verbalized preferences for change (i.e., wanting to get along better with his spouse and children, wanting to keep his job). Because these preferences emanated from Mark's own motivation, I incorporated them as goals for counseling and helped him construct "homework" tasks designed to improve his relationships with others. It became clear that what propelled Mark was what he valued: family life and doing well in his job. Through cooperative dialogue, Mark came to view alcohol as an unnecessary roadblock to happiness.

On termination of counseling, Mark had committed to abstaining from alcohol and was willing to sign an "abstinence contract." He even considered marital counseling to assist with relational issues. It is interesting that when I asked him what was most helpful in counseling, Mark stated that my "honest, nonjudgmental approach" was most appreciated and something quite different from what he was used to in previous counseling and in the legal system. I pointed out, however, that Mark had made important contributions as well and that our combined, cooperative venture provided the foundation and impetus for growth and change. Indeed, reflecting on my interactions with Mark, I became aware that as our relationship became more *egalitarian*, *genuine*, and *cooperative*, space opened for reflections, considerations for change, and the coconstruction of creative, alternative ideas.

CONCLUDING REFLECTIONS ON CONFLUENCE

The case of Mark illustrates that using SFC and MI synergistically can be effective in building a strong therapeutic alliance and reducing initial resistance to change. The counselor (first author) illustrated this by honoring Mark's story, taking a position of curiosity, and demonstrating a genuine interest in his perspective. Amplifying Mark's strengths, illuminating previous times when he was successful in overcoming difficult circumstances, and encouraging coconstruction of goals also demonstrated confluence. SFC and MI operate under the assumption that clients can offer a critical perspective in counseling. Because he believed his ideas were respected, and because he had the supportive context of a strong counseling relationship, space was opened for Mark to examine his behavior and verbalize a preference to reduce his drinking. This is consistent with SFC, which promotes client preferences for change, and with MI, which emphasizes *the client making the argument for change* (i.e., enhancing intrinsic motivation). Highlighting the important

contributions and considerable input that Mark offered in relation to his own counseling further illustrates the "essence" of a synergistic approach. That is, SFC and MI effectively combined can encourage change through a collaborative and respectful counseling relationship, honoring client stories, and recognizing client strengths, intentions, and preferences as important components in the client's own healing.

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A Ten-Year Longitudinal Study of the Career Development of Students: Summary Findings

Andrew A. Helwig

This article summarizes the principal findings of a 10-year longitudinal study of the career development experienced by a sample of students. Beginning with 208 second graders, data were collected 6 times, concluding when the students were in the 12th grade. Principal variables measured included occupational aspirations and expectations, gender role beliefs, out-of-school activities, parental involvement in career awareness, and work experience. Concepts from L. Gottfredson's (1981) circumscription theory and the social cognitive model were tested and supported. Implications for career education are presented.

For many years, the career development of children has been viewed as a critical part of the overall education of the individual. A number of theories examining the career development of children have been developed including Ginzberg, Ginsburg, Axelrad, and Herma (1951), Super (1957, 1980), and Gottfredson (1981, 1996) to name but a few. There is little question or doubt that career development begins early in children's lives, and children as young as 3 report occupational preferences (O'Keefe & Hyde, 1983; Vondracek & Kirchner, 1974). Kohlberg (1966) believed that gender identity developed by age 3, and gender has been shown to be related to career development and occupational aspirations (e.g., Henderson, Hesketh, & Tuffin, 1988; Phipps, 1995; Trice & Gilbert, 1990). School programs in the 1970s encouraged a strong role for career education, beginning with the elementary school years and continuing through high school and beyond. Today's School-to-Work programs, although focused primarily on high school students, build on the career awareness and development that occurs in earlier grades.

This article summarizes some of the findings from a 10-year longitudinal study regarding a number of career development issues experienced by a sample of school children. The study began when the students were in the second grade and continued until they were seniors in high school. Data were gathered six times, when students were in the 2nd, 4th, 6th, 8th, 10th, and 12th grades. A number of variables were examined including occupational aspirations and occupational expectations, gender role beliefs, out-of-school activities, parental involvement in career awareness, Secretary's Commission on Achieving Necessary Skills (SCANS) skills estimates, and work experience. A rich picture of the career development of this sample has been obtained, and an overview is reported here. Some specific variables, their interrelationships, and outcomes have been reported elsewhere (Helwig, 1998a, 1998b, 1998c) for data gathered during the first 5 years of the study.

A number of theoretical concepts from Gottfredson's (1981, 1996) stage development theory of circumscription and compromise and constructs from a social cognitive perspective (Lent, Brown, & Hackett, 1996) were examined. In Gottfredson's (1981, 1996) first stage, children's thought processes are concrete, and they begin learning about occupations. Gottfredson suggested that during this time (ages 3–5), children's primary orientation is to size and power embodied by the adults around them. The second stage of Gottfredson's (1981, 1996) theory indicates that children from ages 6 to 8 choose occupations based on gender role differences and their perception of the world of work. At this age, children become aware that men and women perform different roles and do different kinds of work. The majority of jobs are still dominated by men or women, and children choose occupations consistent with their gender. At the third stage, Gottfredson's (1981, 1996) theory states that children from 9 to 13 years of age become aware of the social value and status differences that exist around them. Children see that jobs have different social value and status levels, and they select occupational aspirations accordingly. The fourth stage of Gottfredson's (1981, 1996) theory, corresponding to the age of 14 and older, indicates that individuals

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choose occupations consistent with their internal, unique selves. Their perception of interests, talents, and vocational needs influences their occupational aspirations; gender and social value lose some importance in occupational selection.

Social cognitive theory suggests that with age children become more aware of their strengths and limitations. Self-efficacy, their personal agency (Bandura, 1986), influences individuals and the activities they engage in and their confidence in successfully completing the activities. In addition to self-efficacy, outcome expectations and goal representations influence career choice (Lent et al., 1996). Perception of barriers to certain careers may also change occupational aspirations (Albert & Luzzo, 1999; Lent, Brown, & Hackett, 2000).

Longitudinal studies are rare, and cross-sectional studies are the norm. Those longitudinal studies that have focused on career development typically began when the participants were in high school, such as the Career Pattern Study (Super, 1985; Super & Overstreet, 1960) and the 25-year study reported by Jepsen (1975) and Jepsen and Choudhiri (2001). The value of the longitudinal design is that intraindividual variation can be accounted for (Baltes, 1968). Thus, using the same sample at multiple points in time reduces the variability that typically occurs in studies with a cross-sectional design. A key dependent variable studied was occupational aspiration, and Rojewski and Yang (1997) suggested that because of the developmental nature of children's aspirations, a longitudinal approach is most appropriate. An extensive cross-sectional study reviewing national data was reported by Tiedeman, Katz, Miller-Tiedeman, and Osipow (1978). Their focus was on youngsters 9, 13, and 17 years of age, and a young adult sample (26–35 years of age). A number of similar variables were examined in both studies.

The purpose of this article is to summarize some of the findings of this 10-year study, with particular focus on occupational aspirations and occupational expectations. A number of variables are described, and some theoretical concepts proposed by Gottfredson (1981, 1996) and Lent et al. (1996, 2000) are examined in light of the data.

METHOD

Participants

The study began in 1987 with a sample of 208 second graders attending four elementary schools serving a contiguous area in a suburban location near Denver. There were 110 boys and 98 girls, and the sample was predominately White (86%) with the remaining students primarily Hispanic Americans. Consent was obtained from parents, and this sample represented about 60% of all second graders in the four schools. The sample was similar to the general student population in this geographic area in terms of age and ethnicity. The mean age of the children was 7.8 years (SD = .37) in fall 1987. Beginning with sixth graders, the youngsters were tested in spring of the school year, so mean ages were 12, 14, 16, and 18 in the 6th, 8th, 10th, and 12th grades, respectively.

A one-page data sheet was sent home for each parent to complete. One or both parents of 77% of the children responded. Mothers' and fathers' mean ages were 34.1 (SD = 4.58) and 36.1 (SD = 6.07), respectively. Education level of mothers and fathers were 13.4 (SD = 1.88) and 13.6 (SD = 2.49) years, respectively. Eighty-four percent of mothers and 83% of fathers reported they were married, indicating that in some households only the mother or the father responded. Sixty percent of mothers reported employment and 90% of fathers reported being employed. Of the employed parents, 43% were working in professional, technical, and managerial occupations as defined in the *Dictionary of Occupational Titles* (U.S. Department of Labor, 1991a).

Instrument

The principal instrument used for data collection was the Survey of Interests and Plans (SIP), which I developed. The 34 items addressed school likes and dislikes, out-of-school activities, occupational aspirations and expectations, college plans, work-related roles of men and women, hobbies, chores and college attendance. The SIP was altered to include items that assessed parental involvement, educational planning, and work experience questions when the children were in high school. Information about academic performance and "with whom" the student lived was gathered at each of the six interview points.

Procedure

Interviews were conducted with each student on an individual basis by me and graduate assistants trained in the use of the SIP. Interviews lasted from 20 minutes to ½ hour depending on the response rate. Children were never interviewed in their classroom or during recess, lunch breaks, or before or after their school day. The interview has been shown to be an effective technique in gathering data from school children (McNulty & Borgen, 1988; Seligman, Weinstock, & Owings, 1988).

Two of the variables measured in this study were occupational aspirations and occupational expectations. Occupational aspirations were measured through the question "As an adult, if you could have any job you wanted, what job would that be?" Occupational expectations were measured through the question "As an adult, what job do you *really* think you will have?" In the second grade, 50% of the students' aspirations matched their expectations; this percentage climbed to 71% by the 12th grade. This article focuses on students' occupational aspirations.

Classification of Occupations

In order to compare the findings to certain theoretical constructs, occupational aspirations named by the students were assigned a social value and given a gender designation. Initially, each occupation was assigned a *Dictionary of Occupational Titles* (DOT; U.S. Department of Labor, 1991a) code. Only the first digit of the code was used in this study. The first digit represents 1 of 9 general categories of occupations. For example, if the first digit is a 0 or 1, the occupation falls into the professional, technical, and managerial category. All the possible first digits in a DOT code represent the following categories of occupations:

0-1 Professional, technical, and managerial
2 Clerical and sales
3 Service
4 Agricultural, fishery, forestry, and related
5 Processing
6 Machine trades
7 Bench work
8 Structural work
9 Miscellaneous

The social value of occupations was measured broadly using the first digit of the DOT code. Occupations in the professional, technical, and managerial category "require substantial educational preparation" (U.S. Department of Labor, 1991a, p. 13). As a group, these occupations have higher Specific Vocational Preparation (SVP) indicators, which range from 1 to 9, than do other occupations. Occupations with an SVP of 9 require more than 10 years of preparation. Consequently, children who identified occupational aspirations in the professional, technical, and managerial category are aspiring to higher social value occupations.

Gender was assigned to occupations based on national data gathered and disseminated by the U.S. Department of Labor (1990, 1995) in their publication *Employment and Earnings*. This publication indicates the gender mix of jobholders in hundreds of occupations. If the occupation had 70% or more male workers, it was designated a "male" occupation. If the occupation had 70% or more female workers, it was designated a "female" occupation. All other occupations were designated as "neutral." Other researchers have used gender ratios between 60% (Hageman & Gladding, 1983; Henderson et al., 1988) and 75% (Garrett, Ein, & Tremaine, 1977; Trice, Hughes, Odom, Woods, & McClellan, 1995). If a student named an occupation not on the national list, an occupation closest to the child's preference that was on the national list was identified and gender assigned accordingly.

RESULTS

Over the 10-year span, the size of the sample decreased as follows: 2nd grade (n = 208), 4th grade (n = 160), 6th grade (n = 130), 8th grade (n = 123), 10th grade (n = 115), and 12th grade (n = 103). Some students dropped out of the study because they moved to a different elementary school after the 2nd or 4th grade, but they were later "found" in middle or high school. Second, 4th, and 6th graders were surveyed in their original four elementary schools. As 8th graders, the children were attending five middle schools, and as 10th and 12th graders, they were found in six high schools.

Of the 208 students who began the study, 75 were available at all six data collection points. Comparison of those students who were available at all time points and those who were not indicated no significant differences between those groups for gender, parental age, or parental education level. There was a group difference for ethnicity. This appeared to be due to the fact that eight Asian American youngsters began the study, but only one was available all six times. The only other noteworthy difference between the two groups was that more students who were available at all six data gathering sessions lived with both parents than did those who were not available at all six time points (83% versus 72%).

Table 1 presents the means, standard deviations, and results of the repeated measures analyses for a number of variables related to the students' out-of-school activities. The

TABLE 1

Means, Standard Deviations, and Repeated Measures Analyses of Variance for Out-of-School Activities for Students Surveyed in Grades 2, 4, 6, 8, 10, and 12

	Grade 2		Grade 4		Grade 6		Grade 8		Grade 10		Grade 12				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*n*	*F*	*p*
Number of sports, lessons, activities participated in outside of school during last 12 months	2.25	1.38	2.31	1.30	2.58	1.51	2.54	1.77	2.58	1.75	1.40	1.43	74	9.36	.000***
Number of hobbies during last 12 months	0.97	0.65	1.29	0.69	1.52	0.76	1.54	0.97	1.76	1.01	1.66	1.49	75	7.26	.000***
Number of chores you do each week around the house	2.81	1.51	3.56	1.35	3.68	1.32	3.62	1.25	2.61	1.29	1.89	0.93	75	29.65	.000***
Allowance you get each week	$1.74	$2.70	$1.66	$2.06	$3.89	$7.03	$5.02	$5.29	$7.27	$10.65	$3.15	$7.06	58	13.60	.000***

Note. Data based on the 75 students at all six interview points.
***$p < .001$.

students were asked about their involvement in sports, lessons, and other activities outside of school; the hobbies in which they participated; the chores they performed at home; and whether they got an allowance and how much that was.

The findings indicate that over the 10 years of the study, there were significant changes in all of these activities. The children were involved in an average of 2.25 to 2.58 activities each year outside of school until their senior year in high school when the average dropped to 1.40. The number of hobbies each student claimed began at about 1.0 in 2nd grade and peaked at 1.76 in 10th grade. Students reported performing a number of chores around the house beginning at an average of 2.81 in 2nd grade and peaking at 3.68 in the 6th grade. By their senior year, they reported doing an average of 1.89 chores each week. The amount of allowance given to each student varied considerably over the 10 years. The lowest average allowance occurred in the 4th grade ($1.66) and the highest in the 10th grade ($7.27). These mean allowance rates must be interpreted cautiously because the standard deviations exceeded the mean allowance at all six data points. Clearly, a wide range of allowances was reported.

Table 2 presents descriptive data for a number of demographic variables. During the interviews, students were asked about their favorite and least favorite school subjects. School subjects receiving the two highest endorsements are reported for each grade. Math was the most liked school subject except in the 8th and 12th grades, when it was rated the 2nd most favorite. It should be noted that the percentage of those reporting math as their most favorite subject generally declined across time. By the 12th grade, only 21% of the sample reported math as a favorite (or 2nd favorite) class, down from an initial 57% in 2nd grade.

For the early grades (2nd and 4th) and the late grades (10th and 12th), language arts and English were the least favorite school subjects. The least favorite subject when the youngsters were in the 6th and 8th grades was math. Math showed up as the 2nd least favorite in the 10th and 12th grades.

Table 2 also presents the percentage of students aspiring to professional, technical, and managerial occupations as

TABLE 2

Percentages and Descriptive Statistics for Selected Demographic Variables for Students Surveyed in Grades 2, 4, 6, 8, 10, and 12 (*N* = 75)

Variable	Grade 2	Grade 4	Grade 6	Grade 8	Grade 10	Grade 12
Two most favorite school subjects						
Math	57	52	36	23	33	21
Reading	15					
Science		20	20	27		
Social Studies					20	24
Two least favorite school subjects						
Language Arts	19	23		23		
Reading	16	20				
Math			28	37	27	27
Science			21			
English					45	41
Occupational aspiration category						
Prof., technical, managerial	55	80	84	96	91	81
Other	45	20	16	4	9	19
Do you plan to attend college?						
Yes	71	81	91	95	89	91
Not sure	24	19	8	4	10	5
No	5	0	1	1	1	4
Should married women without children work?						
Yes	81	80	81	80	70	87
Not sure	12	15	18	16	26	11
No	7	5	1	4	4	2
Should married women with preschool children work?						
Yes	43	29	27	33	19	15
Not sure	9	16	24	27	22	28
No	48	55	49	40	59	57
Who the student lives with						
Both parents	83	77	82	72	71	64
Mother	12	16	14	20	21	28
Other	5	7	4	8	8	8
Money expected for a year on your job as an adult						
Low–high	$5–$2,000,000	$10–$4,000,000	$86–$12,000,000	$2,000–$10,000,000	$2,000–$1,000,000	$20,000–$100,000,000
Mean	$45,857	$258,866	$642,128	$342,246	$84,820	$2,810,465
Median	$175	$3,000	$40,000	$45,000	$50,000	$50,000
Mode	$100	$1,000	$1,000,000	$50,000	$50,000	$50,000

Note. Data based on the 75 students at all six interview points. Prof. = professional.

they progressed through school. Beginning in the 2nd grade, 55% listed a job in this category while 45% chose other occupations. By the 8th grade, 96% chose these high social value occupations for themselves. This dropped to 81% when they were in the 12th grade.

College attendance was always a strong possibility for these students, even when they were in elementary school. In the 2nd grade, 71% indicated they would attend college, and by 8th grade, 95% indicted they would. Only 1% said "no." By high school age, about 90% expected to go to college.

Two survey questions dealt with participants' beliefs regarding gender roles. They were asked whether married women should work and whether married women should work if they have young (preschool) children. Over the years, from 70% (10th graders) to 87% (12th graders) indicated that married women should work. The responses to the question about whether married women with preschool children should work were different. Forty-three percent of the students said "yes" when they were in the 2nd grade; this percentage dropped to 15% by the time they were in the 12th grade. The range of *no* responses was 40% in the 8th grade to 59% when these students were in the 10th grade.

Information about "Who the Student Lives With" was also gathered every 2 years. As 2nd graders, 83% of this sample lived with both parents, but only 64% did so when they were 12th graders. The most common alternative was living with mother (28% of 12th graders).

The final item in Table 2 reports the amount of money students expected to earn on the job for a whole year when they became adults. The low ($5–$20,000) and high- ($1,000,000–$100,000,000) expected salaries might reflect a lack of information about actual compensations.

In the 10th and 12th grade, an additional set of questions was asked about parental involvement in career discussions and sureness and confidence in career aspiration and the future. In addition, questions were asked about the students' perceptions of the help provided by their schools in their career development and their confidence in acquiring skills that employers expect. Finally, each youngster was asked several questions about their work experience. The results of the paired *t* tests for these variables are shown in Table 3.

The depth of their career discussions with each parent was recorded on a Likert scale of 1 *(superficial)* to 7 *(in-depth)*. There was a significant difference between the depth of career interest discussions with their mothers at the 10th and 12th grades, indicating a greater depth in the 12th grade. The differences in the depth of career interest discussions with their fathers were not significant. However, an exami-

TABLE 3

Means, Standard Deviations, and Paired *t* Tests for Students at Grades 10 and 12 for Selected Parental, School, and Career Variables

	Grade 10		Grade 12			
Variable	***M***	***SD***	***M***	***SD***	***t***	***p***
Depth of career discussions with mother during last year[a]	4.38	1.22	4.81	1.47	–2.22	.029*
Depth of career discussions with father during last year[a]	4.43	1.59	4.83	1.48	–1.88	.065
How sure are you that your occupational aspiration is the job for you?[b]	5.26	1.41	5.48	1.42	–1.38	.172
How do you feel about your occupational future?[c]	5.23	1.38	5.52	1.33	–1.84	.069
Can you see a connection between your school subjects and your occupational direction?[d]	4.91	1.63	4.75	1.84	0.75	.458
Since you have been in high school, do you feel that the school has helped and supported you in your						
search for career direction?[e]	4.75	1.64	4.64	1.78	0.46	.648
career preparation?[e]	4.60	1.74	4.52	1.65	0.40	.692
Are you confident that upon completion of high school, you will have the level of skills (i.e., SCANS) required by today's employers?						
Academic (reading, writing, arithmetic)[d]	5.74	1.23	5.70	1.32	0.24	.810
Thinking (problem solving and decision making)[d]	6.00	1.11	5.75	1.18	1.65	.103
Personal (verbal communication, ethical, self-motivation, and responsible mannerisms)[d]	5.77	1.19	5.94	1.16	–1.29	.237
When asked, 62% of 10th graders and 94% of 12th graders worked during the past year.						
Approximately how many weeks did you work?	23.70	17.21	39.49	16.52	–5.85	.000***
Approximately how many hours per week?	15.35	8.10	21.02	7.00	–4.17	.000***
How much did you earn per hour?	5.47	18.81	6.53	18.93	–3.14	.003**

Note. SCANS = Secretary's Commission on Achieving Necessary Skills. Data were obtained from the 97 available students in the 10th and 12th grades.

[a](1 = *superficial,* 7 = *in-depth*). [b](1 = *not sure,* 7 = *very sure*). [c](1 = *worried,* 7 = *confident*). [d](1 = *not at all,* 7 = *very much so*). [e](1 = *no,* 4 = *sometimes,* 7 = *yes*).

*$p < .05$. **$p < .01$. ***$p < .001$.

nation of the means suggests that the depth of discussions was similar to those the students had with their mothers.

Using a similar 7-point scale for most other items reported in Table 3, students reported that they were fairly sure that their occupational aspiration was the job for them, and they were confident about their occupational future. Students seemed to be less sure that their school helped them in searching for a career direction and in preparing them for their career. Their confidence was high that they possessed the academic, thinking, and personal skills employers require. There were no significant differences between the mean ratings on these variables between the 10th and 12th grades.

Work patterns were different between the two time points. Whereas 62% had worked during the past year when they were sophomores, nearly all had worked as seniors (94%). As seniors they were employed significantly longer (39.49 vs. 23.70 weeks) than as sophomores. Hours worked per week (15.35 vs. 21.02) and hourly pay ($5.47 vs. $6.53) were significantly less when these students were in the 10th grade than when they were in 12th. Pay rates at both time points averaged near minimum wage.

Finally, the youngsters were asked to identify the two people or organizations that most affected the development of their occupational interests. This open-ended question yielded many response categories. The most common responses were similar at both times, but the numbers reporting each as an influence were noticeably different as they moved from the 10th to the 12th grade. Besides the Other category, mother, father, and parents together were identified most often in the 10th grade. Teacher, school, sibling, and counselor were each named by a small percentage of 10th graders. The Other category included names of specific individuals whose relationship was unknown and organizations and entities, such as the National Aeronautics and Space Administration, TV, professional athletes, and so on. By the 12th grade, parental influences had moderated and teachers had become the primary influences as reported by one third of the students.

DISCUSSION

A large number of variables were measured in a sample of students beginning in the second grade when the children were 7 years of age (fall semester) and concluded 10 years later when the students were 18 years of age (spring semester) as seniors in high school. The variables centered on educational and career issues but included such concepts as out-of-school and home activities, gender role beliefs, and living circumstances. A number of changes were observed that support vocational behavior and career development theory. The study also provided a rich description of career-related issues of a sample of students moving from the dependence expected in elementary school children to the maturity expected of young adults about to leave high school.

The level of participation and involvement in out-of-school activities was assessed for each student. These activities included sports in community programs such as soccer, baseball, and swimming; lessons in dance; musical instruments; or other community- and church-sponsored youth activities, choir, and so on. These youngsters were highly involved in such activities with a mean 2.2 activities or higher until their senior year. The mean number dropped to 1.4 activities in the 12th grade, and the principal reason for the drop by 12th grade may have been employment. Most seniors (94%) held jobs during the last 12 months at the time of the interview. Clearly, this is an active sample of students. Communities' recreation departments provide many of these opportunities and the middle-class families from which these children came had the resources to take advantage of dance classes and private music lessons.

In addition to activities identified earlier, most students had a hobby. Typical hobbies included collections of all kinds, playing an instrument, computer games, and inline skating. The mean number of hobbies was about 1 in the 2nd grade and peaked at 1.7 in the 10th grade. Students were also expected to perform chores around the house, and these chores went beyond keeping their own room neat and clean. Cleaning bathrooms, vacuuming, doing the dishes, taking care of pets, and helping with younger siblings were common chores. High school level chores included taking care of trash, doing laundry, caring for younger siblings, helping with homework, and such "chores" as taking care of grandma. After the 2nd grade, most students reported an average of three or more chores until the 10th grade.

Reported average weekly allowances tended to rise until the 12th grade with the low occurring at the 4th grade ($1.66). Tenth graders received $7.27. Some older students reported getting a weekly or monthly stipend from which they used money for school lunches, transportation, recreation, and small personal items. The issue of allowance may become moot when students work, as it did for 94% of the seniors. As the data in Table 1 indicate, allowance amounts varied tremendously. Standard deviations of the allowances at all grade levels were higher than mean allowances.

At each interview point, students were asked about favorite and least favorite courses. Math was chosen at all levels as the most or second most favorite subject. However, over the years, there was a trend of fewer students selecting math as a favorite course. On the other hand, math was named as least or 2nd least favorite course as well, beginning in the 6th grade. Clearly, math appears to be a course either to like or dislike by many students over their school years. Other least favorite courses were language arts, in 2nd and 4th grades, and English, in 10th and 12th grades. Looking only at the high school results, over 40% of the students disliked English, and 27% disliked math. This does not bode well for building core competencies in students for later use in work environments or higher education.

One of the principal variables measured in this longitudinal study was occupational aspiration, which had direct theoretical implications. Gottfredson's (1981, 1996) circumscription and compromise theory suggests that 6- to 8-year-old children choose occupations that match their own gender. In this study, 2nd- and 4th-grade boys and girls (7 and 9 years

of age) did just that (Helwig, 1998c). Gottfredson's (1981, 1996) theory further suggests that 9- to 13-year-olds become very aware of the social status and value differences between occupations and, at this age, select an occupation that fits their perception of the social value to which they aspire. In fact, youngsters in the 6th and 8th grades (12 and 14 years of age) aspired increasingly to higher social value occupations. Gottfredson's theory further argues that for individuals 14 years of age and older, a principal determiner of occupational aspiration is internal, unique issues including interests and vocational needs. Gender of occupation and social value may be less dominant in choosing an appropriate career. Some evidence for this trend was found. Beginning in the 10th grade and escalating in the 12th, fewer students named their occupational aspiration from jobs in the professional, technical, and managerial category. More students chose occupational aspirations in sales, service, processing, and other lines of work (Helwig, 2001).

An alternative explanation for the decrease in the number of students opting for professional, technical, and managerial occupations by their senior year may come from social cognitive theory (Lent et al., 1996). With maturity, these youngsters increased their self-awareness and knowledge of their academic and vocational strengths and weaknesses. This affected their self-efficacy and confidence for particular educational and vocational possibilities. Consequently, by the end of their high school careers, these students chose occupations they felt more confident about, and fewer of these were professional, technical, and managerial in nature.

More recently, Albert and Luzzo (1999) as well as Lent et al. (2000) suggested that the identification of barriers influences occupational aspirations. The students in this sample may have become more aware of the barriers found in some professional, technical, and managerial occupations and began opting out of them as they moved through high school. This may also be evident in the number of fantasy occupations students selected over time. There was a decrease in choice of fantasy occupations, especially by boys, and it may have been due to increasing recognition of barriers that became more obvious in the high school years (Albert & Luzzo, 1999; Helwig, 2001; Lent et al., 2000).

Gender roles are perceived and learned by children at an early age. Gottfredson's (1981, 1996) Stage 2 suggests that children from ages 6 to 8 become aware of gender role differences in general and in the workplace specifically. Students were asked two gender role questions throughout this longitudinal study. The first asked if married women without children should work. The response from this sample over time was consistent; most students said it was okay. Students were much more ambiguous about working women with preschool children. In fact, as the students became older, they tended to support the idea less and less. For this predominately White, suburban sample, questions remain about the role of the woman as homemaker and career person when young children are present. By the time these students were in high school, they may have been more aware of or have adopted the lingering social and community dictum "A mother's place is in the home" when there are preschool children. Current issues about social ills, including the need for family involvement in rearing children to prevent early drug use and violence, may be translated by some as the need to have mother at home when the child most needs her.

The trend for more students not to live with both parents, over a 10-year time span, is not surprising. Eighty-three percent of 2nd graders lived with both parents, but only 64% of 12th graders did so. Watching a single parent manage a household (especially with preschool children present) may have influenced older students to report that such mothers should not work.

Annual salaries expected by these students in their adult jobs have a fantasy ring to them but are also informative. The low amounts are perhaps as instructive as the highs and suggest a lack of information and awareness of the world of work. On the other end of the scale, the number of students who reported $1,000,000 or more as annual salaries was 2 (2nd grade), 8 (4th grade), 13 (6th grade), 7 (8th grade), 2 (10th), and 2 (12th grade). Collectively, 6th graders had the highest annual salary expectations in terms of mode (i.e., $1,000,000). The source of the high figure was probably the 36% of boys who expected to be professional athletes, with most of them playing football.

The role of schools in career education has been debated and promoted for generations (Gysbers & Moore, 1987; Hansen, 1970; Herr & Cramer, 1996: Hoyt, 1972; Hoyt & Wickwire, 2001). More recently, the National Occupational Information Coordinating Committee (1989) career guidelines, the U.S. Department of Labor (1991b) SCANS and the U.S. Department of Education and U.S. Department of Labor (1996) School-to-Work Opportunities program have made strong statements about the importance of schools, employers, and the community in preparing youngsters for successful post–high school educational and work opportunities. In light of those efforts, a number of questions were asked of 10th and 12th graders about the involvement of their schools in their career development and the extent to which the schools have been helpful in preparing them for their future roles.

When asked if their school had been helpful and supportive in their search for a career direction and in their career preparation, students' responses were only slightly positive. A continuing dilemma for educators is to convincingly demonstrate the relevance of course material to students. Perhaps a more practical application-oriented approach would be useful.

Even though the students had mixed feelings about their schools' career help and support, by the time they were in the 12th grade, teachers were reported as having the "most impact upon occupational interest" versus family members in the 10th grade. In fact, one third of the senior sample reported teachers as most influential. Thus, even though the school as an educational enterprise was not highly regarded by students as helpful, individual teachers of advanced and specialized courses that students had taken during the last 2 years of high school did have an impact. The 12th graders purposefully did not say school was helpful, they said teachers were helpful.

Of the 17-year-olds in the national study reported by Tiedeman et al. (1978), a total of 46% were working either full- or part-time. In this study, the number of seniors who worked during the 12 months preceding the interview was 94%, which contrasted with 62% of the sophomores. As one would expect, seniors worked more weeks of the year, more hours during the week, and received higher wages than when they worked as sophomores. It is likely that their work experience contributes to their career development in terms of identifying likes and dislikes for certain work activities, job environments, coworkers, and supervisors. Having a job would also build confidence in their abilities to work successfully and use a variety of skills. The high level of confidence students reported in possessing the SCANS skills might be due as much to their work experience as to their school experience. In addition, I have noted that these students are very active in a variety of community activities, the vast majority report one or more hobbies, and nearly all perform chores at home. All of these activities contribute to the building of skills in multiple areas as well as promote awareness and self-confidence. Career development is built on a wide range of experiences and activities including those occurring in the home, community, school, and workplace.

CONCLUSIONS AND IMPLICATIONS

This longitudinal study examined career development issues experienced by a sample of school children over a 10-year time frame, from the 2nd to 12th grades. Beginning with a sample of 208, children were interviewed and completed assessment measures in the 2nd, 4th, 6th, 8th, 10th, and 12th grades. One hundred and three students were available for the 12th-grade interviews, and 75 of them were available at all six data collection points. The value of a longitudinal study is the control of intraindividual variation.

A limitation of this study is the nature of the sample, which is primarily White, suburban, and middle class. Parents of the children averaged 13.5 years of education and lived in their own homes. However, given the size of this sample, having a great deal of diversity would also be problematical because various subgroups would be small in number. In fact, this sample probably reflects the largest number of students in our school systems, those who are White, middle class, and suburban.

The focus of the study was the students', not their schools', academic programs and activities. All the students began their studies in four elementary schools, proceeded to five middle schools, and ended in six high schools. Most sophomores and seniors were enrolled in 3 of the 6 high schools. The elementary schools (Grades K–6) had no school counselors; the middle and high schools averaged about 400 students per counselor. All schools were located in the same large school district, which has more than 20 high schools. It is safe to say that students experienced a variety of career education programs and activities. No particular or unusual career education programs were in place. Most students expected to go to college.

All the students could name occupational aspirations, and, by their senior year, these aspirations were generally similar to their expectations. However, 56% of the aspirations named by students as seniors had never been named by them at any time during the previous 10 years. Clearly, during the last 2 years of high school, many identified an aspiration new to them, and they began moving away from high social value occupations. One third of the seniors reported that a teacher was influential in the development of their occupational interest. All of these developments demonstrate increasing self-awareness and maturity. Nearly all students had jobs by their last semester in high school, and more than half had worked since they were sophomores. They were well into the world of work. Their confidence level about their occupational future and their degree of sureness that their aspiration was the job for them reached 5.54 and 5.46 on a 7-point Likert scale.

Can schools do more to assist students in their career development? Perhaps schools can do more, but probably only marginally and incrementally and only for some youngsters. Until it "really counts," near graduation from high school, most students at younger ages may not be developmentally ready to (or need to) give up their occupational fantasies, high social value occupations, and $1,000,000 salaries. However, they do give up fantasy occupations, settle for somewhat lower social value occupations, and expect more modest salaries. These consequences result from a combination of forces and factors including awareness of strengths and weaknesses, parental discussions, teacher input, work experiences, and the innumerable other variables that differentially affect youngsters as a result of their busy and complex lives. Career education and its consequent career development happen everywhere, all the time, but will only be effective when the recipient is ready.

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The Relationship Between Marital Characteristics, Marital Interaction Processes, and Marital Satisfaction

Jane R. Rosen-Grandon, Jane E. Myers, and John A. Hattie

Structural Equation Modeling techniques were used to clarify the relationship between marital characteristics, marital processes, and the dependent variable—marital satisfaction—in a sample of 201 participants who were in 1st marriages. The Dyadic Adjustment Scale (DAS; G. B. Spanier, 1976) and the Enriching and Nurturing Relationship Issues, Communication and Happiness Inventory (ENRICH; D. H. Olson, D. G. Fournier, & J. M. Druckman, 1987) provided scales to measure marital interaction processes and marital satisfaction. A new instrument, the Characteristics of Marriage Inventory (CHARISMA; J. R. Rosen-Grandon & J. E. Myers, 2001), was developed using factor analysis to determine which marital characteristics were statistically significant. Structural equation modeling identified a path model wherein 6 marital interaction processes had a statistically significant influence on marital satisfaction when mediated by 3 latent factors of marital characteristics (love, loyalty, and shared values) and 2 moderating variables (length of marriage and gender of participant).

Marriage has been described as the most important and fundamental human relationship because it provides the primary structure for establishing a family relationship and rearing the next generation (Larson & Holman, 1994). The desirability of marriage is reflected in surveys suggesting that 90% of Americans will choose to marry at some point in their lives (Brubaker & Kimberly, 1993). According to Aldous (1996), a good marriage provides individuals with a sense of meaning and identity in their lives. A variety of studies have demonstrated that people are generally happier and healthier when they are married (Gottman, 1994; Kelly & Conley, 1987; Orbuch & Custer, 1995; White, 1994). Yet, while marriage seems to be a highly desirable relationship, statistics indicate that marital satisfaction is not easily achieved. One has only to consider the chronically high rates of divorce in order to appreciate the magnitude of this problem.

Between one half and two thirds of all first marriages in the United States end in divorce (Brubaker & Kimberly, 1993; Martin & Bumpass, 1989). The decision to divorce, however, does not mean that these individuals do not want to be married. Most people like to be married and tend to be happier and healthier when they are married. Therefore, it is not surprising that within 5 years of divorce, 77% of women and 84% of men remarry (Brubaker & Kimberly, 1993). Furthermore, the average length of the waiting period between divorce and remarriage seems to be shrinking from 5 to 3 years (Mackey & O'Brien, 1995). Unfortunately, of those who remarry, 60% are likely to divorce again (Martin & Bumpass, 1989), suggesting that even in their remarriages, people are unable to achieve sufficient marital satisfaction. Clearly, knowledge of how to achieve a successful marriage has lagged behind the popularity of this institution.

While the study of marital satisfaction has a long and well-documented history, it is clear from the consistently high divorce rates that still too little is known about ways to achieve and maintain a sufficient level of marital satisfaction to assure marital success (Arcus, 1992; Schvaneveldt & Young, 1992). Historically, much of the research on marital satisfaction has examined simple linear relationships between variables. Studies have typically focused on either the relationship between marital characteristics and marital satisfaction or the relationship between marital interaction processes and marital satisfaction when, actually, both of these sources of variance are operative (Kurdek, 1995). Gender also has been identified as an important, but poorly understood, influence on marital satisfaction (Glenn, 1990; Heppner, Kivlighan, & Wampold, 1992). Although the existing research has accounted for some of the variance in explaining marital satisfaction, there is a need for studies of more complex models to explain how multiple factors influence and are related to marital satisfaction (Robinson & Blanton, 1993). Two of the major factors that should be incorporated in these studies are marital characteristics and marital interaction processes.

Numerous attempts have been made to identify the components of marital satisfaction through studies of characteristics of happy long-term marriages (Fenell, 1993; Glenn, 1990; Lauer, Lauer, & Kerr, 1990; Robinson & Blanton, 1993).

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These include studies of long-term relationships (Fenell, 1993; Lauer et al., 1990; Robinson & Blanton, 1993), or those lasting more than 20 years (Mackey & O'Brien, 1995), studies of newlyweds married less than 3 years, and studies of persons in midlength marriages lasting between 4 and 20 years (Collins & Coltrane, 1991; Larson & Holman, 1994).

Fenell (1993) used a modified "delphi method," a consensus-building technique, to narrow down a larger list of marital characteristics to the 10 most important ones in long-term successful marriages. This method employed a panel of individuals with expert knowledge of this subject, who engaged in a three-round process of elimination to arrive at the desired consensus. The 10 most important characteristics, in order from *most* to *least* important, were identified as

1. Lifetime commitment to marriage
2. Loyalty to spouse
3. Strong moral values
4. Respect for spouse as a friend
5. Commitment to sexual fidelity
6. Desire to be a good parent
7. Faith in God and spiritual commitment
8. Desire to please and support spouse
9. Good companion to spouse
10. Willingness to forgive and be forgiven

In contrast, Collins and Coltrane (1991) reported the results of a public opinion poll indicating that the most important components of marriage were faithfulness (93%), understanding (86%), a good sex life (75%), children (59%), common interests (52%), sharing household chores (43%), having enough money (41%), and sharing similar backgrounds (25%).

Lauer et al. (1990) also studied characteristics of couples that had been married more than 45 years. These couples attributed their marital satisfaction to the following components: (a) They were married to someone they liked, (b) they had a commitment to the person as well as to the marriage, (c) they had a sense of humor, and (d) they were able to reach consensus (i.e., agreement). Robinson and Blanton (1993) studied couples who had been married an average of 40 years. They identified the key characteristics of happy marriages as (a) intimacy, (b) commitment, (c) communication, (d) congruence, and (e) shared religious orientation. According to these authors, characteristics that are related to enhanced marital quality include love, reciprocity, communication, understanding, religious orientation, patience, commitment, intimacy, shared responsibility, personal identity, persistence, hopefulness, flexible boundaries, and congruence.

Kurdek (1991) studied couples at the time of their marriage and 1 year later in the effort to investigate characteristics of marriage from a contextual perspective, where the context was the transition from being single to being married. He reported on couples who stayed together during the 1st year versus those who did not, and he concluded that three personality variables predicted marital satisfaction: (a) motives to be in the relationship, (b) satisfaction with social support, and (c) psychological distress.

Craddock (1991) applied a Circumplex Model of marital and family systems in a study of 100 Australian couples married an average of 8 years, using the two dimensions of cohesion and adaptability, to provide a structural typology of relational systems. He found that couples that were more flexible, adaptable, and cohesive reported greater marital satisfaction than couples that were chaotic, rigid, or random. Craddock also noted a positive correlation between marital satisfaction and similar religious orientation, similar personality issues, ability to resolve conflict, agreement on financial management, leisure activities, children and marriage, and family and friends. Relatedly, Schumm (1985) reported that similarity in religious orientation, quality of communication, and time spent together were the most important determinants of marital satisfaction.

Although some studies suggest that certain aspects of parenting are associated with decreased marital satisfaction (Glenn, 1990), the presence of children seems to be positively related to marital satisfaction (Kurdek, 1995). Children provide an important source of social support throughout life (Collins & Coltrane, 1991), even though certain aspects of marital satisfaction decrease during the child-rearing years (Glenn, 1990; White & Booth, 1991). Marital conflict has been shown to be more severe during the child-rearing phase; however, interpersonal confrontation between spouses is more adaptive than avoiding the problem. When major difficulties remain unresolved, conflict has a disruptive and corrosive effect on marital satisfaction that continues into the post–parenting years (Mackey & O'Brien, 1995).

A review of the literature on marital satisfaction from an ecological perspective, conducted by Larson and Holman (1994), resulted in three categories of factors: (a) background or contextual factors (i.e., family-of-origin variables, sociocultural factors, and current contexts), (b) individual traits and behaviors, and (c) couple interaction processes. They concluded that the strongest predictor of marital instability is young age at the time of marriage. They reported that race was not a good predictor of marital satisfaction and that the role of gender is still not clearly understood. Moreover, they reported that both approval of the relationship by friends and positive perceptions of the couple's marriage are predictive of marital satisfaction, whereas the effects of parental pressure through overinvolvement or intimidation are predictive of marital dissatisfaction. Larson and Holman distinguished between characteristics of individuals and characteristics of relationships, and they concluded that confusion in the literature between marital characteristics and marital interaction processes contributes to an inability to fully understand the factors affecting marital satisfaction. Larson and Holman's conclusion has been supported by other researchers, notably Arcus (1992), Kurdek (1991), and Mackey and O'Brien (1995).

In Mackey and O'Brien's (1995) study of "lasting marriages," the authors described marriage as a developmental process that occurs in adulthood and that results in the establishment of various marital interaction processes. These marital interaction processes are either behaviors that are transacted

within the relationship or interpersonal dynamics that evolve within the relationship and influence marital satisfaction. The authors identified five marital interaction processes: (a) containment of conflict; (b) mutuality in decision making; (c) quality of communication; (d) sexual and psychological intimacy; and (e) relational values of trust, respect, empathetic understanding, and equity.

The work of Lewis and Spanier (Lewis & Spanier, 1979; Spanier, 1976) concentrated on three marital interaction processes: consensus, cohesion, and affectional expression. Consensus refers to agreement on matters of finances, recreation, religious matters, friendships, proper behavior, philosophy of life, ways of dealing with parents and in-laws, agreement on aims and goals, agreement on time spent together, decision making, division of household labor, leisure activities, and career decisions (Spanier & Lewis, 1980). Cohesion refers to the degree to which an individual feels connected to or separate from the marital relationship system. Craddock (1991) indicated that cohesion involves emotional bonding, or how close partners feel to each other, and can be measured on a scale that extends from *enmeshment* (high cohesion) to *disengagement* (low cohesion). Affectional expression pertains to demonstrations of affection and sexual relations. Ade-Ridder (1990) found that continued sexual activity and sexual interest were important to maintaining a high quality marriage in later life.

Spanier (1989) noted that marital interaction processes referred to interactions of the couple, not just to actions of the individual. He also emphasized the "process" component of marital interaction processes and the idea that each process can be measured along a continuum at a given point in time. Spanier (1976) demonstrated that it was possible to assign a value to each variable at a given point and then measure growth and change over time. Because the nature of marital interaction processes is dynamic, research methods must have the capacity to measure changes in these marital interaction processes. Consistent with this logic, Larson and Holman (1994) noted that much recent research has shifted from the study of static, sociocultural, or family-of-origin background factors (e.g., marital characteristics) to the investigation of interactional dynamics of couples (e.g., marital interaction processes). In addition, studies of both marital characteristics and marital interaction processes suggest the importance of gender as a mediating or moderating variable (Ekerdt & Vinick, 1991; Keith & Wacker, 1990), as well as marital longevity (Keith & Wacker, 1990; Mackey & O'Brien, 1995).

Based on the recommendations of Kurdek (1995) and others cited here, the present study was undertaken to determine factors important to understanding marital satisfaction and to explore the relationships among those factors. The primary research question addressed was as follows: What is the nature of the relationship between marital characteristics, marital interaction processes, and marital satisfaction? The manner in which gender and length of marriage influences the relationship between marital interaction processes and marital satisfaction also was of interest.

METHOD

Following an extensive review of the literature on marital satisfaction, we developed a conceptual model that hypothesized a relationship between marital characteristics and marital satisfaction that is mediated by marital interaction processes and moderated by gender and marital longevity (see Figure 1). That is, the relationship between marital characteristics and marital satisfaction is influenced by marital interaction processes, and marital interaction processes, themselves, influence marital satisfaction. It was further hypothesized that the moderating variables, gender and length of marriage, will affect the strength and direction of the relationship between various marital interaction processes and marital satisfaction.

Instruments

Four instruments were used to test the proposed structural model. These included the Dyadic Adjustment Scale (DAS; Spanier, 1976), the Enriching and Nurturing Relationship Issues, Communication and Happiness Inventory (ENRICH; Olson, Fournier, & Druckman, 1987), the Characteristics of Marriage Inventory (CHARISMA; Rosen-Grandon & Myers, 2001), and a demographic questionnaire that assessed a variety of descriptors including gender and length of marriage.

Spanier's (1976) DAS, the most frequently used measure in the study of marital satisfaction, is a 32-item paper-and-pencil instrument that measures four independent factors: consensus, affectional expression, cohesion, and marital satisfaction. Content validity of the DAS was established through examination by a panel of three judges. Construct validity has been established through its use in more than 1,000 studies, and concurrent validity has been established by its correlation of $r = .86$ with the Locke-Wallace Marital Adjustment Scale (Fowers, 1990). Criterion-related validity was established through multiple studies that demonstrate that scores on the DAS distinguish between married and divorced individuals, married and cohabiting couples, heterosexual and homosexual couples, and open and closed relationships, as well as sex role and gender differences and differences between childless and parenting couples (Spanier, 1989).

The ENRICH Inventory is a 125-item multidimensional marital satisfaction scale that contains 14 subscales. Four of

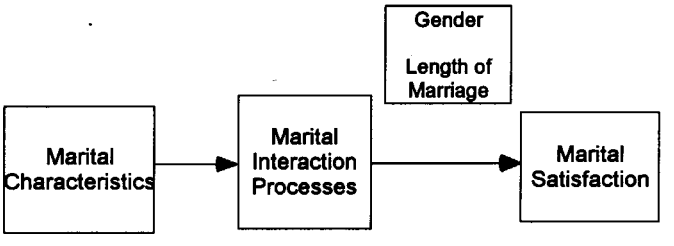

FIGURE 1

Originally Hypothesized Conceptual Model of Marital Satisfaction

the ENRICH subscales provide measures for Mackey and O'Brien's (1995) marital interaction processes: (a) Containment of Conflict, (b) Mutuality in Decision Making, (c) Sexual and Psychological Intimacy, and (d) Communication. Fowers (1990) reported a correlation of .73 between the ENRICH Inventory and the Locke-Wallace Marital Adjustment Test, a moderate correlation with family and life satisfaction measures (i.e., construct validity), and discriminative validity based on the ability of the ENRICH Inventory to distinguish between satisfied and dissatisfied couples.

CHARISMA (Rosen-Grandon & Myers, 2001) is an 18-item per scale instrument that is based on research conducted on marital characteristics by Fenell (1993) and Mackey and O'Brien (1995). Participants were asked to respond to a list of characteristics by rating these items in terms of "importance" of these characteristics and their "satisfaction" with these characteristics in their current relationship. The dependent variable, marital satisfaction, was measured using a composite scale with three items from the DAS Satisfaction scale and three from the corresponding ENRICH scale. The composite scale was developed using results of a factor analysis of the two scales, as described in the following section.

Participants and Procedure

Participants were selected using a purposeful sampling procedure in which volunteer respondents were recruited at a shopping mall in a large southeastern city on three consecutive weekends. Prospective participants were screened to ensure that all were in their first marriage, currently residing with their spouse, and were the only member of their marital dyad to participate. The final sample included 137 women and 64 men, of whom 77% were Caucasian and 23% ethnic minorities (primarily African American). They ranged in age from 20 to 75 years, with an average age of 39 years. The highest levels of education for husbands in this sample were as follows: 8% had less than a high school education, 15% had completed high school, 8% had completed trade or business school, 29% had some college, 21% were college graduates, 6% had some graduate school education, and 13% had completed advanced graduate degrees. The highest levels of education for wives in the sample were 21% had completed high school, 4% had completed trade or business school, 31% had some college, 31% were college graduates, 4% had some graduate school education, and 9% had completed advanced graduate degrees. When marriages were differentiated for longevity, 28% of participants had been married for 3 years or less, 39% had been married 4–20 years, and 33% had been married for more than 20 years.

Data Analyses

Descriptive statistics on the sample were generated using the PRELIS and LISREL-7 computer programs (Jöreskog & Sorbom, 1988). Structural equation modeling (SEM) was used to identify factors and measure the influences of exogenous variables on the endogenous variable, marital satisfaction. SEM was the basis for testing the proposed structural model and developing a new model providing the best fit for the data.

A measurement model composed of marital characteristics, marital interaction processes, and marital satisfaction was developed through the use of factor analysis techniques. Once the latent factors were identified, all but the highest loading items of the subscales were eliminated through item reduction. The SPSS (Version 8) program was used to conduct both exploratory and confirmatory factor analyses, which revealed the best fitting measurement model and structural model for the path analysis under consideration. Once the measurement model and the structural model were determined, hypotheses regarding statistically significant differences were tested by selecting subsamples of the data for comparison (i.e., gender, length of marriage).

The assessment of goodness-of-fit in structural equation modeling evaluates the closeness of the research sample to the actual model for the population. The root mean square error of approximation (RMSEA) is used to assist in assessing the viability of the structural models. Browne and Cudeck (1993) noted,

> Practical experience has made us feel that a value of the RMSEA of about .05 or less would indicate a close fit of the model in relation to the degrees of freedom . . . . We are also of the opinion that a value of about .08 or less . . . would indicate a reasonable error of approximation. . . . [We] would not want to employ a model with an RMSEA > .1. (p. 144; see also Loehlin, 1998, for discussion of cutoff values)

RESULTS

The initial alpha coefficients for the subscales of the DAS ranged from .69 (Affectional Expression) to .88 (Consensus). The alphas for the ENRICH scales ranged between .63 (Equalitarian Roles) and .85 (Communication and Sexual Relationship). For the two scales of CHARISMA, the alphas were .83 (Importance) and .94 (Satisfaction With Marital Characteristics). After the item reduction process, the alphas for the DAS scales ranged from .78 to .80, the ENRICH scales ranged from .73 to .87, and the alphas for the CHARISMA scales ranged from .73 to .90. The alpha for the combined factor for the dependent variable, Marital Satisfaction, was .79.

The Measurement Models

The conceptual model tested in this study hypothesized a relationship between marital characteristics and marital interaction processes and a path that would best lead to marital satisfaction (see Figure 1). To test this model, a measurement model was constructed from a series of exploratory factor analyses on the data, which suggested the number of latent factors that were present and the items that best contributed to the measurement of these latent factors.

Hattie (1981) described a four-stage factor analytic approach to studying behavioral domains: (a) conducting exploratory factor analyses to assess the number of factors, (b) developing viable factor names that are based on theoretical arguments

and ensuring that each factor consists of subscales that many researchers agree appropriately load on the factor, (c) assessing the goodness-of-fit using confirmatory factor analysis, and (d) cross-validating the hypothesis on new data sets.

Using Hattie's (1981) method, the number of factors underlying Importance ratings and Satisfaction ratings was first estimated based on the expected number of factors and their interpretability. The subscales from the ENRICH Inventory and DAS were factor analyzed individually using a maximum likelihood estimation method with oblique rotations (Jöreskog & Sorbom, 1988). Using this approach, the presence of a factor is supported (i.e., identified) by 2 to 4 items that load most heavily on that factor. The factor loading should exceed .30 for that factor to be considered stable.

An exploratory factor analysis of the list of 18 marital Importance and 18 Satisfaction characteristics in the CHARISMA scales clearly suggested the presence of three factors for each scale, but only using 10 of the items (see Table 1). The items were the same for both characteristics, and the patterning was most similar. The only discrepancy was that the "commitment to good parenting" item loaded less successfully on the Importance scale than it did on the Satisfaction scale. Although it was decided to include this item in Factor 3 to ensure sufficient identification, this discrepancy in factor loadings suggests a lower internal consistency and, thus, the need for further exploration of this factor.

Next, according to Hattie's (1981) method, preliminary names were assigned to the latent factors based on their item composition. Four items (i.e., marital characteristics) loaded most heavily on Factor 1 (respect; forgiveness; romance; and sensitivity, support), three items loaded most heavily on Factor 2 (lifetime commitment, loyalty, and strong moral values), and three items loaded most heavily on Factor 3 (belief in God, religious commitment, and commitment to good parenting); hence, the factor names, Love, Loyalty, and Shared Values, respectively, were selected.

Once the three factors and 10 items were identified, a confirmatory factor analysis was conducted to confirm that the items consistently loaded on these factors and to assess the goodness-of-fit for each model. Because the goal in developing the measurement model is to identify distinct factors, ideally, interfactor correlations are low. Both the pattern matrix and interfactor correlations for the Importance and Satisfaction subscales are shown in Table 1. The interfactor correlations for the three Importance factors were .42 or below. A chi-square test of the fit of the three-factor Importance model yielded a chi-square statistic = 273.5, with $df = 102$ ($p < .01$). The interfactor correlations for the three Satisfaction factors were .70 or below, and the three-factor Satisfaction model yielded a chi-square statistic = 316.2, with $df = 102$ ($p < .01$).

A third round of exploratory factor analyses was conducted to confirm the factors underlying the marital interaction processes. Because the three subscales from the DAS (i.e., Affectional Expression, Cohesion, and Consensus) and the four subscales from the ENRICH Inventory (i.e., Communication, Equalitarian Roles, Sexual Relationship, and Conflict Resolution) have been previously developed, the present research sought to confirm these seven factors by selecting those items that made the strongest contribution to each factor. Table 2 displays the results of these factor analyses as provided by the pattern matrix, which describes the degree of association between these seven marital interaction processes. As shown in Table 2, the highest correlation between any two factors in the correlation matrix is .44. As such, it was determined that the factors associated with marital interaction processes were sufficiently distinct, identified, and suitable for the measurement model. A chi-square fit statistic for this seven-factor model of marital interaction processes yielded a chi-square = 144.3, with $df = 129$ ($p = .17$).

The final step in the development of the measurement model was to determine the composition of a single factor

TABLE 1

Factor Loadings and Interfactor Correlations for CHARISMA Scales

	Importance Rating			Satisfaction Rating		
Variable	**Love**	**Loyalty**	**Shared Values**	**Love**	**Loyalty**	**Shared Values**
Marital characteristic						
Respect	0.60			0.77		
Forgiveness	0.60			0.79		
Romance	0.56			0.77		
Sensitivity, support	0.73			0.90		
Lifetime commitment		0.86			0.33	
Loyalty		0.89			0.89	
Strong moral values		0.59			0.77	
Belief in God			0.97			0.98
Religious commitment			0.86			0.83
Commitment to good parenting			0.21			0.33
Interfactor Correlation						
Love	—			—		
Loyalty	0.27	—		0.34	—	
Shared values	0.41	0.42	—	0.70	0.46	—

Note. CHARISMA = Characteristics of Marriage Inventory.

TABLE 2

Factor Loadings and Interfactor Correlations for Marital Interaction Processes

Variable	1	2	3	4	5	6	7
1. Affectional Expression_4	0.48						
1. Affectional Expression_6	0.31						
2. Cohesion_25		0.64					
2. Cohesion_26		0.69					
2. Cohesion_27		0.91					
2. Cohesion_28		0.44					
3. Consensus_14			0.96				
3. Consensus_11			0.51				
3. Consensus_2			0.59				
3. Consensus_15			0.50				
4. Communication_a				0.73			
4. Communication_h				0.65			
4. Communication_j				0.60			
5. Equalitarian Roles_d					0.69		
5. Equalitarian Roles_f					0.78		
5. Equalitarian Roles_l					0.71		
5. Equalitarian Roles_e					0.53		
6. Sexual Relationship_a						0.73	
6. Sexual Relationship_b						0.97	
6. Sexual Relationship_d						0.56	
6. Sexual Relationship_f						0.81	
7. Conflict Resolution_b							0.43
7. Conflict Resolution_e							0.72
7. Conflict Resolution_g							0.74

Note. Variables preceded by the numbers 1, 2, or 3 were adapted from the Dyadic Adjustment Scale (DAS). Variables preceded by the numbers 4, 5, 6, or 7 were adapted from the ENRICH Inventory. Letters or numbers that follow variable names refer to specific items borrowed from the DAS or ENRICH scales.

Interfactor Correlations Matrix for Marital Interaction Processes

	1	2	3	4	5	6	7
1. Cohesion	—						
2. Sexual Relationship	0.42	—					
3. Consensus	0.44	0.35	—				
4. Equalitarian Roles	0.08	0.05	0.03	—			
5. Conflict Resolution	0.32	0.20	0.36	0.01	—		
6. Communication	0.43	0.36	0.44	0.02	0.28	—	
7. Affectional Expression	0.18	0.27	0.22	0.07	0.21	0.05	—

Note. When compared with Figure 2, the following factor names should be considered synonymous: Sexual Relationship and Sexuality/Intimacy; Conflict Resolution and Conflict Management.

that would best represent the dependent variable—marital satisfaction. To ensure stability in the final model, only a small subset of items was desired for the dependent variable. A subset of six items, three from the DAS and three from the ENRICH Inventory, that best represented the total behavioral domain were selected (see Table 3). A single factor provided an excellent fit for these items ($\chi^2 = 12.5$, $df = 9$, $p = .19$).

The final model thus consisted of seven marital interaction processes: three factors that represent the importance of marital characteristics, three factors that represent the individual's level of satisfaction with those marital characteristics, and the dependent variable (marital satisfaction). As shown in Figure 1, marital interaction processes were initially thought to be mediators of the relationship between marital characteristics and marital satisfaction. However, when an early test of the structural model (as originally hypothesized) failed to identify significant paths, this result suggested the need to revise the conceptual model such that marital characteristics, rather than marital interaction processes, serve as the mediators in this model. Once revised, the structural model revealed significant indirect paths extending from all but one marital interaction process, to the dependent measure, marital satisfaction.

The Structural Model

Once the measurement model was completely identified, the structural model was tested using the SPSS LISREL-7 program (Jöreskog & Sorbom, 1988). It soon became evident that the Cohesion factor (from the DAS) was unrelated to any other factor in the model and was thus deleted from further analyses. The RMSEA value of .07 falls within the acceptable range ($\chi^2 = 1865$, $df = 940$, $N = 201$). As such, a reasonable amount of confidence is placed in the structural model shown in Figure 2. As shown in Figure 2, statistically significant paths ($p < .05$) were found between the six marital interaction process factors, the three Importance factors for marital characteristics, three Satisfaction factors on those same marital characteristics, and the overall Marital Satisfaction factor. Three significant paths

TABLE 3

Content of Items and Factor Loadings for the Dependent Variable: Marital Satisfaction

Variable	Item Content	Factor Loading
Marital		
Satisfaction_b	I am very happy with how we handle role responsibilities in our marriage.	0.68
Satisfaction_f	I am very happy with how we manage our leisure activities and time we spend together.	0.58
Satisfaction_j	I feel very good about how we each practice our religious beliefs and values.	0.47
Satisfaction18	In general, how often do you think that things between you and your partner are going well?	0.75
Satisfaction19	Do you confide in your mate?	0.78
Satisfaction20	Do you ever regret that you married (or lived together)?	0.57

were found to extend from the six exogenous factors, representing marital interaction processes, through three Importance factors, and then through three Satisfaction factors, prior to reaching the factor for overall Marital Satisfaction. In other words, the relationship between marital interaction processes and marital satisfaction was found to be mediated by both the relative importance of marital characteristics and the relative satisfaction with that marital characteristic. Thus, results were found that confirmed Frisch's (1994) concept of weighted satisfaction and demonstrated the importance of including both measures of marital characteristics in the structural model.

Assessment of Gender and Marital Longevity Factors

We hypothesized that gender differences would have a statistically significant moderating effect on the strength of the relationship between marital interaction processes and marital satisfaction. This hypothesis was tested by applying the structural model to each subset of the sample based on gender and was found to be supported by the data based on differences in the strengths of various gamma and beta weights between the two models. All paths were significant in the model for female participants ($n = 137$, $\chi^2 = 2388$, $df = 940$, RMSEA = .11). In the subsample for male participants, paths leading from affectional expression, consensus, and sexuality to marital characteristics were not statistically significant ($n = 64$, $\chi^2 = 3234$, $df = 940$, RMSEA = .10).

We also hypothesized that there would be statistically significant differences in the ratings of importance of marital characteristics related to length of time in the present marriage. To test this hypothesis, separate models were tested for participants married less than 20 years and those married more than 20 years. All paths were significant for individuals married 20 years or less ($n = 134$, $\chi^2 = 2739$, $df = 940$, RMSEA = .12). However, for participants married more than 20 years, paths between affectional expression, sex, conflict management, and marital characteristics ceased to be significant

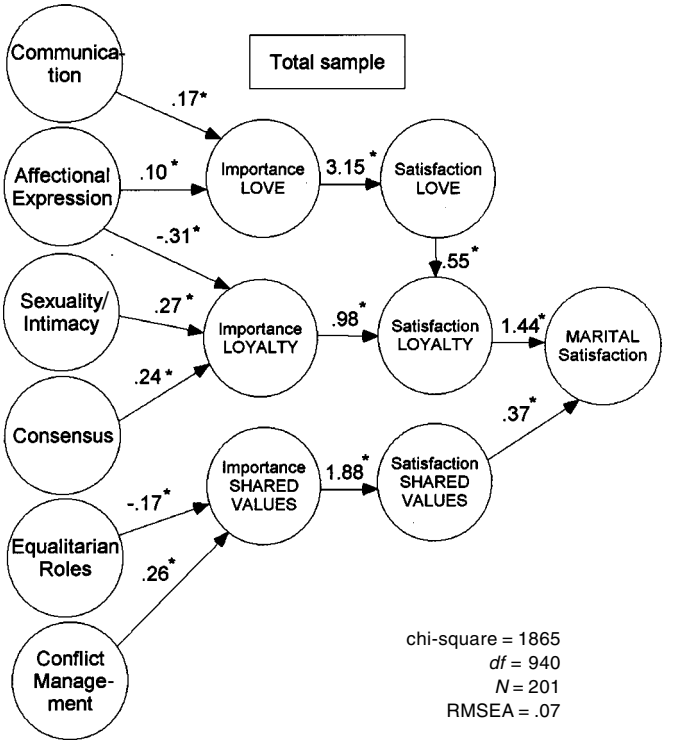

FIGURE 2

The Complete Structural Model Applied to the Total Sample (*N* = 201)

Note. Values in figure are beta coefficients derived from the LISREL-7 (Jöreskog & Sorbom, 1988) fully standardized solution. RMSEA = root mean square error of approximation.
*$p < .05$.

($n = 67$, $\chi^2 = 5434$, $df = 940$, RMSEA = .27). Similarly, the path between satisfaction with shared values and marital satisfaction became nonsignificant for those married more than 20 years. Thus, the hypothesis of statistically significant differences based on length of marriage was supported.

DISCUSSION

The use of structural equation modeling techniques allowed for testing of the conceptual model introduced in Figure 1. Originally, marital characteristics were hypothesized to have a direct influence on marital interaction processes, and marital interaction processes were conceptualized as mediating. When the structural model was tested and failed to find significant paths, however, it became necessary to reexamine the measurement model to find an alternate explanation for the relationships between the variables. Only by rearranging the conceptual model so that marital characteristics were positioned as mediators in the model, and rearranging the measurement model such that marital interaction processes were located as endogenous factors, was it possible to find a defensible model.

When the conceptual model was revised, the measurement model and factor analysis identified three distinct

latent factors of marital characteristics. These factors were assigned the factor names: Love, Loyalty, and Shared Values. The structural model shown in Figure 2 illustrates three paths to marital satisfaction based on a mediated relationship between marital interaction processes and marital satisfaction. Although Factors 1 and 2 appear to be adequately identified, the composition and identification of Factor 3, Shared Values, gives rise to further questions. Given the very low factor loading for the parenting characteristic, future research should investigate the possibility of a fourth distinct factor, which pertains specifically to importance and satisfaction with parenting. (This would require adding more such items to the scale.)

Loving relationships are those in which open communication and agreement on the expression of affection are important. The most important characteristics of loving marriages were identified as respect, forgiveness, romance, support, and sensitivity. In loving relationships, a path extends from communication and affectional expression to the importance factor and then extends from the importance factor to satisfaction. However, the results of the present study suggest that satisfaction with the characteristics of a loving relationship is not sufficient to achieve marital satisfaction. Rather, the path to marital satisfaction is mediated by satisfaction with loyalty in the relationship. Thus, according to this model, loyalty mediates the relationship between satisfaction with loving characteristics and marital satisfaction.

Relationships in which loyalty is important are those in which devotion to one's spouse is viewed as a priority, regardless of sexual activity and despite possible disagreements about the expression of affection. It is interesting that the most important characteristics of what we have called "loyal relationships" were the top three identified by Fenell (1993) as the most important characteristics of marriage: lifetime commitment to the marriage, loyalty to one's spouse, and strong moral values. According to the path model in Figure 2, spouses who value loyalty and who are satisfied with the loyalty in their relationship can achieve marital satisfaction.

Significant paths extend from three marital interaction processes (i.e., affectional expression, consensus, and sexuality/intimacy) through the importance factor for loyalty and through the satisfaction factor for loyalty, to overall marital satisfaction. This model suggests that sexual satisfaction is a very important ingredient in loyal relationships, despite disagreements that spouses may have about the expression of affection in the relationship. This finding supports previous research on the relationship between sexual satisfaction and marital satisfaction (Ade-Ridder, 1990); however, further research is needed to better understand the relationship between sexuality/intimacy and affectional expression.

Relationships in which there are shared values are those in which conflict is managed, gender roles are traditional, and high priorities are placed on religiosity and parenting. Other studies (e.g., Craddock, 1991; Greenstein, 1995) have similarly found that there is less conflict when spouses subscribe to traditional gender roles. The results of the present study suggest that if "traditionality" is highly valued by both spouses in a relationship, then satisfaction with the shared value of traditionality can lead to overall marital satisfaction. This finding is consistent with earlier findings by Greenstein (1995) and Zvonkovic, Schmiege, and Hall (1994). However, an even stronger implication is that satisfaction with gender roles depends on whether couples share common values about those roles.

A comparison of the different models for men and women revealed a difference in the paths to marital satisfaction for men in contrast to women. For men, loving relationships are more highly influenced by communication than by affectional expression; loyal relationships are more highly influenced by affectional expression than by sex or consensus. Similar to women, these results indicate that men who are satisfied with the values in their marriages tend to be more traditional, or less equalitarian, and they tend to be satisfied with conflict management in the relationship. In contrast, the model for women indicates that significant paths for women are the same as those reported for the total sample.

The present findings suggest that the influence of shared values on marital satisfaction may be different for men and women. According to these results, women in the sample who are satisfied with traditional gender roles, satisfied with the level of conflict management in their marriage, and satisfied that they and their spouses share a common set of values tend to be satisfied in their marriages. However, even when men are satisfied with the values shared in their marital relationships, this satisfaction does not necessarily lead to marital satisfaction. Regarding marital longevity, couples that have been married less than 20 years resembled the total sample in that all marital interaction processes contributed significant paths to the model of marital satisfaction. However, for those married more than 20 years, changes occurred in two out of three paths to marital satisfaction. Although the path from loving relationships to marital satisfaction remained the same, paths through loyalty and shared values changed over time. After 20 years of marriage, loyal relationships were singularly influenced by the level of consensus in the marriage, and relationships in which couples maintained shared values were singularly influenced by gender role traditionality. Although the path from loyalty to marital satisfaction remained significant, the path from shared values to marital satisfaction did not. Future research should investigate whether the influence of some marital interaction processes actually diminishes over time, as these findings suggest.

Gelles (1995) noted that research in the area of marital satisfaction has been moving in the direction of investigating more complex multidimensional models of marital satisfaction, in an attempt to more fully understand happy marriages. In much of the existing research, marital satisfaction has been thought to be influenced by three types of independent variables: (a) antecedent personality dynamics (i.e., marital characteristics), (b) interpersonal dynamics that evolve within the relationship (i.e., marital interaction processes), and (c) contextual factors that are not independent of each other

(e.g., gender, length of marriage; Kurdek, 1991; Mackey & O'Brien, 1995). The results of the present study support earlier findings that all three of these types of independent variables contribute significantly to marital satisfaction.

The present study yielded a list of the 10 most important marital characteristics among the original 18 being measured. Referring back to Fenell's (1993) results, the present study found agreement with 7 out of 10 marital characteristics. The current findings confirm the relative importance of lifetime commitment, loyalty to spouse, strong moral values, desire to be a good parent, faith in God, religious/spiritual commitment, and the willingness to forgive and be forgiven. The characteristics that were not as strongly supported were respect for one's spouse as a friend, commitment to sexual fidelity, a desire to please and support one's spouse, and being a good companion to one's spouse.

As suggested by Kurdek (1991) and others, studies of marital satisfaction should differentiate between marital interaction processes and marital characteristics. This differentiation was accomplished through the development of the measurement model wherein marital interaction processes and marital characteristics were assigned to different axes. A test of the structural model then supported the existence of significant relationships between specific marital interaction processes and marital characteristics.

As shown in the structural model, loving marriages (i.e., those that highly value the qualities of mutual respect, forgiveness, romance, and sensitivity) are most strongly associated with the marital interaction processes of communication and affectional expression. Loyal marriages (i.e., those that most highly value a lifetime commitment to the marriage, interpersonal loyalty, and strong moral values) are most strongly associated with the marital interaction processes of consensus and sexual satisfaction. Somewhat surprisingly, loyalty is positively related to sex/intimacy but inversely related to agreement on affectional expression, meaning that couples in loyal relationships are likely to disagree about the expression of affection.

Marriages in which there are shared values (i.e., those which most highly value belief in God, religious commitment, and commitment to good parenting) are associated with traditional gender roles and the ability to manage conflict. This finding is consistent with research by Craddock (1991), who reported a positive correlation between marital satisfaction, similar religious orientation, similar personality issues, the ability to resolve conflict, and consensus on parenting. Whisman and Jacobson (1989), however, also reported a relationship between traditional sex roles and depression in women, because traditional relationships are associated with less task-sharing and less satisfaction with decision making. According to research by Zvonkovic et al. (1994), marital satisfaction in relationships with traditional gender roles only remains high as long as both husband and wife agree about the level of traditionality within the relationship.

The results of this study should be considered in light of several possible limitations. First, data were collected in a single location (i.e., one shopping mall) and in only one southeastern state. Second, whereas the sampling design proved effective for gathering the necessary data on persons in first marriages, twice as many women as men volunteered for the study. The 2:1 ratio of women to men and the higher RMSEA values limit the ability to generalize the findings on gender differences. Third, because the study targeted individuals in their first marriages, the findings should not be construed as generalizable to marital satisfaction in remarriages. The goodness-of-fit indicators discussed earlier suggest that other factors that influence marital satisfaction are not accounted for by the structural model.

IMPLICATIONS

The art and science of marriage counseling depends largely on the ability of counselors to recognize and understand the underlying dynamics in a given marriage. In clinical circles, marital satisfaction has long been recognized as a subjective phenomenon. The task of the counselor is not to define marital satisfaction for a particular individual or couple, but rather to help the spouses clarify their own feelings about the marriage (i.e., the importance of and their satisfaction with marital characteristics), develop insight about their marital behaviors and the nature of their reciprocal interpersonal interactions (i.e., marital interaction processes), and learn to communicate their differing needs to each other. The structural model defined in this study may be useful in helping both counselors and their clients to conceptualize marriage and recognize the various influences that are likely to affect a spouse's level of marital satisfaction.

This research suggests that counselors may also benefit from evaluating the impact of various moderating variables on marital satisfaction. Although additional research is needed to fully understand the effects of gender and marital longevity on marital satisfaction, it is useful to hypothesize about and explore the importance of these moderating variables. This research suggests that certain marital interaction processes are less significant based on one's gender and/or length of marriage. The idea that husbands and wives have different preferences in marriage is not a new concept for counselors. However, as counselors attempt to conceptualize the overall nature of a marriage, it is useful to organize that conceptualization into specific characteristics and processes.

Couples often seek counseling when they are unhappy in their relationships but unsure (i.e., lack of clarity) of the source of their unhappiness. The present research suggests a clear way to conceptualize and measure some of the influences on relationships. The findings of this study suggest that the path to marital satisfaction, for a given individual, will be influenced by several variables, including marital interaction processes, the values placed on certain marital characteristics, the perceived level of satisfaction the individual experiences with those most highly valued marital characteristics, gender, and the number of years the individual has been married.

As shown in the structural equation models, the three paths to marital satisfaction are relatively distinct and have

minimal overlap. Clinicians may find that spouses who value different paths experience greater interpersonal conflict. Because this model makes sense from a clinical perspective, marriage counselors may wish to draw on this research to assess whether spouses or prospective spouses agree or disagree about their desired routes to marital satisfaction.

The structural model demonstrated that gender and marital longevity serve as moderators of marital satisfaction, which affect the strength of the relationship between marital interaction processes and marital satisfaction. However, the goodness-of-fit statistics suggest the presence and influence of other variables that have not been accounted for in this model. Therefore, further research is needed to incorporate additional contextual variables that reflect the changing trends and demographics of contemporary marriages and that may account for some of the unexplained variance in this model of marital satisfaction, such as variables associated with dual-earner households, stress management, different work schedules, lack of time together, the use of coping strategies, and management of work–family conflicts.

Future research should include consideration of the premarital context for relationships (e.g., age at first marriage, family history) and other personality variables that set the stage for a healthy marriage or that are predictive of divorce (Kurdek, 1991). The findings of this study suggest the need for further research on variables that influence marital satisfaction—such as gender differences; differing needs of younger and older marriages; and the dimensions of love, loyalty, and shared values—in order to further the goal of teaching couples how to achieve greater marital satisfaction.

Further research should also attempt to overcome the limitations to generalization of the present study by examining samples of the population in different geographic locations and by retesting hypotheses about differences based on gender and marital longevity. In addition, future studies should assess the extent to which the identified relationships between marital interaction processes and marital characteristics generalize to other research samples. As more of the variance in this model is accounted for, it is likely that the overall fitness of the model will improve and contribute additional explanations about the nature of factors affecting marital satisfaction.

CLOSING REMARKS

The present study investigated the relationship between marital interaction processes, marital characteristics, and marital satisfaction. Through the use of structural equation modeling techniques, the relationship between marital interaction processes and marital satisfaction was shown to be mediated by the relative importance of marital characteristics and the individual's satisfaction with those characteristics in his or her marital relationship. A total of three statistically significant pathways to marital satisfaction were identified in this research. The pathway through love was associated with communication and expression of affection. The pathway through loyalty was associated with sexuality/intimacy and the ability to build consensus. The pathway through shared values was associated with traditional versus nontraditional marital roles and the ability of the couple to manage conflict.

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Differentiation of Self Mediates College Stress and Adjustment

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Differentiation of self involves the capacity to modulate affect, maintain a clear sense of self, and balance intimacy and autonomy in significant relationships. Given the central role of family relationships for individual functioning, the authors tested whether differentiation mediated or moderated relations between college stress and personal adjustment. Differentiation of self partially mediated effects of academic and financial stress and exerted a direct influence on adjustment. Limitations, directions for future research, and implications for counseling are discussed.

In the last two decades, the field of counseling has attended more than previously to the role of the family in the development of young adults, with growing recognition that the quality of family relationships plays an important role in fostering successful adjustment (e.g., Kenny, 1987; Kenny & Rice, 1995; Lopez & Brennan, 2000). Although the question of how individuals cope with stress, and why some cope relatively well while others struggle, has continued to challenge the field (Somerfield & McCrae, 2000), both theory (e.g., Alymer, 1988) and research (e.g., Arnett, 1998; Kenny & Rice, 1995; Kennedy, Kiecolt-Glaser, & Glaser, 1988) suggest that the relative success with which an individual manages the stress inherent to university life may be tied to experiences in family relationships regarding emotional regulation, support, and opportunities for autonomy. As such, the purpose of this study is to examine the way in which family experiences function to protect college students from the negative effects of college-related stress.

College is a time of transitions, change, and new experiences for students and their families (Arnett, 2000). Among college-bound individuals, a constellation of stressors is frequently experienced (e.g., Colten & Gore, 1991; Kenny & Rice, 1995), including academic issues, (e.g., Crespi & Becker, 1999; Prillerman, Myers, & Smedley, 1989), financial concerns (e.g., Frazier & Schauben, 1994), and/or social strain (e.g., D'Aurora & Fimian, 1988; Prillerman et al., 1989). Among the general population, higher levels of stress have been shown to tax one's cognitive resources (Glass & Singer, 1972), increase strain on the immune system (Cohen & Herbert, 1996), and may lead to the development of learned helplessness and depression (Seligman, 1975). Among college students, for example, academic exams have been associated with suppression of the immune system (Kiecolt-Glaser et al., 1986), leading to increased physiological difficulties. Stress may also arise from challenging course loads, university bureaucracies, problems in managing one's time and personal finances, and challenges in creating and maintaining satisfying interpersonal relationships (e.g., Hilsman & Garber, 1995; Jones, 1993; Kenny & Rice, 1995; Solberg et al., 1998), potentially leading to increased levels of depression, anxiety (e.g., O'Malley, Wheeler, Murphey, O'Connel, & Waldo, 1990), academic failure, and "emotional exhaustion" (D'Aurora & Fimian, 1988, p. 48). However, successful negotiation of this transition has been linked to better psychological adjustment, fewer risk behaviors, and academic success (e.g., Eccles et al., 1993; Petersen et al., 1993). In fact, Crespi and Becker (1999) noted that individuals face higher levels of stress in response to the transition to college, and place a higher demand on counseling center services, than they experienced in earlier academic settings. This, in turn, necessitates that professional counselors develop a more complete understanding of factors that may protect some students while leaving others at risk.

Among relational theories, psychoanalytic (Arnett, 2000; Blos, 1979; Sandler & Rosenblatt, 1962), attachment (Ainsworth, 1989; Bowlby, 1982, 1988), and family systems (e.g., Bowen, 1978; Kerr & Bowen, 1988) theories all provide frameworks for understanding how both the health and functioning of a family system and the quality of parent–child relationships play an important role in regulating the negative influence of life stress emerging in adulthood. According to Bowen family systems theory (Bowen, 1976, 1978; Kerr & Bowen, 1988), healthy adaptation is predicated on the

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internalization of family relationships characterized by a balance of both autonomy and connection. This balance is termed *differentiation of self* (Bowen, 1978), a construct with intrapsychic as well as interpersonal dimensions. On an intrapsychic level, differentiation involves one's ability to engage in thoughtful examination of situations, to maintain full awareness of one's emotions, and to engage in either calm logical reasoning or affective experiencing depending on situational demands. On an interpersonal level, differentiation of self involves the capacity to develop an autonomous sense of self while still maintaining close connections with important others, most notably one's family (Bowen, 1978; Kerr & Bowen, 1988). Mature autonomy may entail neither the wholesale acceptance nor rejection of one's parents' values or opinions but rather a thoughtful consideration of the relative merits of those positions and their goodness of fit with one's own convictions and beliefs.

Differentiated individuals are thought to be more flexible and adaptive under stress, not because they are more intelligent per se, but rather because they are more capable of modulating the emotional arousal stemming from psychological pressure imposed during a stressful event. As a result, they are thought to have greater access to existing cognitive resources that permit expression of more flexible and thoughtful responses. In contrast, poorly differentiated individuals are described as more emotionally reactive (Kerr & Bowen, 1988), and they may find it difficult to remain calm in response to the emotionality of others (Bowen, 1976; Kerr & Bowen, 1988). In interpersonal situations, less differentiated persons are thought to engage in fusion or emotional cutoff in response to stress or overwhelming anxiety (Nichols & Schwartz, 2000).

Individuals who report well-differentiated family boundaries appear more capable of autonomous functioning and, in turn, greater personal adjustment (Lopez, Campbell, & Watkins, 1988). Differentiation of self has been shown to predict greater psychosocial maturity and fewer problem behaviors (Gavazzi, Anderson, & Sabatelli, 1993) and better problem-solving skills and psychological adjustment among African, Asian, Latino, and Native American college students (Skowron, 2000a). Only one study was located that directly examined relations between differentiation, stress, and adjustment among college students. Murdock, Gore, and Horosz (1998) found support for the role of differentiation of self as a moderator of stress and adjustment. Specifically, an interaction between stress and differentiation of self was observed. Individuals with varying levels of differentiation of self who reported low stress reported no differences on symptom indices, whereas among individuals reporting higher levels of stress, those who were more differentiated reported better adjustment than did less differentiated persons.

The current study was designed to clarify the relationship between college stress, differentiation of self, and personal adjustment. Because this is one of the first studies to explore this area, we sought to determine if differentiation of self mediated or moderated (e.g., Baron & Kenny, 1986; Holmbeck, 1997) the negative relation between college stress and personal adjustment. A mediated relationship is characterized by the presence of a variable (i.e., differentiation of self) that functions as a

> generative mechanism through which the focal independent variable is able to influence the dependent variable of interest. . . . Mediators explain how external physical events take on internal psychological significance. Whereas moderator variables specify when certain effects will hold, mediators speak to how or why such effects occur. (Baron & Kenny, 1986, pp. 1173, 1176)

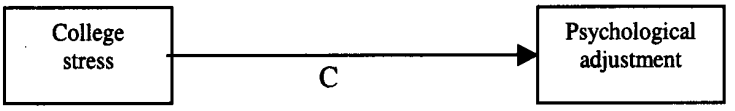
As shown in Figure 1 (Section b), we elected to conceptualize differentiation of self as a mediating variable based on our interpretation of Bowen's (1976, 1978; Kerr & Bowen, 1988) writings that an individual's level of differentiation mediates the relationship between stress and adaptation. In other words, differentiation was articulated as a vehicle through which stress influences adjustment. According to Bowen (Kerr & Bowen, 1988), "As the levels of basic differentiation increase and decrease down the generations, the amount of stress experienced by an individual . . . varies accordingly" (p. 232). We interpreted Bowen's writings to indicate that the negative influence of college stress on personal adjustment operates through one's level of self differentiation, or the capacity to regulate emotion, to take "I" positions in relationships, and to maintain close interpersonal connections.

Alternately, on the basis of the findings of Murdock et al. (1998), we also tested in the present study a competing hypothesis that differentiation of self would function as a moderator. A moderated relationship is observed when

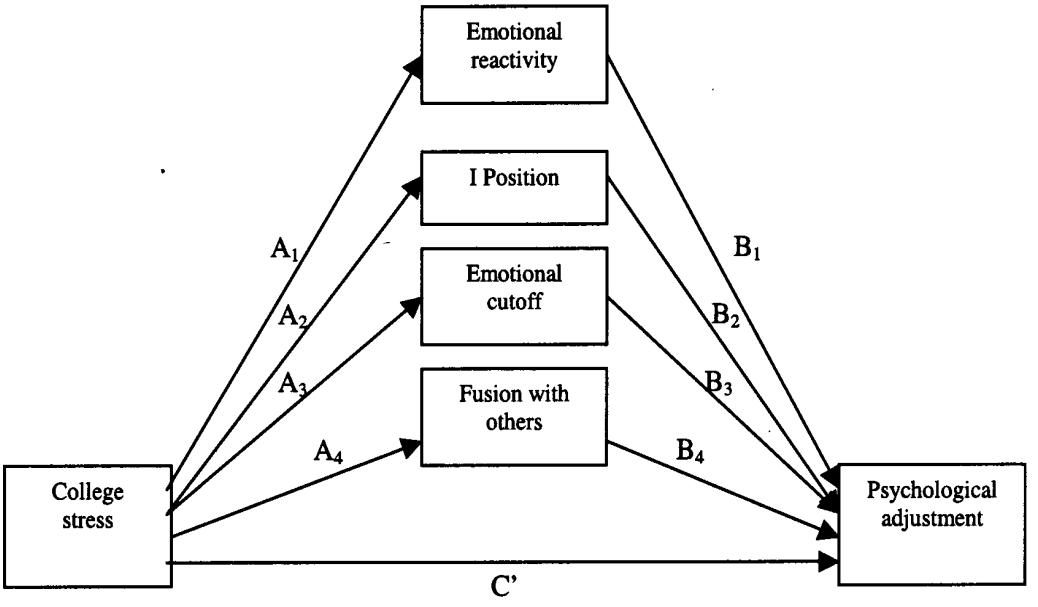
> a moderator variable partitions a focal independent variable into subgroups that establish its domains of maximal effectiveness in regard to a given dependent variable. . . . Moderator variables are typically introduced when there is an unexpectedly weak or inconsistent relation between a predictor and a criterion variable. (Baron & Kenny, 1986, pp. 1173, 1178)

The moderation hypothesis, as shown in Figure 1 (Section c), would be supported if a weak relationship or no relationship was observed between college stress and adjustment and if differentiation and stress were found to interact such that under conditions of varying stress, levels of differentiation would predict different levels of personal adjustment. Specifically, the moderation hypothesis would hold if, under conditions of low stress, no differences between high and low differentiation groups would exist on the criterion variable of adjustment while, at greater stress levels, high differentiation individuals would report greater adjustment than would low differentiation persons.

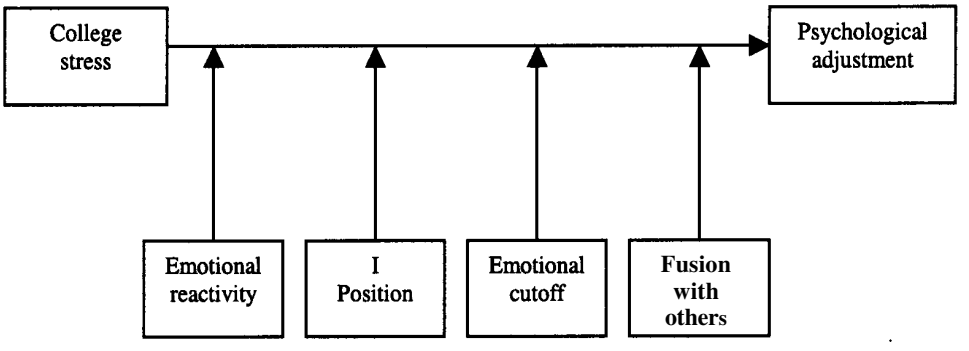
We first tested whether the components of differentiation of self would *mediate* the relationship between academic stress and psychological adjustment among college students. Baron and Kenny (1986) described three necessary conditions for testing the mediating effects of variables on the relation between two other variables. Briefly, variables have a mediating effect on the relationship between two other variables when significant correlations exist between (a) the predictor (college stress) and criterion (psychological adjust-



(a) Simple Regression Model



(b) Mediation Model



(c) Moderation Model

FIGURE 1
Modeling Relations Among College Stress, Dimensions of Differentiation, and Psychological Adjustment

ment) variables, (b) the predictor (college stress) and proposed mediating variables (differentiation of self), and (c) the criterion variable (adjustment) and the proposed mediators (differentiation of self). Furthermore, to infer mediation, the relationship between college stress (predictor) and adjustment (criterion) must be smaller in the presence of the mediators than in their absence (Baron & Kenny, 1986; Holmbeck, 1997).

Second, we tested a competing hypothesis that differentiation of self would *moderate* the stress–adjustment rela-

tionship. In order to test for moderation, Baron and Kenny (1986) recommended that the moderator be uncorrelated with the predictor and criterion variables. Furthermore, the differentiation of self variable would have a moderating effect if its interaction with the predictor (stress) significantly accounts for the criterion variable (personal adjustment). Although we held no specific hypotheses regarding the role of gender in mediating or moderating the stress–adjustment relationship, given the existence of several studies documenting gender differences in the ways that men and women express differentiation (e.g., Schultheiss & Blustein, 1994; Skowron & Friedlander, 1998), we also examined gender for inclusion as a possible covariate in the major analyses. In sum, it was expected that knowledge of the specific manner (i.e., mediating or moderating) in which relational characteristics influence the interplay between college-related stress and personal adjustment may benefit counseling professionals working with college students by providing greater understanding of the way in which relational processes influence the role of stressful events on adjustment, leaving some students more resilient and others at risk.

METHOD

Participants

Participants were 126 undergraduate students, 23.8% men and 75.4% women, at a large, urban, midwestern university, ranging from 18 to 50 years of age, mean age = 22.25 years (*SD* = 5.98). The majority of students were in a committed relationship (45.4%) or married (12.2%), whereas 42.4% were single. Only 9.8% of participants had children. In terms of college standing, 29.6% were freshmen, 28.8% were sophomores, 22.4% were juniors, 13.6% were seniors, and 5.6% were graduate students. Ethnicity of the sample was predominantly European American (84.8%), with 7.2% African American, 2.4% Asian American, 0.8% Native American, and 4.8% biracial students.

Most students were working part-time (73.6%), 5.6% held full-time jobs, and 20.8% were not employed. The majority (89.6%) of students also received financial support from outside sources, with 58.60% of those reporting financial support from parents and 61.9% from government student loans. With respect to parent's levels of education, participants reported one third (33.3%) of mothers were high school graduates, 4.1% did not finish high school, 30.9% had received some college or technical training, 25.2% had obtained a college degree (associates or bachelors), and 6.5% had obtained an advanced degree. Of the participants' fathers, 30.3% had high school degrees, 8.2% were high school dropouts, 25.0% had some college or technical training, 19.7% had a college degree, and 14.7 % had obtained an advanced degree. Eighty percent (80.0%) of mothers were employed, while 89.0% of the participants' fathers were working.

Instruments

College stress. Information regarding the participants' experienced college-related stress was obtained using the College Stress Inventory (CSI; Solberg, Hale, Villarreal, & Kavanagh, 1993), a 21-item self-report instrument measuring experience of stressors in college students, namely academic (i.e., "Difficulty meeting deadlines for course requirements"), financial (i.e., "Difficulty paying tuition fees for the next term"), and social strain (i.e., "Difficulty living in the local community"). Individuals rate each item on a 5-point Likert scale from 0 = *never* to 4 = *always*. Scores on the total scale range from 0 to 84, with higher scores indicating greater college stress. Internal consistency reliability for the full scale has been reported at .89 (Solberg et al., 1993). Lower total CSI scores have been shown to predict greater well-being (Solberg et al., 1998; Solberg & Villarreal, 1997), and greater college self-efficacy (Solberg et al., 1998) in ethnically diverse students. Cronbach's alpha calculated on the total CSI in the current sample was .89.

Differentiation of self. The Differentiation of Self Inventory (DSI; Skowron & Friedlander, 1998)—a 43-item self-report instrument that focuses on individuals, their significant relationships, and their current relations with family of origin—was used to assess level of differentiation. The DSI contains four subscales: Emotional Reactivity (ER; emotional flooding, emotional lability, or hypersensitivity), I Position (IP; clearly defined sense of self and ability to thoughtfully adhere to one's convictions under outside pressure), Emotional Cutoff (EC; threatened by intimacy, feeling excessive vulnerability in relationships, defensive overfunctioning, distancing, or denial), and Fusion with Others (FO; emotional overinvolvement and overidentification with parents and significant others). Respondents rate each item with a 6-point Likert scale in which 1 = *not at all true* to 6 = *very true* of him or her. To compute subscale scores, raw scores on all items on the ER, EC, and FO subscales and one item (#35) on the IP subscale are reversed; all items are then summed and divided by the total number of items on the subscale, such that scores range from 1 to 6. Higher scores reflect less emotional reactivity, cutoff, or fusion with others, and greater ability to take an I position in relationships, or greater differentiation of self. Internal consistency reliabilities for the DSI, calculated using Cronbach's alpha, have been reported as follows: ER = .84 and .85, IP = .83 and .85, EC = .82 and .80, and FO = .74 and .59 (Skowron, 2000b, and Skowron & Friedlander, 1998, respectively). Internal consistency reliabilities calculated on the current sample scores were similar at ER = .85, IP = .80, EC = .83, and FO = .71. Construct validity is indicated by documented relations between DSI scores and less chronic anxiety, less symptomatology (Skowron & Friedlander, 1998), and problem-focused coping styles (Murdock et al., 1998). Confirmatory factor analyses have supported the DSI's multidimensional factor structure (Skowron & Friedlander, 1998).

Psychological adjustment. Psychological adjustment was examined using the General Severity Index (GSI) of the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994). Respondents rate items on a 5-point Likert scale from 0 = *not at all* to 4 = *very*, such that higher scores reflect greater symptomatology or maladjustment. The GSI reflects intensity of distress independent of the number of symp-

toms endorsed (Derogatis, Yevzeroff, & Wittelsberger, 1975), is sensitive to symptom changes over the course of psychotherapy (Rickels et al., 1971), and is used most often to provide a summary measure of symptomatology (Derogatis, 1994). The GSI is computed by summing the five raw symptom subscales and dividing by 90; scores range from 1 to 4, with higher scores indicating greater symptomatology. Internal consistency reliability estimates range from .79 to .90, while test–retest reliability estimates range from .78 to .90 (Derogatis, 1994). Cronbach's alpha calculated on the GSI scores in the current sample was .97.

Procedure

Sixty-one courses were randomly selected through the course bulletin during a single semester. Instructors were contacted by electronic mail with a letter that explained the purpose of the study and requested permission to solicit prospective participants during class. Fifteen instructors responded affirmatively and allowed access to their classes. Interested students were asked to complete a packet consisting of the randomly ordered questionnaires (DSI, SCL-90-R, CSI, and a demographic sheet). Each packet included a cover letter stating the purpose of the study and explaining the voluntary and anonymous nature of the research. Approximately 450 packets were distributed, and 130 were collected from students 1 to 2 weeks later, for a 29% return rate. Four students returned packets that contained missing data on at least one measure, yielding a final total sample of 126. Students who completed surveys were eligible for cash prizes, $50 and $25, randomly awarded at the study's conclusion.

RESULTS

Table 1 presents the means and standard deviations for the scales along with the intercorrelations among the variables (college stress, differentiation of self, and psychological adjustment). Given research attesting to gender differences in the expression of differentiation (e.g., Schultheiss & Blustein, 1994; Skowron & Friedlander, 1998) and the heterogeneity in participants' ages, preliminary analyses were conducted to determine the need for including gender and age as covariates in the major analyses. Four *t* tests were conducted on gender and each of the DSI subscales (ER, IP, EC, and FO). Significant relations emerged between gender and ER, $t(125) = 3.02$, $p < .01$; IP, $t(125) = 2.27$, $p < .05$; and FO, $t(125) = 2.20$, $p < .05$, indicating that men reported higher ER, IP, and FO scores than did women. Thus gender was included in subsequent analyses. A multiple regression analysis on the four DSI predictors (ER, IP, EC, and FO) and age was not significant, $F(4, 121) = .35$, $p = .84$.

Test of Mediation

To test the hypothesis that differentiation (four DSI subscales) would mediate the relationship between academic stress (CSI) and psychological adjustment (GSI) among college students, three regression models were fit to the data to satisfy the initial conditions necessary for mediation (Baron & Kenny, 1986). First, in a test of path C (see Figure 1, section a), a univariate regression of GSI scores onto CSI scores was significant, with $t(125) = 8.54$, $p < .0001$, $R^2 = .37$, indicating that lower stress was associated with higher adjustment. Second, in a test of paths A_1 through A_4 in Figure 1 (Section b), a multivariate multiple regression on a single predictor, CSI scores, and on four criterion variables, DSI subscales ER, IP, EC, and FO, was significant on all multivariate fit statistics (e.g., Wilks's lambda = .73), $F(4, 121) = 11.15$, $p < .0001$. Results indicated that college stress predicted a significant amount of the variance in the collective mediators. As shown in Table 2, follow-up tests revealed that college stress significantly predicted ER, IP, and EC separately: ER, $t(125) = -4.63$, $p < .0001$; IP, $t(125) = -2.09$, $p < .05$; and EC, $t(125) = -5.29$, $p < .0001$, such that greater emotional reactivity, cutoff, and problems taking an I position predicted higher stress.

Third, a test of the additional variance accounted for when the mediators were considered in addition to stress for predicting adjustment was significant, $\Delta F(4, 121) = 6.38$, $p = .0001$, $\Delta R^2 = .11$, indicating that less emotional reactivity, emotional cutoff, fusion, and greater ability to take an I position in relationships, taken together, predicted adjustment, over and above college stress (see Table 2). Likewise,

TABLE 1

Means, Standard Deviations, and Intercorrelations Among College Stress, Differentiation of Self, and Psychological Adjustment

Variable/Subscale	1	2	3	4	5	6	*M*	*SD*
1. College stress (CSI)	—						20.01	11.36
2. Emotional Reactivity (DSI)	–.38**	—					3.11	0.96
3. I Position (DSI)	–.19*	.34**	—				4.06	0.82
4. Emotional Cutoff (DSI)	–.43**	.27**	.06	—			4.47	0.88
5. Fusion With Others (DSI)	–.10	.45**	–.07	–.15*	—		2.60	0.84
6. Psychological adjustment (GSI)	.61**	–.47**	–.36**	–.35**	–.18	—	0.81	0.59

Note. CSI = College Stress Inventory; GSI = General Severity Index on the Symptom Checklist-90-R; DSI = Differentiation of Self Inventory. Higher scores on the CSI indicate greater stress. Higher scores on the DSI subscales indicate less emotional reactivity, emotional cutoff, and fusion with others and greater ability to take an "I" position. Lower GSI scores indicate greater psychological adjustment.
*$p < .05$. **$p < .001$.

TABLE 2

Regressions Testing the Effects of College Stress and Differentiation of Self on Psychological Adjustment: Testing Mediation

Analysis and Predictor Variable	*B*	*SE*	R^2	*t*[a]	*F*	Criterion Variable
Analysis 1			.37		72.92**	
College stress (CSI)	.031	.004		8.59**		GSI
Analysis 2				0.73	11.15**	
College stress (CSI)	–.032	.007		–4.63**		ER
	–.013	.006		–2.09*		IP
	–.033	.006		–5.29**		EC
	–.007	.007		–1.07		FO
Analysis 3			.48		22.22**	
College stress (CSI)	.023	.004		5.86**		GSI
Emotional Reactivity (ER)	–.079	.055		–1.44		GSI
I Position (IP)	–.163	.053		–3.09*		GSI
Emotional Cutoff (EC)	–.086	.052		–1.66		GSI
Fusion With Others (FO)	–.078	.056		–1.38		GSI

Note. CSI = College Stress Inventory; GSI = General Severity Index on the Symptom Checklist-90-R.
[a]In the case of the multivariate regression in Analysis 2, *t* value represents Wilks's Λ.
*$p < .05$. **$p < .001$.

follow-up tests indicated that lower college stress and greater ability to take I positions in relationships uniquely predicted greater psychological adjustment, $t(125) = 5.86$, $p < .0001$ and $t(125) = –3.09$, $p < .01$, respectively. Given that college stress continued to evidence a significant relationship with adjustment scores in the presence of the mediators, complete mediation was not observed.

Finally, to test whether the amount of mediation (i.e., the indirect effect) was significant, we tested whether the regression coefficient between stress and adjustment was reduced in the presence of the four mediating DSI variables (ER, IP, EC, and FO; Baron & Kenny, 1986; Holmbeck, 1997). The total reduction is computed as (C – C´), where C = the regression coefficient for the predictor and criterion in the absence of the mediators (see Figure 1, Section a), and C´ = the regression coefficient for the predictor and criterion in the presence of the mediators (see Figure 1, Section b). In the case of a single mediator, the procedure for testing this reduction is readily available (e.g., Baron & Kenny, 1986). However, the method for calculating the reduction in the case of multiple mediators is more complicated and involves calculating and summing the total of the individual indirect effects (i.e., $C – C´ = A_1B_1 + A_2B_2 + A_3B_3 + A_4B_4$), then estimating the standard error of (C – C´) (for complete procedures, see Bollen, 1987; MacKinnon, 2000). As recommended by MacKinnon (2000), each of the individual indirect effects associated with the four mediators (ER, IP, EC, and FO) was calculated, and the standard error of (C – C´) estimated by taking the square root of the variance of (C – C´). This variance is computed as the sum of the products of the squared A_i coefficient for each mediator and the variance of the B_i coefficient of that mediator, the products of the squared B_i coefficient for each mediator and the variance of the A_i coefficient of that mediator, plus twice the product of each pair of A_i coefficients and the covariance between the corresponding B_i coefficients (MacKinnon, 2000, see equation 5.11 on p. 148). Results showed the total reduction or indirect effect was .0082 (*SE* = .0025), yielding a *z* score of 3.25, $p < .0006$, and a confidence interval that did not include 0 (i.e., .0032 to .013). These results showed a statistically significant reduction in the direct relation between stress and adjustment in the presence of the mediators and provided the final support for mediation. None of the four DSI subscales emerged as significant unique mediators.

Next, the total mediated effect was then computed as (C – C´)/C, or the reduction as a percentage of the total variation (MacKinnon, 2001), and was equal to .33. That is, 33% of the variability in the relationship between stress and adjustment was explained as a function of the set of four differentiation mediators. The proportion of the mediated effect attributable to each of the four mediators (ER, IP, EC, FO) was calculated using the equation A_iB_i/C (MacKinnon, 2001). Results showed that the proportion of the mediated effect attributable to each of the four mediators was as follows: ER = .104 (31.5%); IP = .088 (26.6%); EC = .116 (35.1%); and FO = .022 (6.8%).

Given the significant relationship observed between gender and aspects of differentiation, we concluded by testing a moderated mediation model to determine whether mediating effects of differentiation on the stress–adjustment relationship were different for men and women in the sample. First, the predictor (CSI scores) and moderators (four DSI subscale scores) were centered in order to eliminate multicollinearity effects between main effect terms and the interaction term (Aiken & West, 1991). A centered variable is transformed into a deviation score form with a sample mean = 0 and is obtained by subtracting the sample mean from each individual's score on the variable (Holmbeck, 1997). Next, a hierarchical regression was performed with CSI, centered DSI subscales, and gender entered first, followed by the four centered DSI-gender interaction terms in the second step.

No support was found for a gender-differentiation interaction, $\Delta F(4, 114) = 1.89$, $p = .12$, $\Delta R^2 = .03$.

Test of Moderation

Next, the alternative hypothesis that differentiation of self moderated the relation between stress and adjustment was tested. A hierarchical multiple regression was conducted using GSI scores as the criterion. The predictor (centered CSI scores) and moderators (four centered DSI scores) were entered first, followed by the four interaction terms (centered CSI × DSI subscales) in the second step. As shown in Table 3, significant main effects emerged, $F(5, 120) = 22.22$, $p < .0001$, $R^2 = .48$, but entry of the interaction produced a nonsignificant increment, $\Delta F(4, 116) = .99$, $p = .42$, R^2 change = .02. Thus no support for moderation was observed, and no gender effects were examined for this model.

DISCUSSION

This study examined the relationship between differentiation of self, college stress, and psychological adjustment. Results indicated that differentiation of self mediated, rather than moderated, the relationship between exogenous stress and psychological symptoms. In the current study, college stress was negatively related to greater levels of differentiation of self, and in turn, differentiation of self was positively related to psychological adjustment. Interpretation of these findings suggests that the association between college-related stress and actual level of personal adjustment is accounted for, in part, by one's capacity to regulate emotional reactivity, maintain connections with others, avoid emotional cutoff, and yet take I positions in important relationships. Moreover, no gender differences were observed with this effect, suggesting that differentiation of self mediates the relationship between college stress and personal adjustment in both male and female students. It is important to note that statistical mediation was examined in this study, and, as such, no causal inferences may be drawn from this study. Simply put, these results are merely consistent with the hypothesis that differentiation operates as a vehicle through which college stress influences adaptation.

Conversely, no evidence was found to support the moderation hypothesis for differentiation. Unlike Murdock et al.'s (1998) finding that differentiation of self appeared to moderate the link between general stress and dysfunction, the results of the current study suggest that differentiation partially mediated the link between college-specific stressors and adjustment. Key methodological and sampling differences could account for the discrepant findings: While Murdock et al.'s sample was composed of a similar gender breakdown (75% female, 25% male), their participants were older on average by 6 years. Likewise, Murdock et al. operationalized stress as a general feeling of being in control or degree to which demands are experienced as overwhelming, while we examined the impact of specific college-related strain on individual functioning.

The current findings suggest that an individual's self-differentiation—or their capacities for autonomous, independent thinking, emotion regulation, and a comfort with connections to family—accounted for approximately one third of the linkage observed between stress and capacity for personal adjustment among college students. Moreover, these findings appear to be consistent with, and extend the findings of others (e.g., Campbell, Adams, & Dobson, 1984; Grotevant & Cooper, 1985; Rice, Fitzgerald, Whaley, & Gibbs, 1995) concluding that for young men and women, the maintenance of positive ties with one's parents and important others goes hand in hand with the achievement of mature autonomy. Indeed, these collective findings point to the importance of distinguishing adaptive or mature autonomy from pseudoautonomy, characterized by emotional cutoff, separation anxiety, and/or detachment from family members (cf. Rice, Cole, & Lapsley, 1990). The failure of some previous studies to establish the joint importance of connection and autonomy in relationships to adaptive outcomes in college students (e.g., Schultheiss & Blustein, 1994) might be due to use of

TABLE 3

Hierarchical Multiple Regression of Differentiation of Self and College Stress on Psychological Adjustment: Testing Moderation

Step and Predictor Variable	*B*	*SE*	R^2	ΔR^2	ΔF
Step 1[a]			.48		22.22**
College stress (CSI)	.023*	.004			
Emotional Reactivity (ER)	−.079	.055			
I Position (IP)	−.163*	.053			
Emotional Cutoff (EC)	−.086	.052			
Fusion With Others (FO)	−.078	.056			
Step 2[b]				.02	0.99
CSI × ER	−.0001	.006			
CSI × IP	−.003	.005			
CSI × EC	.005	.006			
CSI × FO	−.005	.007			

Note. CSI = College Stress Inventory; GSI = General Severity Index on the Symptom Checklist-90-R.
[a]Main effects of predictor variable and moderators on criterion. [b]Interaction effects of predictor and mediators on criterion variable.
*$p < .001$. **$p < .0001$.

separation-individuation measures that tap elements of pseudoautonomy, in the form of attitudinal and emotional independence from parents (e.g., the Psychological Separation Inventory; Hoffman, 1984). According to Bowen's (1978) family systems theory, one would not expect healthy autonomy among college students to be characterized necessarily by clear attitudinal differences or emotional separation between an individual and his or her parents. Mature autonomy or the ability to take "I" positions in relationships entails neither the wholesale acceptance nor rejection of one's parents' values or opinions but rather a thoughtful consideration of the relative merits of those positions and their goodness of fit with one's own convictions and beliefs. Attitudinal separation from parents, according to Bowen (1978) family systems theory, is not evidence of greater differentiation of self—for some, it may indicate the presence of undifferentiation marked by emotional reactivity or cutoff.

Another explanation for the current findings may lie with the role of emotion regulation—a critical intrapsychic element of differentiation—in facilitating personal adjustment under stress. Of the four components of differentiation examined, our findings indicate that emotional cutoff and emotional reactivity scores together were responsible for the majority (66.6%) of the mediated effect observed. Emotional regulation from a Bowen (1978) family systems perspective is described as an ability to distinguish fact from feeling and choose to "be thoughtful about the facts that stimulate feelings and . . . think through actions, despite powerful feelings" (Meyer, 1998, p. 90). According to Bowen (Kerr & Bowen, 1988), "a successful effort to improve one's level of differentiation and reduce anxiety strongly depends on a person's developing more awareness of and control over his emotional reactivity" (p. 127). Indeed, research has demonstrated that the capacity to regulate one's emotional states can mediate the relationship between secure attachment and peer social competence among middle school students (Contreras, Kerns, Weimer, Gentzler, & Tomich, 2000).

Recent research has demonstrated relationships between greater differentiation of self and use of more adaptive coping strategies, such as reflective coping, and less use of reactive and suppressive styles (Murdock et al., 1998). However, more work is needed to examine the role of differentiation in successful coping. Does one's level of differentiation influence selection of or reliance on problem-focused or emotion-focused coping strategies? Because differentiation of self involves the capacity for both rational thought and deep emotional experiencing, one might hypothesize that individuals who are more differentiated are better skilled at both problem-focused and emotion-focused coping. Leading coping researchers (e.g., Lazarus, 2000) have suggested that problem-focused and emotion-focused coping likely function interdependently and that researchers should be studying these respective strategies in unison.

We offer several suggestions for clinical practice based on these general findings. Support for the mediation model suggests that one's differentiation skills are relevant at all levels of the stress continuum and indicate that differentiation may be an important target of preventive interventions as well as traditional counseling for college students. Campus prevention and outreach programs provided by college counseling centers and residence halls that introduce the concept of differentiation of self and its role in influencing adjustment under stress, in addition to training in stress management and adaptive coping, might be beneficial to students experiencing a variety of college-related stressors.

Students referred to college counseling centers with stress reactions and/or adjustment difficulties may benefit from individual, family-of-origin therapy. For example, Bowen (1978) therapy is designed to decrease emotional reactivity and facilitate development of insight into or awareness of the life forces operating in one's family system (McGoldrick & Carter, 2001; Meyer, 1998). Early sessions focus on stimulating a client's interest in his or her own family history, and more important, curiosity about the impact of key family events on his or her own functioning (Meyer, 1998). Clients are taught about the principles of differentiation of self and emotional systems, encouraged to maintain regular contact with family members by establishing person-to-person relationships, and helped to identify and extricate self from the primary family triangles in which he or she participates (Kerr & Bowen, 1988; Titelman, 1998). In turn, clients gradually come to accept responsibility for their role in the development of their life problem and begin to formulate personal life principles that have been neglected in response to high anxiety or in exchange for fitting in with the crowd or approval from important others (Meyer, 1998). Through the process of formulating one's personal life principles, differentiation of self is thought to strengthen.

Although some counselors may hesitate to use family systems therapy with their individual clients, Bowen (1978) espoused working with individual members of a family, asserting that when an individual raises his or her level of differentiation and remains in contact with family, the level of differentiation in the family system, in turn, increases. The effectiveness of these interventions on the functioning of the individual client, as well as his or her family system, are still unknown at this time and require systematic evaluation to determine whether they may facilitate better adaptation among college students under academic and financial stress and their families.

More research is also needed to understand the mediating role of differentiation of self on the adaptation of college students under stress. For example, does differentiation of self also account for successful work adjustment in the face of job-related stressors for non-college-bound individuals who transition directly from high school to the world of work? or are these findings unique to college students? Answers to these and other questions will have important implications for the refinement of Bowen (1978) theory, including our empirical understanding of the role of relationships in facilitating optimal functioning and the role of differentiation during the launching phase of the family life cycle among traditional college students or during the midlife phase of nontraditional, returning adult students, to name a few.

Likewise, the role of differentiation of self among college students of color has only recently begun to receive attention. Competing perspectives can be found in the literature as to whether the concept is cross-culturally relevant, with some (Essandoh, 1995; Tamura & Lau, 1992) arguing that differentiation is a culturally bound construct while others (e.g., Boyd-Franklin, 1989; Carter & McGoldrick, 1999; Gushue & Sicalides, 1997) have praised Bowen theory for the importance it places on the role of connection for mature functioning. Although support for a mediational model of differentiation was observed herein, cross-validation of these findings in college students of color is needed to determine whether differentiation of self operates in similar ways across diverse ethnic-cultural groups.

Given the cross-sectional design of this study, the issue of putative cause-and-effect relations in the mediated model tested was not resolved in the current study. The possible presence of small gender effects, for example, may have been obscured in the current study. Heterogeneity in age of college students surveyed introduced additional variability into this sample; however, the lack of age differences observed was consistent with prior research (e.g., Skowron & Friedlander, 1998) and suggests that younger adults may be just as capable of defining a self and achieving a healthy balance of autonomy and intimacy as their older counterparts. Likewise, the sole reliance on self-report data introduced a monomethod bias. Future cross-validation and quasi-experimental research is needed to replicate these findings using alternate measures of the constructs and greater levels of control, perhaps by manipulating levels of stress and using alternate methods to operationalize differentiation of self (e.g., friendly differentiation on the Structural Analysis of Social Behavior Intrex; Benjamin, 1996). The search for mediators of the relationship between stress and adaptation is progressing but continues to challenge researchers (cf. Cohen & Wills, 1985; Funk, 1992; Somerfield & McCrae, 2000). Nonetheless, the present data provide initial support for the importance of studying the role of family connections, autonomy, and capacity for emotion regulation in unpacking the stress-functioning association.

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Intervention Studies on Forgiveness: A Meta-Analysis

Thomas W. Baskin and Robert D. Enright

*In this meta-analysis, 9 published studies (*N *= 330) that investigated the efficacy of forgiveness interventions within counseling were examined. After a review of theories of forgiveness, it was discovered that the studies could logically be grouped into 3 categories: decision-based, process-based group, and process-based individual interventions. When compared with control groups, for measures of forgiveness and other emotional health measures, the decision-based interventions showed no effect, the process-based group interventions showed significant effects, and the process-based individual interventions showed large effects. Consequently, effectiveness has been shown for use of forgiveness in clinical and other settings.*

A promising area of counseling research that emerged in the 1990s is the scientific investigation of forgiveness interventions. Although the notion of forgiving is ancient (Enright & the Human Development Study Group, 1991), it has not been systematically studied until relatively recently (Enright, Santos, & Al-Mabuk, 1989). Significant to counseling because of its interpersonal nature, forgiveness issues are relevant to the contexts of marriage and dating relationships, parent–child relationships, friendships, professional relationships, and others. In addition, forgiveness is integral to emotional constructs such as anger. As forgiveness therapies (Ferch, 1998; Fitzgibbons, 1986) and the empirical study of these therapies (Freedman & Enright, 1996) begin to unfold, it is important to ask if these interventions can consistently demonstrate salient positive effects on levels of forgiveness and on the mental health of targeted clients.

The purpose of this article is to analyze via meta-analysis the existing published interventions on forgiveness. Meta-analysis is a popular vehicle of synthesizing results across multiple studies. Recent successful uses of this method include the study by McCullough (1999), who analyzed five studies that compared the efficacy for depression of standard approaches with counseling with religion-accommodative approaches. Furthermore, in order to reach conclusions about the influence of hypnotherapy on treatment for clients with obesity, Allison and Faith (1996) used meta-analysis to examine six studies that compared the efficacy of using cognitive-behavioral therapy (CBT) alone with the use of CBT combined with hypnotherapy. Finally, Morris, Audet, Angelillo, Chalmers, and Mosteller (1992) used meta-analysis to combine the results of 10 studies with contradictory findings to show that the benefits of chlorinating drinking water far outweighed the risks. Although there may be some concern that using forgiveness as an intervention in counseling is in too early a stage of development and that too few studies exist for a proper meta-analysis, the effectiveness of these recent meta-analyses supports this meta-analytic investigation. Certainly any findings must be tempered with due caution. However, this analysis may serve as important guidance for the structure and development of future counseling studies of forgiveness.

We first examine the early work in forgiveness interventions by examining the early case studies. From there, we define forgiveness, discuss the models of forgiveness in counseling and the empirically based interventions, and then turn to the meta-analysis.

EARLY CASE STUDIES

The early clinical case studies suggested that forgiveness might be helpful for people who have experienced deep emotional pain because of unjust treatment. For example, Hunter (1978) reported on Harriet, a 25-year-old woman with acute emotional distress. Harriet's mother frequently condemned her daughter for the slightest deviation from her unreasonably high standards. Harriet's anger toward her mother eventually led to symptoms of anxiety and depression. In addition, she started showing such externalizing symptoms as excessive anger and frustration directed at family members. With Hunter's help, Harriet came to understand how she was reacting to her own victimization by victimizing others. In counseling, she was able to see her parents as capable of both good and bad behaviors. Forgiving her parents allowed her to take greater responsibility for her own behavior; she did not have to belittle others. Forgiving her parents allowed Harriet to experience a greater self-acceptance and to establish meaningful friendships.

One of Kaufman's (1986) early case studies involved Uri, an Israeli army officer in his 40s, who came to counseling

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because of an inability to establish positive relationships with women. Through forgiveness counseling, Uri realized how much unconscious and deep anger he had toward his father, who died when he was young, and his mother, whom he blamed for the family's subsequent poverty. Uri realized that he had not yet matured, displacing his anger onto his relationships with women and showing regressive, rebellious behavior similar to behavior in his adolescence. Forgiving his father for dying allowed Uri to symbolically bury his father. Forgiving his mother for not providing a higher standard of living allowed him to leave behind the debilitating anxiety that had plagued him since childhood. As a result, Kaufman observed Uri growing in courage and accepting adult responsibility. He married and was able to reestablish a loving relationship with his mother.

From his clinical practice, Fitzgibbons (1986) reported that forgiveness counseling seemed to reduce anger, anxiety, and psychological depression in his clients. He observed that as people learn to forgive, they also learn to express anger in more appropriate ways, similar to the observations by Hunter (1978) and Kaufman (1986). At the time of these clinical reports, however, the observations had not been tested.

FORGIVENESS DEFINED

If forgiveness was to become part of the scientific study of counseling, then an accurate, comprehensive definition had to be established. Forgiveness has been defined as the willful giving up of resentment in the face of another's (or others') considerable injustice and responding with beneficence to the offender even though that offender has no right to the forgiver's moral goodness (see, for example, Enright & the Human Development Study Group, 1991). Forgiveness is an act freely chosen by the forgiver.

Forgiveness is distinguished from *condoning and excusing*, *reconciling*, and *forgetting*. When someone condones or excuses, he or she realizes that there was no unfairness. If, for example, Jack takes Mary's car to drive an injured child to the hospital, Mary, on realizing what had happened, would not forgive Jack, but excuse him under the circumstances. Reconciliation involves two people coming together again in mutual trust, whereas forgiveness is one person's choice to abandon resentment and offer beneficence in the face of unfairness. One can forgive without reconciling. When one forgives, he or she rarely forgets the event. People tend to recall traumatic events, but on forgiving, a person may remember in new ways—not continuing to harbor the deeply held anger.

COUNSELING MODELS

Counseling models and measures of forgiveness emerged out of the aforementioned or similar definitions of forgiveness. Three basic intervention models have been developed.

Model One

The first model, by Enright and the Human Development Study Group (1991), encompasses 20 processes or units within four phases: Uncovering, Decision, Work, and Deepening. Over the years, the model has been refined from 17, then to 18, and finally to 20 units as seen in Table 1. The different interventions via this model have used slight variations of the model's units over the years.

Denton and Martin (1998) asked more than 100 clinical social workers their opinion about the way forgiveness therapy usually proceeds. The findings closely approximated the model described as follows. Also, Osterndorf, Hepp-Dax, Miller, and Enright (1999) reported on a study in which people hurt unfairly by another ordered the variables in Table 1 according to their own experience of forgiving. The

TABLE 1

Processes of Forgiving Another

Phase	Reference
Uncovering phase	
1. Examination of psychological defenses	Kiel, 1986
2. Confrontation of anger; the point is to release, not harbor, the anger	Trainer, 1981
3. Admittance of shame, when it is appropriate	Patton, 1985
4. Awareness of cathexis	Droll, 1984
5. Awareness of cognitive rehearsal of the offence	Droll, 1984
6. Insight that the injured party may be comparing self with the injurer	Kiel, 1986
7. Realization that oneself may be permanently and adversely changed by the injury	Close, 1970
8. Insight into a possibly altered "just world" view	Flanigan, 1987
Decision phase	
9. A change of heart, conversion, new insights that old resolution strategies are not working	North, 1987
10. Willingness to consider forgiveness as an option	Enright, 2001
11. Commitment to forgive the offender	Neblett, 1974
Work phase	
12. Reframing, through role taking, who the wrongdoer is by viewing him or her in context	Smith, 1981
13. Empathy toward the offender	Cunningham, 1985
14. Awareness of compassion, as it emerges, toward the offender	Droll, 1984
15. Acceptance, absorption of the pain	Bergin, 1988
Outcome phase	
16. Finding meaning for self and others in the suffering and in the forgiveness process	Frankl, 1959
17. Realization that self has needed others' forgiveness in the past	Cunningham, 1985
18. Insight that one is not alone (universality, support)	Enright, 2001
19. Realization that self may have a new purpose in life because of the injury	Enright, 2001
20. Awareness of decreased negative affect and, perhaps, increased positive affect, if this begins to emerge, toward the injurer; awareness of internal, emotional release	Smedes, 1984

Note. Table is an extension of Enright and the Human Study Group (1991). The references listed for each item are prototypical examples or discussions of that item.

participants' average correlation between their own rankings of the process (from first experience to last in the forgiveness process) correlated $r = .79$ with the theoretically established order.

The eight units of the Uncovering Phase assist the participant to explore the injustice he or she has experienced, assess the amount of anger, and understand the ways in which harboring that anger may be clinically compromising the person. For example, in the first unit, the person examines the various psychological defenses he or she may use to protect against emotional pain (Kiel, 1986). Although such defenses may be adaptive in the short run, they need to be recognized if the person's true emotion about the unfairness is to be confronted and understood. Prior to forgiving, a person usually needs to express the anger over a genuinely hurtful offense (Unit 2). In Unit 3, the person acknowledges and assesses the amount of guilt and shame that he or she has over the incident (Patton, 1985). Incest survivors, for example, oftentimes experience guilt over pleasurable physical sensations that occurred when they were being victimized; the person needs to realize that such feelings are normal and in no way implicates the person as cooperating with the offense. Units 4 and 5 focus on the person's tendency to attach much emotional energy to the offense and to ruminate excessively on it in an attempt to find a solution (Droll, 1984). At times, the person begins to compare his or her less fortunate state with what is perceived to be the offender's more fortunate state (Unit 6) and to realize that he or she has been permanently changed by the event (Unit 7). Both can deepen the person's anger and distress. The point of Units 6 and 7 is to assess the extent to which these thought patterns are occurring. Finally, people oftentimes conclude that based on all of the emotional pain experienced, life is unfair (Unit 8). The insights from uncovering the pain lead to the Decision Phase in which the person rethinks past attempts to regulate emotions and solve the problem (Unit 9), explores the meaning of forgiveness and the option of forgiveness in dealing with the problem (Unit 10), and commits to forgiveness (Unit 11).

The Work Phase encompasses four units: a set of thinking exercises to see the offender in a new light, or reframing who he or she is (Unit 12), stepping inside the offender's shoes to emotionally experience his or her confusion, vulnerability, or stress (Unit 13), which can increase a sense of compassion for the offender (Unit 14) and lead to what Bergin (1988) and others called bearing the pain (Unit 15). Here the forgiver gives a moral gift to the offender by not seeking revenge and by showing respect for him or her, not because of what was done but despite what was done.

Finally, the Deepening Phase includes such units as finding meaning in what was suffered (Unit 16), realizing that he or she is imperfect and in need of others' forgiveness from time to time, garnering support for forgiving, sometimes finding a new purpose in life (helping others in similar situations), and experiencing emotional relief (Units 17–20). All counseling programs done with this model have incorporated manuals as guides to the interventions (Al-Mabuk, Enright, & Cardis, 1995; Coyle & Enright, 1997; Freedman & Enright, 1996; Hebl & Enright, 1993).

Model Two

A second intervention model was described by McCullough, Worthington, and Rachal (1997). Presented as a way of fostering both cognitive and affective empathy, the model outlined by the authors has nine different components. First, the participants built rapport with the intervener, and second, each participant explored what the hurtful event was and what his or her reaction was to it. The exercises here were similar, at least to a degree, to the first eight units of the aforementioned model, except that all the exercises were summarized in part of one session. The third step involved understanding empathy through the use of vignettes and discussion. Fourth was a didactic unit in which the leader described the link between being empathic toward an offender and eventually forgiving that offender. Fifth, through written and verbal exercises, the participants practiced cognitive reframing and focused on the offender's psychological state and general situation in life (similar to Unit 12 of Table 1). Next, the respondents considered times in which they, themselves, needed other people's forgiveness (Unit 17, Table 1). The analysis of attribution errors followed in which the participants were encouraged to see the offender's behavior in terms of its situational determinants (Unit 12 again). Next, came an emphasis on the offender's needs (Unit 13, Table 1) and how forgiveness may enhance the offender's well-being (Unit 14, Table 1). Finally, constructs such as repentance and reconciliation were distinguished from forgiveness (Unit 10, Table 1), and strategies for generalizing the learning were discussed (Unit 19, Table 1).

Model Three

The third model, by McCullough and Worthington (1995), was designed to elicit forgiveness in a 1-hour session by focusing empathically on the offender and writing letters (which were not sent) in which feelings were expressed to the offender. Given the brief nature of the intervention, the model introduced people to the idea of forgiveness and served as a forum to consider a decision to forgive.

In all three models, the participants in the interventions are asked to think about one person who has hurt them unfairly and to do the work of forgiveness relative to that particular person.

PROCESS VERSUS DECISION

These models highlight an important underlying philosophical difference. The first two models are *process* based, whereas the third is *decision* based. The philosopher Neblett (1974) argued that the essence of forgiveness is in the decision to forgive, along with the proclamation "I forgive you." As the person decides to forgive and so proclaims, several important things happen. First, the forgiver has crossed an important line, so to speak. He or she has moved from a position of resentment to one of not letting the resentment dominate the

interaction. Although the one who forgives may still feel resentful, the person chooses not to let it be a controlling factor. Second, the decision and proclamation show that the forgiver is consciously aware of his or her new position. The forgiver, in other words, is not abandoning resentment because of taking some memory-loss pill or simply letting time run its course. Instead, the decision is a defining moment regarding who the forgiver is ("I am one who forgives"), who the forgiven is ("He/she is worthy of respect"), and what their relationship may be like as a result of this decision. The emphasis on forgiveness as a decision, then, centers the construct in the cognitive domain.

In contrast, the philosopher North (1987) argued that forgiveness is a process, with the defining-moment decision embedded within it. Forgiveness develops from resentment and anger, through the decision, to the struggles to love and feel compassion toward a person who is difficult to love. This process can take time and effort (see Smedes's, 1984, early writing on this). From this perspective, a decision by itself leaves one with only half a story to tell and therefore cannot qualify as forgiveness per se, although it is a vital part of that story.

A similar difference emerged in the early psychological literature. Worthington and DiBlasio (1990) published an intriguing article in which they outlined a decision-based counseling plan for forgiveness. The essence of the intervention is to have one forgiveness session with two people in which each person takes turns offering and granting forgiveness, along with a commitment to atone for wrongdoing and a genuine attempt to do better in the future. There is a sense of process here in that much preparation occurs between the therapist and the pair prior to the session. Yet, as with Neblett (1974), the session, the decision to offer and receive forgiveness, is the defining moment of the counseling.

Another insightful contribution was made by Ferch (1998). He outlined a method of *intentional forgiving* such that there is first a psychoeducational stage, which prepares clients to forgive, and then there is a face-to-face processing of forgiveness when appropriate. The choice to forgive is described as both a decision, with immediate opportunity, and as the opening of doors to a journey that encompasses an entire forgiving process.

Perhaps another way to look at this difference of decision-based versus process-based models is the contrast between an exclusively cognitive approach and one that includes a more extended cognitive and affective/empathy approach. Fitzgibbons (1986) became aware early that clients tend to first approach forgiveness cognitively—saying they forgive—before they feel like forgiving and offering empathy.

EMPIRICAL STUDIES

This meta-analysis seems to be the first quantitative assessment of all existing published forgiveness counseling interventions. A review of the literature indicates that nine empirical studies with a quantitative measure of forgiveness have been published thus far.

Hebl and Enright (1993)

Hebl and Enright (1993) implemented the first counseling forgiveness intervention following a treatment model based on Enright and the Human Development Study Group (1991). Participants were elderly women with a mean age of 74.5 years who qualified in all of four conditions for participation: (a) The participant had something to forgive, (b) the participant felt emotionally hurt by what happened, (c) there was a definite person in mind to forgive, and (d) the participant was not going through a grieving process. All 26 participants were randomly assigned to a control group intervention versus a forgiveness group intervention. The forgiveness group intervention consisted of eight 1-hour weekly sessions. A prepared manual was used, which was based on a process model of forgiveness, and clients went through 17 units related to forgiving another person. All 13 participants assigned to forgiveness group intervention completed it. The control group intervention also consisted of eight 1-hour weekly sessions. Participants determined topics that they would like to discuss with each other during the first session, and successive sessions consisted of talking through these issues. Eleven of 13 participants assigned to this group completed it. Both groups completed the Psychological Profile of Forgiveness Scale to measure forgiveness. Furthermore, the mental health constructs of self-esteem, state anxiety, trait anxiety, and depression were measured.

McCullough and Worthington (1995)

McCullough and Worthington (1995) studied two different brief psychoeducational group interventions on participants' forgiveness for an offender and compared them with a waiting list control group. Participants were recruited from an undergraduate psychology class, and they qualified by reporting that they had not committed severe offenses, such as incest, sexual abuse, and family strife, at early ages and by arriving for the intervention at an appointed time. The 86 participants were grouped as follows: 30 participants in an interpersonal group intervention, 35 participants in a self-enhancement group intervention, and 21 participants into a waiting list control condition. In the interpersonal intervention, the participants were divided into two groups and given a 1-hour intervention to encourage them to decide to forgive. The rationale given was the restoration of participants' relationships with the offenders and significant others. The self-enhancement intervention was the same as that of the interpersonal intervention, except that participants were encouraged to forgive because forgiveness was seen as providing physical and emotional benefits for the forgiver. All three groupings were given Wade's (1989) Forgiveness Scale to measure their level of forgiveness. No other mental health constructs were measured.

Al-Mabuk et al. (1995)

Al-Mabuk et al. (1995) examined two interventions with parental-love-deprived college students. In each case, effects

were compared with a control group intervention. In Study 1 and Study 2, participants were randomly selected from college students who scored 1 standard deviation above the mean on a parental love-deprivation screening questionnaire for at least one parent. In the first study, 48 college students were randomly placed in experimental intervention and control intervention groups. In the second study, the same was done with 48 different participants. In Study 1, the experimental intervention group received four 1-hour group sessions designed to take participants through the decision to forgive (similar to 11 of 20 units of forgiveness in Table 1). It was reasoned that this would be effective based on Neblett's (1974) argument that one's commitment to forgive is the crux of forgiveness. The control intervention met for the same amount of time, yet the sessions included different material. The control intervention consisted of a human relations program that focused on leadership, communication, self-discovery, and perception. Forgiveness and parent-relations were absent from the curriculum. All 24 participants completed each of these groups. In Study 2, the experimental intervention group received six 1-hour sessions designed to take participants through all forgiveness units (similar to the 20 units in Table 1). Here participants were exposed to the entire theorized process of forgiveness. In addition, while Study 1 had two sessions per week, Study 2 had one session per week. The control intervention met for the same amount of time as the experimental group and had the same topics as the control intervention of Study 1, with the added topics of avoiding vagueness in communication and of personal affirmations in rewarding others. All 24 participants completed the experimental intervention, while 21 of 24 had complete data for the control intervention.

Freedman and Enright (1996)

Freedman and Enright (1996) compared a forgiveness intervention with female incest survivors to a waiting list control. Participants were 12 women recruited from a midwestern community who were sexually abused, involving contact when they were children, by a male relative. Also, the abuse must not have occurred within the previous 2 years, and participants needed to show signs of experiencing psychological difficulties. Average age was 36 years (range = 24–54 years). The intervention group was given weekly individual counseling sessions for an average of 14.3 months. Sessions followed a process model, giving a complete set of 17 units (similar to those in Table 1). During each session, no more than one unit was covered, and the intervention would remain on one unit until the client felt ready to move on to the next. All 6 participants completed this intervention. The wait-listed control group waited an average of 14 months before receiving the intervention. These participants had a small amount of monthly contact with the experimenter to maintain the connection, although the topic of forgiveness was never mentioned. After a matched member of the intervention group finished her treatment, control participants were then given the identical full intervention. All 6 participants assigned to this group completed the aforementioned process. Both groups completed the Psychological Profile of Forgiveness Scale to measure forgiveness, as well as scales to measure the mental health constructs of hope, state anxiety, trait anxiety, self-esteem, and depression.

McCullough et al. (1997)

McCullough et al. (1997) conducted an empathy intervention group, a comparison intervention group, and a waiting list group with college students from an introductory psychology course. Participants wished to learn information and skills that might help them to forgive a specific person whom they wanted to forgive but had been previously unable to forgive. They were not taking psychotropic medications or receiving counseling; did not manifest substance abuse problems, psychotic behavior, or personality disorders that might disrupt the groups; and agreed to being randomly assigned to either a seminar or a waiting list. Assignment to groups consisted of 13 participants to the empathy seminar, 17 to the comparison seminar, and 40 to a waiting list. The empathy intervention was a seminar that promoted forgiveness through encouraging a process of both cognitive and affective empathy. The seminar consisted of eight 1-hour sessions conducted over one weekend. Each seminar consisted of between 5 and 8 participants. At follow-up, complete data were available for 12 of 13 participants assigned to the empathy intervention. The comparison intervention focused only on a cognitive understanding of the benefits of forgiveness, the definitions of forgiveness, and hearing other people's stories of how they forgave. The practices of reframing and empathy were omitted. The intent of these sessions was to commend forgiving as a health-promoting behavior without explicitly enhancing empathy for the offender. To this end, the cognitive decision to forgive was emphasized. The duration and size of the comparison seminars were the same as that of the empathy seminar. At follow-up, complete data were available for 15 of 17 participants assigned to the comparison intervention. For the control group, 39 of 40 participants completed the assessments. A Forgiving Scale (FS) was given to measure forgiveness. The constructs of affective empathy and cognitive empathy were also measured.

Coyle and Enright (1997)

Coyle and Enright (1997) implemented an intervention designed to foster forgiveness with "postabortion men." Participants consisted of 10 men who self-identified as hurt by the abortion decision of a partner. They were randomly assigned to either the treatment or the control (waiting list) condition, which received treatment after a 12-week waiting period. The treatment condition consisted of 12 weekly 90-minute individual sessions. Sessions were conducted by a graduate student in educational psychology under the supervision of a licensed psychologist. The intervention was based on psychological variables and units of a process model of forgiveness (similar to those in Table 1). The Enright Forgiveness Inventory (EFI) was used to measure forgive-

ness. Other mental health variables measured included state anger, state anxiety, and grief.

CATEGORIZING THE STUDIES

Given the theoretical foundations of the interventions, we divided them into three groupings: (a) those studies that are primarily decision based; (b) those studies that are process based and had a group format; and (c) those studies that are process based and followed an individual format (see Table 2). The decision subdivision contains single session interventions and partial interventions, which use a decision-based model. This includes the first intervention in Al-Mabuk et al. (1995), both interventions in McCullough and Worthington (1995), and the second intervention in McCullough et al. (1997). The process-group subdivision includes group interventions of six to eight sessions that are process based. This includes Hebl and Enright (1993), the second intervention in Al-Mabuk et al. (1995), and the first intervention in McCullough et al. (1997). Last, the process-individual subdivision includes those interventions of 12 or more sessions of individual therapy, using a process-based model. Specifically, this is Freedman and Enright (1996) and Coyle and Enright (1997). All nine studies fit unambiguously into one of these three categories.

IMPORTANT QUESTIONS

Based on these forgiveness interventions and their differences in theoretical foundations, this review has three important tasks that will be addressed through numerical analysis. First, is there evidence for grouping the studies into three categories versus considering them all as one category? Second, a philosophical difference between decision-based and process-based models has emerged: a onetime event or a series of procedures designed to elicit forgiveness. Looking across studies, can it be shown that interventions based on one theoretical foundation give stronger results than those based on the other, or are they equivalent? Third, it is important to ascertain the nature of the effects of forgiveness therapy within counseling. Again, looking across studies, and according to their theoretical basis, are these counseling interventions effective in increasing forgiveness? Furthermore, do their benefits go beyond forgiveness to other well-established emotional health constructs, such as depression, anxiety, and others? These are the questions of our meta-analysis.

THE META-ANALYTIC PLAN

To answer our first question, we determine whether the studies are more accurately viewed as one or three groups based on a test of homogeneity. Regarding the second question, we sum the effect size of the studies within each group for forgiveness and compare these among groups. To answer our third question, we sum the effect sizes of all nonforgiveness emotional health variables within a study, then sum these across studies within each group to assess a final level of effect for each group. We then compare these totals across groups.

TABLE 2

Overview of Studies in Meta-Analysis

Study and Author	Group	Intervention	Forgiveness Measure	Emotional Health Dependent Variable
1 Hebl & Enright, 1993	Process–Group	Elderly women, 8 group sessions, full intervention	PPFS	Self-esteem, state-anxiety, trait-anxiety, depression
2 Al-Mabuk, Enright, & Cardis, 1995	Decision	PLD adolescents, 4 group sessions, 9/17 units	PPFS	Attitude toward father, attitude toward mother, hope, state-anxiety, trait-anxiety, self-esteem, depression
3 Al-Mabuk et al., 1995	Process–Group	PLD adolescents, 6 group sessions, 17/17 units	PPFS	Attitude toward father, attitude toward mother, hope, state-anxiety, trait-anxiety, self-esteem, depression
4 McCullough & Worthington, 1995	Decision	Undergraduates (nonserious hurt), 1 group session, restore relationship focus	9 Wade subscales	None
5 McCullough & Worthington, 1995	Decision	Undergraduates (nonserious hurt), 1 group session, benefits for the forgiver focus	9 Wade subscales	None
6 Freedman & Enright, 1996	Process–Individual	Incest survivors, 52+ individual sessions, full intervention	PPFS	Hope, state-anxiety, trait-anxiety, self-esteem, depression
7 McCullough, Worthington, & Rachal, 1997	Process–Group	Undergraduates, 8 group sessions (one weekend), empathy-focused forgiveness	FS	Affective empathy, cognitive empathy
8 McCullough et al., 1997 9 Coyle & Enright, 1997	Decision	Undergraduates, 8 group sessions (one weekend), nonempathy forgiveness	FS	Affective empathy, cognitive empathy
	Process–Individual	"Postabortion men," 12 individual sessions, full intervention	EFI	Forgiveness, state anxiety, state anger, grief

Note. PPFS = Psychological Profile of Forgiveness Scale; PLD = parental love-deprived; 9 Wade subscales = Wade's (1989) Forgiveness Scale subscales; FS = Forgiving Scale; EFI = Enright Forgiveness Inventory.

METHOD

Establish Studies

To be included in this meta-analysis, a study had to have been empirical, with a quantitative measure of forgiveness, have had a control group, and had to have been published in a refereed journal. Furthermore, interventions had to have been based on some model of forgiveness. First, a search of electronic databases was conducted to find all relevant studies. Second, as studies were located, their references were used to check for further studies that may exist. Third, qualitative reviews of forgiveness literature were examined for references to empirical studies. Nine empirical studies were found, all of which fit the outlined criteria, with a total $N = 330$. All studies were accomplished with well-trained therapists/leaders, and each fell within one of the forgiveness models described earlier.

Test for Homogeneity

To determine whether the studies could be more accurately viewed as one group or three, a test of homogeneity is needed. Because the variance of each statistic can be estimated, the modified medium chi-square test (Cramer, 1946) can be used to test for homogeneity (Hedges & Olkin, 1985). In this case,

$$Q = \Sigma\,(d_{Si} - d_{S\,-\,agg})^2 / \sigma^2(d_{Si}) \qquad (1)$$

is distributed as a chi-square with k–1 degrees of freedom, where k is the number of studies yielding effect sizes, d_{Si} is the obtained effect sizes for study i, and $d_{Si\,-\,agg}$ is the aggregated effect size across studies. Significantly large values of Q signal the rejection of the null hypothesis of homogeneity.

In investigating these three groups, we hoped to shed light on the effectiveness of decision-based versus process-based interventions. In addition, in our examination of the group and individual formats, we sought to deepen our understanding of what is effective in forgiveness interventions that emphasize processes. Next we determined if, within each grouping, there is a preponderance of evidence that suggests that these interventions are effective in increasing forgiveness. Finally, we examined whether there is sufficient evidence to support the hypothesis that these benefits extend beyond forgiveness to other important mental health variables.

Calculation of Effect Size

The next task was to compute the effect sizes of the interventions for the dependent variables. As previously outlined, two groups of dependent variables were examined: (a) forgiveness and (b) all other emotional health dependent variables. These effect sizes were calculated using the methods outlined by Hedges and Olkin (1985).

Two studies presented a challenge about possible inclusion where no single measure of forgiveness was reported. McCullough and Worthington (1995), which included two studies, reported nine subscales of the Wade Forgiveness Scale but not the aggregate single measure. Statistically, simple aggregation of the subscales would lead to an inaccurate result, because their correlation would not be accounted for. The subscales could, however, be aggregated using the same method we used to combine multiple measures within one intervention in this present analysis (see the following), as long as intercorrelations were known. Because McCullough and Worthington did report these intercorrelations for the subscales at preintervention, the aggregation was successfully accomplished.

For each outcome, the effect size g was calculated by taking the difference between the intervention mean and the control mean and dividing by the pooled standard deviation of the two, according to the following formula:

$$g = (M_I - M_C)/s, \qquad (2)$$

where M_I and M_C are the mean levels of measurements (with I denoting the intervention and C the control group, and with s the pooled standard deviation). The unbiased population effect size d for each result was calculated by correcting for the bias in g (Hedges & Olkin, 1985):

$$d = [1 - 3/(4N - 9)]g, \qquad (3)$$

where $N = n_I + n_C$, the sum of the participants in the intervention and control groups. The variance of d was estimated by (Hedges & Olkin, 1985):

$$\sigma^2(D) = [N/(n_I n_C)] + [D^2/2N]. \qquad (4)$$

Furthermore, Hedges and Olkin's method of weighting the contribution of each study by the inverse of its variance was used. This corrects for random variation resulting from divergent sample sizes.

Dependent Measures and Correlation

In aggregating all nonforgiveness dependent variables, an additional component must be accounted for: the correlation among measures. An estimate of the effect size for an entire study d_s was derived from a vector of the effect size d for each dependent variable and the correlation between each of these variables, as described by Hedges and Olkin (1985). This is accomplished by taking d_i as the vector of effect sizes across all dependent variables in a study and R as the correlation matrix between the outcome measures. Because it is uncommon for correlations between outcome measures to be published with a study, an estimate of this relationship is needed. Taking the lead of Wampold et al. (1997), 0.5 was used as a standard correlation between all dependent variables. This is rooted in the knowledge that in any given study there are typically several measures of several constructs. Furthermore, depression and anxiety are very common constructs to measure. Shapiro and Shapiro (1982) found that 56% of outcome studies targeted depression, anxiety, or both. Furthermore, Tanaka-Matsumi and Kameoka (1986), in a comprehensive study of the validity of popular measures of depression and anxiety, found that the average correlation of the measures was slightly

greater than 0.5. On this foundation, a correlation of 0.5 was chosen to aggregate the effect sizes of dependent variables to properly take into account the relationship between constructs in each study.

Again, following Hedges and Olkin (1985), the integration of a 0.5 correlation into the calculation is accomplished through the covariance matrix $\Sigma = DiRDi$, where Di is a diagonal matrix of the respective SDs of d_i. If e is a column vector of *1*s and Λ is the inverse of Σ, then the aggregate estimate of the effect size for a comparison is given by

$$d_s = [\Lambda e / e' \Lambda e] d_i \quad (5)$$

with a corresponding estimated variance of

$$\sigma^2(d_s) = 1/e' \Lambda e \quad (6)$$

(Hedges & Olkin, 1985, pp. 212–213). These values, calculated with Equations 5 and 6, were used as the aggregate estimate of the effect size of nonforgiveness dependent measures within each study. Once the effect size of forgiveness for each study was calculated, the results were aggregated to determine the mean effect size for each of the three theory-based groupings.

Initial posttest measurements of intervention and control groups were used exclusively for data analysis. Regarding long-term posttests, three studies did not include follow-up measurements (Hebl & Enright, 1993, and the two studies in Al-Mabuk et al., 1995), four studies measured follow-up at 6 weeks (McCullough & Worthington, 1995; McCullough et al., 1997), and two studies measured follow-up at longer than 6 weeks (Coyle & Enright, 1997; Freedman & Enright, 1996). Consequently, follow-up measures were not included due to their variability of inclusion and duration within the studies.

RESULTS

Test for Homogeneity

Forgiveness results were used to test for homogeneity. The results, taken as one group, did not pass the test for homogeneity. The aggregated Q value was 30.05, which, according to chi-squared values, should have been no more than 15.51. Consequently, the nine studies did indeed need to be divided into groups according to a logical method.

For the three groups into which the studies were divided using theoretical foundations, $Q_{BETWEEN\ GROUPS}$ equaled 23.31, which was well above the chi-squared critical value of 5.99 (that Q would be expected to be below, if the groups were in fact homogeneous). In each of the three groups, an empirical test of homogeneity confirmed the value of this division. For decision-based interventions Q_1 equaled 3.93, below the critical value of 7.82. For process-based group interventions Q_2 equaled 2.05, below the critical value of 5.99, and for process-based individual interventions Q_3 equaled 0.89, well below the critical value of 3.84.

Forgiveness as Dependent Variable

The mean effect size for levels of forgiveness in decision-based interventions, versus a control group (4 interventions with a total $n = 188$), was $d_{1f} = -0.04$ (95% confidence interval [CI]: –0.24 to 0.16). Because this confidence interval encompassed zero, the result could be considered to differ from zero. Therefore, these results suggested no significant difference in forgiveness between those receiving a decision-based intervention and those receiving no intervention. The mean effect size for levels of forgiveness in process-based group interventions (3 interventions, total $n = 120$) was $d_{2f} = 0.82$ (95% CI: 0.43 to 1.21). This effect size can be considered in terms of the average person in the intervention group doing as well as or better than 75% of the control group. The mean effect size for levels of forgiveness in process-based individual interventions (2 interventions, total $n = 22$) was $d_{3f} = 1.66$ (95% CI: 0.68 to 2.64). This effect size can be considered in terms of the average person in the intervention group doing as well as or better than 95% of the control group. These results are shown in Table 3 and Figure 1.

TABLE 3

Quantitative Results of Studies in Meta-Analysis

Group		Study and Author	Treatment *n*	Control *n*	Forgiveness Effect Size	Emotional Health Effect Size
Decision	2	Al-Mabuk, Enright, & Cardis, 1995	24	24	–0.30	–0.14
	4	McCullough & Worthington, 1995	30	21	0.05	—
	5	McCullough & Worthington, 1995	35	21	0.10	—
	8	McCullough, Worthington, & Rachal, 1997	15	39	–0.46	0.56
Total			104	84[a]	–0.04	0.16
Process–Group	1	Hebl & Enright, 1993	13	11	0.70	0.72
	3	Al-Mabuk et al., 1995	24	21	1.17	0.42
	7	McCullough et al., 1997	12	39	0.53	0.75
Total			49	71	0.83*	0.59*
Process–Individual	6	Freedman & Enright, 1996	6	6	2.16	1.44
	9	Coyle & Enright, 1997	5	5	1.21	1.40
Total			11	11	1.66*	1.42*

[a]The control group was the same for Studies 4 and 5.
*$p < .05$.

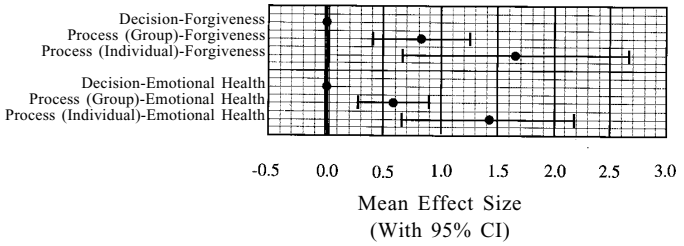

FIGURE 1

Aggregate Effect Sizes

Emotional Health Dependent Variables

The mean effect size for all emotional health dependent variables in decision-based interventions, versus their control groups (2 interventions with a total $n = 102$), was $d_{1e} = 0.16$ (95% CI: –0.16 to 0.48). Because this CI encompasses zero, the result cannot be considered to differ from zero. However, for this subgroup, results were heterogeneous. The mean effect size for all nonforgiveness dependent variables in process-based group interventions (3 interventions, total $n = 120$) was $d_{2e} = 0.59$ (95% CI: 0.28 to 0.90), with homogeneous results. This effect size can be considered in terms of the average person in the intervention group doing as well as or better than 65% of the control group. In addition, the mean effect size for all nonforgiveness dependent variables in process-based individual interventions (2 interventions, total $n = 22$) was $d_{3e} = 1.42$ (95% CI: 0.66 to 2.18), with homogeneous results. This effect size can be considered in terms of the average person in the intervention group doing as well as or better than 92% of the control group. These results are shown in Table 3 and Figure 1.

DISCUSSION

The results of this study suggest a number of conclusions. First, the low scores of the studies in the decision grouping relative to those in the two process groupings (group and individual interventions) suggest support for the greater effectiveness of the process models of forgiveness. Second, the significantly higher scores for the longer term individual counseling versus the medium-length group counseling suggest something about the time and energy required by clients and counselors to fully and successfully forgive a person for a deep injustice. Third, the large effect size of the process-based individual counseling suggests the value of their continued use, especially with the specific groups of clients already assessed. Although caution must be exercised because of the numbers of studies, results include important evidence meriting a thoughtful examination at this time.

The empirical evidence currently does not endorse the predominantly cognitive decision-based interventions. As a group, the results were not shown to be significantly different from the control group. This was clearly true for forgiveness measurements. Emotional health measurements lacked homogeneity, leaving some level of ambiguity. However, taken as a whole, these interventions did not show a significant effect, either because the model is incomplete or because forgiveness is not likely to be affected by counseling. The results are low, given that placebo psychological interventions are known to have an average 0.42 effect when compared with no treatment (Lambert & Bergin, 1994). The predominantly cognitive component may still be important but may properly be based in an expanded process model and not in isolation of that process.

The empirical evidence supporting process models of forgiveness is apparent from the second category of studies. Forgiveness can be affected by counseling. Again, the 0.82 effect size on forgiveness can be considered in terms of the average person in the intervention group doing as well as or better than 75% of the control group. The difference in findings between this grouping and the decision-based grouping supports the use of a process model of forgiveness in counseling. In addition, the results were extended from forgiveness to emotional health constructs at an effect size of 0.59, again meaning that the average person in the forgiveness group did as well as or better than 65% of the control group. According to Lipsey (1990), empirical norms for describing the magnitude of effect sizes include less than 0.33 as *small*, between 0.33 and 0.55 as *medium*, and any value larger than 0.55 as *large*. Consequently, across mental health variables, the effect of this set of interventions can be considered large. This extends the findings to endorse not only the process model of forgiveness but also the effectiveness of forgiveness counseling as a treatment. This moves forgiveness beyond a study of improving people's moral development, which was a key idea in the earliest study on forgiveness (Enright et al., 1989), to a factor in improving mental health.

The support of the process model of forgiveness counseling continues in the results from the individual interventions. With an effect size of 1.66 (average person in intervention group did as well as or better than 95% of control group) for forgiveness, process models appear to be working. Furthermore, the emotional health effect size of 1.42 (average person in intervention group did as well as or better than 92% of control group) supports both the efficacy of process-based forgiveness counseling and the link between forgiveness and mental health. According to Lipsey's (1990) assessment of effect sizes, the results are almost 3 times the minimum level for a large effect size. In a different assessment, Lambert and Bergin (1994) placed the standard effect size for effective psychotherapies across theoretical orientations at 0.82. The 1.42 effect size remains strong, being almost twice the standard value for professional treatments. These results move forgiveness therapies into the realm of being important within the counseling community.

Perhaps a concern for endorsing forgiveness interventions, and indeed whether counselors should be giving this variable attention, is that forgiveness is not an established mental health variable. Anger resulting from an injustice or a lack of forgiveness has yet to be included as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychiatric Association [APA], 1994),

although a concomitance of anger with numerous psychological disorders is now being recognized (Deffenbacher, Lynch, Oetting, & Kemper, 1996; Fauz, Rappe, West, & Herzog, 1995; Fauz & Rosenbaum, 1997). In addition, effectiveness of process-based forgiveness interventions may be distorted across the board both by self-selection for a forgiveness study and by such an emphasis on forgiveness that clients feel compelled (for the sake of the researchers) to improve in this area. Yet, these points become a strength of the forgiveness interventions when the scope of inquiry is expanded to include all measured emotional health constructs. The large effect sizes in the nonforgiveness measures affirm the value of the interventions beyond a focus on forgiveness. Furthermore, if clients felt compelled to forgive at a posttest, then in all likelihood, they would not feel so compelled at a 12-week or 14-month follow-up. Positive results are maintained at such follow-ups (Coyle & Enright, 1997; Freedman & Enright, 1996).

It might be argued that the significant results are not simply due to the effectiveness of the interventions but instead to the skill of the counselors. Counselor differences have been reported (Crits-Christoph et al., 1991; Garfield, 1997; Jennings & Skovholt, 1999; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Orlinsky, 1999; Project MATCH Research GroupUSA, 1998). Although this is possible, it is the case that five different counselors were involved across studies in the process-based group and process-based individual forgiveness interventions. Forgiveness therapy does appear to be a valuable mental health option apart from the skills of a few counselors. Of course, all counseling is subject to some counselor variation; there is no reason to believe that forgiveness would be any different.

Another important consideration is the confound between the type of intervention and the duration of the intervention. The interventions with greater effects were consistently longer than those with lesser effects. Specifically, the decision-based interventions ranged from between 1 and 8 sessions, the process-based group interventions ranged from 6 to 8 sessions, and the process-based individual interventions ranged from 12 sessions to 60 sessions. It can be argued that the increased effects are merely a result of greater attention paid to clients. This critique merits two important responses. First, the length of treatment is integral to the theoretical foundation of decision-based versus process-based interventions. By their very nature, decision-based interventions are shorter. According to this orientation, once the decision has been made, most of the work of forgiveness has been done. By contrast, process-based models have significant decision components subsumed within them, along with additional elements. Consequently, time factors accurately mirror theoretical foundations, and therefore correctly express their efficacy. Second, the conclusion of the confound—"more is better" regarding time spent with clients—is not problematic. Precisely the concern of this analysis is to determine if forgiveness counseling is efficacious. To determine that more counseling is more effective contributes to the thesis that this counseling method is potent. The concern is not to prove that forgiveness measures are superior across the board to what a counselor might otherwise be doing but that they are an equally effective element in the repertoire of a professional counselor.

Although forgiveness is not an intervention for every disorder, its empirical showing in this meta-analysis is encouraging. Empirical strength has been shown with traditionally challenging populations. For example, with incest survivors (Freedman & Enright, 1996), no consistently effective interventions had yet been established, even after attempts by expert counselors. The gains with this group suggest the value of using this approach with certain select clients. For example, when problems such as sexual abuse, divorce, and family-of-origin concerns are considered, it is realized that a number of mental health issues are significantly related to anger. With benefits across a range of mental health constructs, counselors should be aware of the potential benefits that forgiveness can have with clients suffering significantly from issues that involve anger borne out of unfair treatment.

An important consideration is whether these results establish forgiveness therapy as an empirically supported treatment. According to determined criteria (Chambless & Hollon, 1998; Chambless et al., 1996; Crits-Christoph, 1996; Garfield, 1996; Kendall, 1998; Shapiro, 1996), many of the studies in this analysis have significant aspects to be considered "efficacious." This includes the fact that some have been compared with a psychological placebo (Al-Mabuk et al., 1995; McCullough et al., 1997); others have been compared with established interventions, such as a support group (Hebl & Enright, 1993); many have been conducted with treatment manuals (Al-Mabuk et al., 1995; Coyle & Enright, 1997; Freedman & Enright, 1996; Hebl & Enright, 1993); and all of the studies clearly specify characteristics of their client sample. Over the corpus of studies, all criteria are met. However, because there are not two specific studies from two independent research settings demonstrating all of these criteria, we are not yet able to make a final assessment. Significantly, these studies do establish themselves among the older criteria of Probably Efficacious Treatments. A sufficient criterion for this designation is having two experiments that show the treatment to be more effective than a waiting list control group (Chambless et al., 1996). This is true for the process-based individual interventions and is independently true for the process-based group interventions. To be fully considered "efficacious" would require only a few modifications in research design. This is certainly the direction future research should take.

Given these encouraging results, more research is called for. From the foundation established by the current study, the research needs to progress in three ways. First, quality studies, building on the strengths of those mentioned here, should be conducted to establish process-based forgiveness counseling as an "efficacious" treatment. Second, given the success of the process-based model, more exploration is needed. Continued investigation, verification, and elaboration of the model itself would enrich our current understanding. Third, these encouraging results should be expanded to other populations. Among *DSM-IV* (APA, 1994) diagnoses

such as conduct disorder, oppositional defiant disorder, mood disorders, and anxiety disorders, a subset of clients merit investigation regarding whether etiology is rooted in anger issues and whether forgiveness therapy might offer relief.

In conclusion, forgiveness counseling is an addition to the repertoire of applications for the professional counseling community. The large effect sizes establish forgiveness counseling as a contribution to that community. Although it should not be seen as a cure for all psychological concerns, there are certain emotional health issues for which it is particularly well suited, such as incest survivors, adolescents hurt by emotionally distant parents, and men hurt by the abortion decision of a partner. It is important within the counseling community to have a diversity of options with a sound empirical base. In addition, forgiveness therapy reveals the strength of relationship-based versus psychopharmacology-based interventions. For one incest survivor, emotional difficulty had remained for 50 years. Drug-based treatment may have provided short-term alleviation of symptoms. However, few would desire to maintain a drug treatment over 50 years. Fourteen-month process-based individual forgiveness counseling brought about significant change that was maintained 14 months later. It is unclear whether a 14-month drug treatment would yield long-term gains that could be similarly maintained. The findings here suggest that the effects of forgiveness counseling on clients are worthy of further study.

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Male Restricted Emotionality and Counseling Supervision

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This study attempted to determine (a) if 103 male psychology interns would, in the context of supervision, deal with their socialized restricted emotionality (RE) by using either the turning-against-other or the turning-against-self defensive style and (b) assess the impact of the sex of the supervisor on this behavior. Results indicated that male supervisees with higher levels of RE evidenced a turning-against-self style. Male supervisees working with a male supervisor reported poorer perceptions of the supervisory working alliance.

There is a growing body of literature demonstrating that some aspects of the traditional male gender role are associated with negative outcomes for men (see Brooks & Good, 2001a, 2001b, for review). For example, men who strictly adhere to the socialized behavioral norm of not expressing their emotions in certain situations, termed *restricted emotionality* (RE; O'Neil, Helms, Gable, David, & Wrightsman, 1986), often experience increased (a) anxiety (Cournoyer & Mahalik, 1995), (b) depression (Good & Mintz, 1990; Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996), (c) anger (Blazina & Watkins, 1996), (d) homophobia (Jome & Tokar, 1998), (e) increased relationship difficulties (Fischer & Good, 1995; Sharpe, Heppner, & Dixon, 1995), and (f) physiological distress (Shepard, 1994). Overall, this line of research is associated with the construct of male gender role conflict (GRC; O'Neil et al., 1986). Male GRC is "a psychological state in which socialized gender roles have negative consequences on the person or others" (O'Neil, Good, & Holmes, 1995, p. 165). It typically results from rigid, sexist, or overly restrictive male gender roles interacting with incompatible demands of everyday life and, therefore, leading to negative affective, cognitive, and behavioral consequences for men as well as for those around them (see O'Neil et al., 1995, for review).

Research also demonstrates the importance of investigating the impact on the therapeutic process of RE experienced by male counselors. Indeed, Wisch and Mahalik (1999) asserted, "therapists undergo the same gender role socialization as do their clients" (p. 51), thus implying that male therapists are not immune to the potential impact of GRC-related distress (Mintz & O'Neil, 1990). In fact, it is possible that male counselors actually experience a more intense struggle with this issue (Tokar & Jome, 1998), as counseling typically focuses on emotion and emotional process (Heesacker & Bradley, 1997), which are considered difficult for men experiencing RE (Levant & Pollack, 1995). Hayes (1984), for example, concluded that increased levels of RE in counselors-in-training were associated with less empathy for, and more interpersonal difficulties with, nontraditional (i.e., highly emotional) male clients. This finding was echoed by Wisch and Mahalik (1999), who determined that greater levels of RE contributed to male counselors overpathologizing gay male clients.

However, despite Wisch and Mahalik's (1999) assertion that "[those] involved in the training of doctoral and masters students would do well to address gender role issues" (p. 58) in order to avoid the occurrence of such clinical biases, we uncovered no published studies investigating the impact of male RE during counseling training. Such investigations would seem paramount, because one of the more essential aspects of training—supervision—is also one of the most likely places where RE-related difficulties could begin to emerge (e.g., Holloway, 1992). Supervision is "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (Loganbill, Hardy, & Delworth, 1982, p. 4). Male supervisees with higher levels of RE may have difficulty with such an intense relationship (e.g., Brooks, 1998; Good, Dell, & Mintz, 1989) because of their traditionally socialized resistance against expressing emotions, appearing vulnerable (e.g., Levant & Pollack, 1995; O'Neil, 1981), and relinquishing power in interpersonal relationships (Good et al., 1989; Lips, 1991).

Investigating the impact of RE within the realm of supervision also affords a unique opportunity to assess the role of

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potential moderators (Baron & Kenny, 1986). For example, the prevailing explanation for the relationship between RE and appropriate clinical behaviors is that male counselors experiencing increased levels of RE use the defensive style known as "turning-against-object" to deal with their feelings of anxiety and distress (Mahalik, Cournoyer, DeFranc, Cherry, & Napolitano, 1998). Use of this defensive style on the part of an individual involves their dealing with such negative feelings and psychological distress by becoming angry and upset at a real or imagined object (see Ihilevich & Gleser, 1993, for review). In general, people exhibiting this style have been described as "vengeful and destructive, [with] an inclination to ignore ethical principles when to one's advantage" (Mahalik et al., 1998, p. 253). Counselors using this style seem to experience less empathy for nontraditional male clients and assign them more negative diagnoses (Wisch & Mahalik, 1999).

However, another potential explanation for this effect is the power differential present within a therapeutic relationship. In the case of Wisch and Mahalik's (1999) study, for example, participants were all experienced therapists who, by virtue of their position, had power over their clients. It may be the case that male counselors' behavior demonstrated in previous research was determined less by RE and more by the powerful role as therapists. Supervisors have power over the supervisee (see Watkins, 1997), which is, in effect, a power relationship opposite to counseling. Such a reversal could result in the use of a defensive style opposite to that demonstrated in previous research. This turning-against-self defensive style is characterized by individuals dealing with psychological distress by directing aggressive behavior toward themselves (Ihilevich & Gleser, 1993), perhaps in the form of depression, low self-esteem, or a lower sense of their counseling ability. Partial support for such an idea comes from recent work on racism, sexism, and psychotherapy (e.g., Harrell, 2000; Thompson & Neville, 1999), which asserts that long-term exposure to such biases leads to depression, anxiety, and low self-esteem.

The sex makeup of the supervisory dyad may also contribute to the emergence of RE-related difficulties in counseling supervision (Brooks, 1998). Unfortunately, the role sex plays in supervisory outcome has not been clearly established (see Holloway, 1992, for review). However, it is possible that male/female supervisory dyads could be problematic for men experiencing greater RE in that some men might feel more comfortable using the turning-against-other defensive style while working with a female supervisor, regardless of their less powerful role as supervisee. At the same time, however, GRC theory (see Levant & Pollack, 1995, for review) would suggest that male/male dyads would be the most challenging. Specifically, men experiencing greater levels of RE would potentially avoid disclosing affective material in front of another man for fear of violating the traditional male gender role and appearing vulnerable. This, in turn, could interfere with the development of an appropriate supervisory working alliance. Partial support for this assertion comes from work demonstrating that RE has the greatest impact on male/male therapeutic dyads (Wisch & Mahalik, 1999).

We want to note here that we are not in any way suggesting that men cannot be effective counselors or supervisors. Nor do we support the notion that men are emotionally deficient and "unable to feel emotionally alive" (Brooks & Gilbert, 1995, p. 260; see Wester, Vogel, Pressly, & Heesacker, 2002, for discussion). However, it is possible that the combination of dealing with gender role issues, interpersonal issues, professional development issues, one's own emotions, and the emotions of the client could make supervision particularly challenging for individuals higher in RE (Luhaorg & Zivian, 1995; Tokar & Jome, 1998) by overwhelming the adaptive defensive styles of a male counselor-in-training (Mahalik et al., 1998). Wisch and Mahalik (1999) suggested that a similar confluence of forces may have been responsible for their finding that practicing male counselors experiencing higher RE assigned poorer prognoses to both gay and nontraditional (i.e., highly emotional) male clients. Therefore, we believe a better understanding of the impact of RE on the supervision experience of men could be an essential contributor to improving the training of male therapists, in general, and those male therapists dealing with the consequences of their socialized male gender role, specifically.

Thus, the present investigation examined the impact of RE on counselor supervision. We selected RE over other aspects of male GRC because it has been the most consistent predictor of negative outcomes for men (e.g., Brooks & Good, 2001a, 2001b). We also believe RE was most likely to interact with the emotional nature of counseling supervision. To operationalize the turning-against-other defensive style, we used the trainee version of the Supervisory Working Alliance Inventory (Efstation, Patton, & Kardash, 1990). This decision was based on the similarities between the supervisory working alliance and the therapeutic relationship, as well as the negative impact of RE on the therapeutic relationship. To operationalize the turning-against-self defensive style, we used the Counseling Self-Estimate Inventory (Larson et al., 1992). This decision was based on the (a) importance of counseling self-efficacy to the outcome of counseling training (Larson, 1998); (b) relationships between lower counseling self-efficacy, increased depression, increased anxiety, and emotional exhaustion (see Larson & Daniels, 1998, for review); as well as (c) reported links between the turning-against-self defensive style and increased psychological distress (see Ihilevich & Gleser, 1993, for review).

We developed three hypotheses. Because the current study is one of the first examining RE in the context of supervision, Hypothesis 1 explored the degree to which male psychology trainees experienced RE. Increased client contact and the nature of counseling training have been postulated as being responsible for lower levels of RE in practicing counselors as compared with the general population (Wisch & Mahalik, 1999). Accordingly, we predicted that male psychology interns would report less RE than the general population, but more than practicing counselors, by virtue of their having some training but limited client contact.

Hypothesis 2 examined the role of power in the way that some men deal with feelings of RE. If the participants in this study use the turning-against-other defensive style, it should be expressed in the form of negative evaluations of the supervisory working alliance. However, if power does influence the way that participants react to RE, then they should respond by using the opposite defensive style—turning against self. In the case of supervision and training, we believe that this defensive style will be expressed by a lower sense of counseling self-efficacy. Therefore, we predicted a negative relationship between RE and counseling self-efficacy.

Hypothesis 3 was based on the rationale that the sex makeup of the supervisory dyad is important (e.g., Goodyear & Guzzardo, 2000). However, while it is possible that a supervisory dyad consisting of a male supervisee and a female supervisor would be problematic for men experiencing RE, it is equally possible that a supervisory dyad consisting of two men would be particularly difficult for male supervisees. Therefore, although we predicted that the interaction of RE and supervisor sex would have a significant impact, we made no predictions as to the direction of this result.

METHOD

Participants

Prior to data collection, the sex composition of the current intern groups at each of the 540 psychology internship sites was determined either by accessing the training sites' Web pages or by calling the training director and/or support staff. This information was used to ensure that each site was sent enough materials to allow all of their male interns to participate.

Internship sites. We randomly selected 216 of the 540 internship sites listed in the 1998–1999 Association of Psychology Postdoctoral and Internship Centers (APPIC) directory to participate in this study. Of these 216 sites, personnel from 134 returned an enclosed postcard indicating that they had distributed the study materials to their male interns. This resulted in a site return rate of 63%. Of these 134 sites, 32 (24%) were university-based counseling centers, 51 (38%) were medical centers and/or veterans' hospitals, and 51 (38%) were independent, outpatient clinics.

Interns. Personnel from the 134 internship sites who responded indicated that they had distributed the study materials to 253 male interns. Of those 253 packets, 103 were returned, for an individual return rate of 41%. Ninety-three of these participants were Caucasian (90.3%), 9 were Hispanic American (8.7%), and 1 was African American (1.0%). The mean age of these participants was 33.3 (SD = 7.4) years, and their average amount of counseling experience was 43.1 (SD = 38.7) months. Forty-nine (47.6%) of the respondents were working toward their doctor of philosophy (PhD) degree, 15 (14.6%) were working toward their doctor of psychology (PsyD) degree, and 35 (34%) were working toward a master of arts/ master of science (MA/MS) degree.

Measures

Demographics. The personal data sheet (PD) was developed for this study to obtain information about participants' age, race, degree, and current training setting. In addition, the PD contained questions about the respondents' current or most recent supervisor, including age, sex, race, and years of supervisory experience.

Gender role conflict. The Gender Role Conflict Scale (GRCS; O'Neil et al., 1986) is a measure of men's reactions to the inconsistent and unrealistic gender role expectations they face in current society. It consists of 37 items divided into four subscales: (a) Success, Power, and Competition (SPC—13 items); (b) Restrictive Emotionality (RE—10 items); (c) Restrictive Affectionate Behavior Between Men (RABBM—8 items); and (d) Conflict Between Work and Family Relations (CBWFR—6 items). Although participants completed the entire questionnaire, this study focused on the RE subscale. This subscale refers to the degree to which the respondent acknowledges "fears about expressing one's feelings" (O'Neil et al., 1995, p. 176), as well as difficulty dealing with the feelings of others. A sample item is "Expressing my emotions to other men is risky." Respondents rate their agreement with each item on a 6-point Likert scale (1 = *strongly agree* to 6 = *strongly disagree*). The scale is reverse scored so that higher scores indicate increased RE.

Principal components factor analysis indicates that the GRCS tapped four factors, corresponding to the four subscales, which accounted for 36% of the total variance (O'Neil et al., 1995; O'Neil et al., 1986). For the RE subscale, each item had a factor loading of .35 or higher. Initial development demonstrated that the RE subscale had an alpha of .82, and a 4-week test–retest reliability of .76 (O'Neil et al., 1986). More recently, across 11 studies, the RE subscale had an average alpha of .84 (O'Neil & Owen, 1994). For the sample used in this study, the RE subscale had an alpha of .92. Validity of the RE subscale has also been established through positive correlations between it and measures of positive attitudes toward the traditional male role as well as negative correlations between it, emotional expressiveness, and psychological adjustment (Sharpe, Heppner, & Dixon, 1995).

Supervisory working alliance. The Supervisory Working Alliance Inventory–Trainee Version (SWAI-T; Efstation et al., 1990) is a measure of the supervisee's perceptions of factors considered essential to an effective supervisory relationship. It consists of 19 items divided into two separate subscales: (a) Rapport (R—12 items) and (b) Client Focus (CF —7 items). Respondents rate each item on a 7-point Likert scale (1 = *almost never* to 7 = *almost always*). Higher scores indicate the degree to which the supervisee perceives that his or her current supervisory relationship possesses these criteria. Validity, as reported during initial development by Efstation et al., was established via positive correlations between the SWAI-T and other measures of the supervisory process such as the supervisor style and counseling self-efficacy.

The R subscale refers to the effectiveness of the supervisor in developing rapport with the supervisee by encouraging and supporting him or her. A sample item is "I feel comfortable working with my supervisor." The CF subscale re-

fers to the emphasis supervisors placed on understanding clients and their issues. A sample item is "My supervisor helps me work within a specific treatment plan with my clients." However, because of the high degree of correlation between these two subscales, both as demonstrated in this study (r = .70) and as reported in previous research (e.g., Ellis & Ladany, 1997; Patton & Kivlighan, 1997), we decided to follow the lead of Patton and Kivlighan and combine the R and CF subscales in our analyses. For this sample, the overall SWAI-T score had an alpha of .95.

Counseling self-efficacy. The Counseling Self-Estimate Inventory (COSE; Larson et al., 1992) is a 37-item measure of counseling supervisees' judgments of their counseling abilities, as well as their expectancies for success in counseling situations. It consists of 37 items divided into five subscales: (a) Microskills (MS—12 items), (b) Process (PS—10 items), (c) Difficult Client Behaviors (DCB—7 items), (d) Cultural Competence (CC—4 items), and (e) Awareness of Values (AV—4 items). However, Larson recommended the use of the total score, as opposed to the individual subscale score, as an overall measure of counseling self-efficacy (L. Larson, personal communication, March 9, 1999). Respondents rate their agreement with items on a 6-point Likert scale (1 = *strongly disagree* to 6 = *strongly agree*). Some items are reverse scored. Higher total scores reflect stronger perceptions of self-efficacy in counseling situations (Larson et al., 1992). Validity of the COSE has been demonstrated through positive correlations between the inventory and levels of self-esteem, higher practicum performance, and positive outcome expectations, and through negative correlations between the inventory, anxiety, and feelings of fraudulence (Larson & Daniels, 1998). Original development of the scale indicated that the COSE total score had an alpha of .93 and a 3-week test–retest reliability of .87. Subsequent research demonstrates consistent reliability estimates of .85 or higher (Larson & Daniels, 1998). For this sample, the COSE total score had an internal consistency alpha of .80.

Procedure

We combined all dependent measures into one questionnaire. However, because we were unable to locate any published research discussing the advantages of any one specific measure order over another, we determined the ordering of the questionnaires by coin toss. This resulted in our listing the COSE first, followed by the SWAI-T, the GRCS, and the PDS, respectively. This questionnaire and a cover letter describing the study were both inserted into a prestamped envelope addressed to the first author. Each envelope was color coded in order to monitor return rate. The participant cover letter served as the informed consent for the study, and it asked that the dependent measures be filled out. This letter stressed the contribution to supervision that the intern's responses would make, because response rates can be enhanced through personalized requests for expert knowledge in their field (Dillman, 2000). It also noted the anonymous nature of their responses, because there was no identifying information included in the dependent measures packet.

These return envelopes were then sealed into a separate envelope, along with another cover letter. This letter, addressed to the individual training directors, briefly described the study and the measures involved. It asked the training directors to distribute the enclosed envelopes to their male interns. One month after these envelopes were mailed, postcard reminders were sent to each training director, asking them to remind their interns to complete the dependent measures packet and return it directly to the first author.

RESULTS

Means and standard deviations for all dependent measures are provided in Table 1. For Hypothesis 1, we predicted that male psychology interns would report less RE than the general population, but more than practicing counselors, by virtue of their having some training in gender issues but rather limited client contact. Independent sample t tests supported Hypothesis 1 in that interns (M = 26.1, SD = 18.6) experienced less RE than published samples of both middle-aged men, $t(190) = 2.94$, $p \leq .01$, Cohen's d = .43 (M = 32.6, SD = 9.9), and collegians, $t(189) = 2.34$, $p \leq .01$, Cohen's d = .34 (M = 31.3, SD = 9.9), but more RE than published samples of practicing mental health professionals, $t(297) = -2.48$, $p \leq .01$, Cohen's d = .29 (M = 22.3, SD = 7.6). Parenthetically, our sample was not significantly different from published samples of mental health trainees, $t(150) = 0.28$, $p \geq .10$, Cohen's d = .04 (M = 26.9, SD = 8.8).

Both Hypothesis 2 and Hypothesis 3 were tested using 2 (RE: high/low) × 2 (supervisor sex: male/female) analyses of variance (ANOVAs). We used ANOVAs, rather than multivariate analyses of variance (MANOVAs), because (a) of the focused nature of the questions being tested and (b) the low correlation between the SWAI-T and the COSE (r = .27) indicated, in our view, that these instruments measured related but independent constructs (see Huberty & Morris, 1989, for discussion). We dealt with the risk of increased Type I error associated with multiple tests by using Bonferroni correction procedures. RE (high: n = 45, or low: n = 58) served as the independent variable, with group membership being determined via a median split procedure (Rosenthal & Rosnow, 1991). Supervisor sex (male: n = 58,

TABLE 1

Means and Standard Deviations for All Dependent Measures

Measure	*M*	*SD*	*n*
SWAI-T	103.1	18.6	103
COSE	138.2	7.9	103
RE	26.1	18.6	103

Note. SWAI-T = Supervisory Working Alliance Inventory–Trainee Version (Efstation, Patton, & Kardash, 1990); COSE = Counseling Self-Estimate Inventory (Larson et al., 1992); RE = Restrictive Emotionality subscale of the Gender Role Conflict Scale (O'Neil, Helms, Gable, David, & Wrightsman, 1986).

or female: $n = 45$) served as the second independent variable. This resulted in four conditions: (a) High RE/Male Supervisor ($n = 25$), (b) High RE/Female Supervisor ($n = 20$), (c) Low RE/Male Supervisor ($n = 33$), and (d) Low RE/Female Supervisor ($n = 25$).

For Hypothesis 2, we predicted that male supervisees experiencing more RE would express a lower sense of self-efficacy as a counselor than those supervisees with lower levels of RE. The ANOVA results, using a Bonferroni correction of .017 (.05/3), indicated a statistically significant main effect of RE. Specifically, participants differed significantly in their COSE scores, $F(1, 99) = 7.86$, $p \leq .01$, $\eta = .27$. Our examination of the group means supported our idea that our participants would use a turning-against-self defensive style as opposed to a turning-against-other defensive style. Male supervisees with higher levels of RE reported a lower sense of their self-efficacy as a counselor (COSE: $M = 136$, $SD = 8$) than those male supervisees with lower levels of RE (COSE $M = 140$, $SD = 7.4$). Differences in SWAI-T scores were not statistically significant ($p = .19$).

For Hypothesis 3, we predicted that the sex of their supervisor would significantly affect both the impact of male supervisees' experienced RE on their perception of the quality of the supervisory working alliance and their sense of self-efficacy as a counselor. Although the interaction of the sex of the supervisor and RE was not statistically significant ($p = .11$), the main effect of the sex of the supervisor on SWAI scores was, $F(1, 99) = 6.4$, $p \leq .01$, $\eta = .24$, thus partially supporting Hypothesis 3. Our examination of the group means suggested that male supervisees working with a male supervisor reported a poorer perception of the supervisory working alliance (SWAI-T: $M = 70$, $SD = 15$) than did those male supervisees working with a female supervisor (SWAI-T: $M = 76$, $SD = 11$). Differences in COSE scores were not statistically significant ($p = .19$).

DISCUSSION

Because this is one of the first studies to examine the impact of RE on counseling supervision, it is important to first discuss the overall level of supervisees' RE found in this study. As expected, results indicate that this sample of male interns and practicum students fell between the published scores of men sampled from the general population and the published scores of practicing male mental health professionals. As such, our data are congruent with previous research that supports the idea that male therapists are not immune to the potential impact of RE. Furthermore, although the reasons behind this need to be empirically explored, these results are consistent with the idea that counseling training and increased client contact may lessen both the experience and impact of RE. Indeed, similar progressions have been noted on other measures related to masculinity and emotions (Heesacker et al., 1999).

The main finding of this study builds on existing research by demonstrating the negative impact of male RE in a situation in which the power structure is opposite to what has been studied previously, suggesting that the relationship between male RE and psychological defenses is more complex than originally thought. For example, Wisch and Mahalik (1999) asserted that greater RE leads some male counselors to deal with the negative feelings and psychological distress associated with RE by turning against their nontraditional male clients and assigning more negative diagnoses. However, in the case of this study, male supervisees experiencing higher RE did not turn against their supervisors and report more negative perceptions of the supervisory working alliance. Rather, as predicted, they responded to their lack of power within the supervisory relationship and expressed the opposite psychological defense, turning-against-self, in the form of more negative perceptions of their own counseling self-efficacy.

Therefore, it seems as if power within a given situation may influence men's reactions to the consequences of RE and, accordingly, may influence the defensive style used. Indeed, it is likely that the sample groups in previous research, practicing male counselors dealing with RE, were in a powerful position that allowed them to respond to GRC-related distress with the turning-against-other defensive style. The same can potentially be said for men in the general population demonstrated as dealing with RE, because their sex potentially affords them some degree of power and privilege. In both cases, men may have the ability, by virtue of the power granted them by a patriarchal society, to use the turning-against-other defensive style. However, male supervisees, who certainly have less interpersonal power within the context of a supervisory relationship, seem to deal with their psychological distress produced by RE through a turning-against-self defensive style. Such a reaction would seem consistent with literature discussing the long-term effects of racism and sexism (e.g., Harrell, 2000; Thompson & Neville, 1999). For example, society often prevents women and people of color from outwardly expressing their negative feelings. Such individuals often turn against themselves (i.e., depression, substance use) to avoid potential retribution and/or "backlash" (Faludi, 1991, p. xxi). Therefore, although it is difficult to conceive of men as bereft of societal power, it seems as if they respond to situations in which they experience less of it with a turning-against-self defensive style.

The interesting finding that male supervisees working with male supervisors expressed poorer perceptions of the supervisory working alliance, regardless of their degree of RE, is congruent with research asserting that certain aspects of the socialized male role (i.e., competition between men, not showing vulnerability) may make male/male didactic interactions problematic for some men (see Scher, 2001, for review). Although further research is needed, some male supervisees may have seen the supervisory relationship as competitive and responded accordingly, regardless of the potential consequences. Furthermore, it seems as if this sense of competition between men had a powerful impact on participants' perceptions of supervision, because it precluded any negativity in male supervisee/female supervisor dyads.

However, at the same time, two additional explanations need to be examined. First, participants' perceptions of male

supervisors versus female supervisors may have resulted from their supervisors' differential use of certain interventions (i.e., amount of negative feedback, support and/or encouragement) linked to positive perceptions of the supervisory working alliance. This is not to say that either women or men make better supervisors. It is possible that supervisor style variables, rather than physical sex per se, were behind the current results. Furthermore, it is possible that male supervisors of the study participants were also experiencing some degree of GRC-related distress. Such supervisor distress, as well as its interaction with that of the supervisee, could have interfered with the development of an appropriate supervisory working alliance. In any event, however, the findings of this study seem to justify the view that those involved in the training of male counseling graduate students need to be sensitive to issues of GRC in general, and RE specifically, within supervision.

Counseling Self-Efficacy

The main finding of this study—that male supervisees experiencing higher RE expressed more negative perceptions of their own counseling self-efficacy—raises questions about the relationship between male RE, male GRC, and counseling self-efficacy. For example, what is the longer term impact of RE and/or GRC on counseling self-efficacy? Self-efficacy beliefs (Bandura, 1986) have been called "the primary causal determinant of effective counseling action" (Larson, 1998, p. 226). In her Social Cognitive Model of Counselor Training, Larson identified several variables related to low self-efficacy applicable to this line of reasoning. The results of this study suggest that male RE is an example of what she termed a "counselor characteristic" (p. 252), with the potential to interfere with counseling self-efficacy. Furthermore, Larson also noted that variables associated with the "training environment" (p. 254), such as a perceived lack of interpersonal power or the identified lack of training in male gender role issues (Dupuy, Ritchie, & Cook, 1994; Heesacker & Prichard, 1992; Wester, 2001), could compound this interference and result in some male trainees expressing substantially lower than expected counseling self-efficacy. Such low self-efficacy beliefs hinder counseling training because they "lead to unwillingness to take risks, avoidance of the learning process, of [a] lack of perseverance in the face of failure" (Larson & Daniels, 1998, p. 206). Although this process needs to be empirically examined, it is possible that individuals higher in RE may never develop the sense of self-efficacy required to effectively work with nontraditional male clients, and they respond "more negatively" (Wisch & Mahalik, 1999, p. 51) to such clients in the course of their clinical practice. Such a process could have accounted for the findings of previous research in this area.

Implications for Counseling Training

The findings of this study seem to confirm Wisch and Mahalik's (1999) assertion that male counselors are not immune to the effects of their gender role socialization. Therefore, the implications for counseling training are fourfold. First, those involved in the academic training of male interns, doctoral candidates, and master's students might do well to educate themselves on male gender role issues. This would allow them to identify issues such as RE in their students. In addition, their understanding of a traditional male socialization seems very important to their being able to mentor, supervise, and train male counselors to recognize and overcome the potential limitations placed on them by this gender role socialization. Second, it may be important for those involved in this training to "examine their own countertransferential [feelings] in the context of gender related issues" (Wisch & Mahalik, 1999, p. 57), because these feelings may interfere with their ability to understand the impact of gender role socialization on members of what has traditionally been considered the dominant culture.

Third, it may also be important for those involved in the clinical training and supervision of male students to address male gender issues from the outset of the supervisory process. For example, through self-disclosure and empathic understanding, it may be possible for the supervisor to communicate to the supervisee that they are working toward creating an environment safe enough to discuss GRC-related issues. Doing so may also sensitize the supervisor to the potential impact of their supervisee's socialization, both on their clinical work and on the supervisory working alliance. This seems particularly true for male/male supervisory dyads, in which issues of competition and RE may interfere with the development of the relationship and the overall acquisition of clinical skills. At the same time, it should be noted that female supervisors may face issues of credibility and supervisee ambivalence (see Brooks, 1998), which may require them to take an approach consistent with multicultural counseling by "highlight[ing] the differences [between themselves and their supervisee]" (Brooks, 1998, p. 208) and using those differences as an educational experience.

Finally, it may be the case that those involved in the training of male counselors need to pay specific attention to the degree of counseling self-efficacy experienced by their charges (Larson, 1998). Personal characteristics, such as those inherent in the socialized gender role, could be responsible for a lower than expected level of CSE. The interaction of those characteristics and the counseling training environment—which tends to (a) focus on emotion and emotional process (Heesacker & Bradley, 1997), primarily from the feminine perspective (Heesacker & Prichard, 1992), and (b) ignore male gender role issues during the training process (Dupuy et al., 1994)—may force the male supervisee to choose between either "pretend[ing] to be someone else" (Larson & Daniels, 1998, p. 207) in order to be evaluated as an effective counselor or being true to their "masculine identity" (Wade, 1998, p. 349). All told, supervisors may need to use interventions aimed at improving their students' sense of self-efficacy, in general, and doing so within the context of male RE/GRC, specifically.

Parenthetically, the results of this study also have an implication for the profession of counseling. We need to expand the work of feminist and multicultural scholars and consider, as a profession, the potential impact of male socialization on the men themselves, as opposed to focusing exclusively on the impact

that socialization has on other groups. Unfortunately, this may require the profession to reframe how we see multicultural training, in general, and gender sensitivity training, specifically. For example, despite the impact of works such as Levant and Pollack's (1995) *A New Psychology of Men*, Brooks and Good's (2001a, 2001b) *The New Handbook of Psychotherapy and Counseling With Men*, as well as a dramatic increase in the investigation of male socialized gender roles (Kiselica, 1999), we were unable to locate any published references discussing how to best address male socialization within the training environment of male counselors and/or graduate students. If we are to be true to our commitment of respecting others and valuing human differences, the profession must embrace this new area of study and work to ensure that training programs are inclusive for all people, not just those who fit the dominant counseling culture.

CONCLUSION

Some limitations of this study must also be noted. While the institutional return rate in this study (63%) was excellent, the individual return rate was below 50%. Accordingly, the results can be generalized to the larger population of male interns only with caution, because the question remains as to whether those who chose not to respond would have produced different results than those who did. At the same time, however, it should be noted that this return rate was comparable with, or in some cases better, than the response rates of other studies looking at male GRC and mental health professionals.

In addition, the participants in this study were obtained exclusively from internship sites approved by the American Psychological Association (APA). It is possible that some aspect of the APA-mandated intern selection process screens out those male applicants experiencing greater levels of GRC, resulting in such men accepting non-APA-approved internships. Furthermore, many mental health professions do not require their students to obtain an APA-approved internship. Such professions were not sampled by the procedure used in this study, and future research should determine a method of accessing their experiences in supervision.

Future research should continue to explore men's experiences of counseling training, in general, and the impact male socialization has on that process, specifically. For example, perhaps there is a relationship between supervisee-experienced RE and supervisor-experienced RE. GRC theory, existing research, as well as the results of this study would support such an investigation. In addition, it might be important to explore the influence of developmental factors such as male identity and/or "male reference group identity dependence" (Wade, 1998, p. 349). This exploration might allow increased insight into the impact of GRC, just as work on racial identity (Cross, 1995; Helms, 1990) has increased the profession's understanding of the developmental experiences of people of color. Pursuit of these ideas as well as this line of overall research into the impact of traditional male gender roles can only serve to better the profession of counseling by ensuring that its graduates are equipped to best serve their clients.

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Testing and Assessment Issues With Spanish-English Bilingual Latinos

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This article critically examines and integrates previous research in cross-cultural and cross-linguistic assessment. Issues that apply to the assessment of Latinos who speak both Spanish and English are examined. For ease of presentation, testing concerns with this population are divided into 3 broad areas: client issues, test issues, and clinician/assessor issues. Recommendations are made to assist in the provision of cross-culturally and cross-linguistically valid testing of Spanish-English bilingual Latinos.

The most recent U.S. census (Therrien & Ramirez, 2000) estimated that 32.8 million Latinos in the United States account for 12% of the U.S. population. Future projections indicate that by the year 2025, Latinos will account for 44% of the population growth in the United States. In the current national population of 262,375,152 individuals ages 5 and above, approximately 46,951,595 speak a language other than English at home. Of these, more than half—amounting to more than 28,101,052 individuals—speak Spanish (Bureau of the Census, 2000). Along with the growing numbers of Latinos in the United States comes an increasing need for an efficient and fair means of assessing such a culturally and linguistically diverse population. There is also a need for better understanding of the effects of the native language on psychological assessment results.

Numerous issues have arisen in the literature of cross-cultural testing. Main concerns include assessment validity, the use of inappropriate norms, ethnocentrism and ethnorelativism, cultural stereotypes and prejudice, acculturation, and language barriers (Brems, 1998; Curtis, 1990; Jones & Thorne, 1987; Rogler et al., 1983; Sattler, 2001). However, material focusing specifically on assessment of bilingual individuals has been scant. In addition to questions pertaining to cultural differences, assessment of bilinguals raises questions specific to language use. For instance, the assessment of fully bilingual and partly bilingual persons may indicate different decisions about what language to use and how to interpret results.

The dearth of research in this area reflects an absence of information that may ultimately contribute to the inaccurate assessment of Spanish-English bilinguals and, more generally, the burgeoning Latino population as well. The purpose of this article is to examine these issues as they pertain to the assessment of Latinos, and especially to those individuals who speak both Spanish and English.

BACKGROUND INFORMATION

Ethnic Self-Designation

Although the terms *Hispanic* and *Latino* are often used interchangeably, they do not always carry the same meaning. The U.S. Census Bureau introduced use of the term "Hispanic" to refer to individuals of Mexican, Puerto Rican, Central or South American, or alternate Spanish heritage (Beals & Beals, 1993; Bureau of the Census, 2000). "Latino" is used to refer to individuals who are of Latin American heritage and may refer to anyone whose forbears came from any of the Latin American countries (Muñoz, 1982). Both terms have been associated with controversy. At one time, "Latino" was used as an expression of rejection toward Mexicans in the U.S. Southwest. Individuals who object to the term "Hispanic" have connected it negatively with the Spaniards who conquered areas of the West. Other labels associated with Latinos include Nuyorican, La Raza, and Chicano/Chicana (Beals & Beals, 1993; Muñoz, 1982). Each of these terms connotes a different sociocultural and ethnopolitical worldview (see Comas-Díaz, 2001). In this article, the term "Latino" will be used simply because it has gained wider currency among people from varied Latin American backgrounds.

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Homogeneity and Heterogeneity of the Latino Population

Latinos share minority status in the United States. They tend to share a similar culture. The greater portion of the Latino population speaks Spanish, is devoted to the Roman Catholic faith, and shares essential values such as *familism* (centrality of family connection for well-being to anchor individual identity) and *simpatia* (positive valuing of a warm and respectful interpersonal style; Marín & Marín, 1991). But many values, beliefs, and practices within each group vary from subgroup to subgroup. These differences range from language to types of employment, socioeconomic status, religion, character traits, belief systems, and culture (Beals & Beals, 1993). In addition, principles, income, and educational background tend to vary among the subgroups (American Medical Association's Council on Scientific Affairs, 1991). Because linguistic and acculturation elements vary with each subgroup, it is recommended that consideration be given to each individual's specific Latino subgroup throughout the therapeutic process (Malgady, Rogler, & Constantino, 1987). This recommendation holds for psychological testing, as well. However, underlying the variations between subgroups are specific issues that pertain to the testing of all Spanish-English bilingual Latinos. These testing concerns may be divided into three broad areas: client issues, test issues, and clinician/assessor issues.

CLIENT ISSUES

Spanish Language

Linguistic skill and language maintenance vary among Latinos and Latino subgroups, which are heterogeneous in this respect (Sattler, 2001). When clinicians are lacking in language and cultural knowledge, nuances of speech and the client's manner of speech are subject to misinterpretation (Marcos, 1994). Assessment in the language with which the client is most comfortable might ameliorate some of these assessment errors.

The dissimilarity with which the Spanish-speaking community practices language offers a manner of expediently identifying each subgroup (Muñoz, 1982). For instance, Spanish spoken by speakers from different groups may vary in speed, intonation, and pronunciation. Regional, class, and educational differences may also affect the way in which Spanish is spoken. Some Spanish-speakers are careful to pronounce all the letters and syllables in each word. Others may soften or drop the final "s" in a word, add diminutives such as *tico* or *tica* to nouns, or change the sound of "r" to "l." Among members of the Spanish-speaking community, vocabulary preferences and usage also vary by geographic region (Marín & Marín, 1991). For example, due to the predominant concentration of Mexican Americans in Texas, it is more appropriate to use the Spanish words with which that population is familiar and comfortable (e.g., the word *carro* for "car," rather than *coche*).

A person new to an area may not be familiar with the variation of Spanish used in that particular region. To avoid misunderstandings, the use of "standard Spanish" is helpful, because it is free of regional or national variations and substitutes standard terms for nouns that change from country to country (Marín & Marín, 1991, p. 52). However, communication problems may occur with either standard or nonstandard terms. For instance, while the word *amigo* is standard Spanish for "friend," a Spanish-speaker from Mexico may use the nonstandard word *vato* and a Puerto Rican might use *pana*. To further complicate this difficulty, in Puerto Rico, the word *pana* also refers to breadfruit and to felt-fabrics.

Another set of problems linked to the use of standard and nonstandard Spanish falls under the general category of rapport. For instance, the use of standard Spanish by the clinician may signal higher social status, thus inadvertently implying a lower social status for the client accustomed to speaking nonstandard Spanish. In some circumstances, the differences in background denoted by the kind of Spanish spoken by each member of the dyad may prove disruptive to the establishment of a working relationship. For example, a working-class Puerto Rican may perceive a clinician with a middle-class Argentinean accent as haughty and uninterested. However, while a clinician's choice of nonstandard usage may indicate a willingness to relate in a more personal, familial manner, the client under assessment may or may not welcome it.

In general, we advocate standard language use, with the caveat that the clinician should become as familiar with nonstandard usage as is feasible. When subgroup variations in Spanish occur locally, the clinician should include all possible linguistic variations in the same sentence (Marín & Marín, 1991). Consider the example given by folk healing: In discussing the folk condition held to be a consequence of the "evil eye," the clinician should strive to use the words *ojo, mal de ojo,* and *mal ojo* (Beals & Beals, 1993) in the same sentence. Using all the different terms for a concept enables the clinician to avoid giving preference to one over the others and thus to avoid alienating the client through choice of vocabulary.

Spanish-English Bilinguals

A person's mother tongue is the language spoken at home when that person was young (Bean & Tienda, 1987). Because Latino children in this country are exposed to two languages, many are bilingual. Sattler (2001) noted that Latino children may be fluent in both English and Spanish, or they may struggle with both languages. Latino children may experience the following four problems when speaking their mother tongue: (a) they may incorporate English words into Spanish phrases, (b) they may use English words to devise certain speech patterns, (c) they may encounter problems pronouncing words in either language, (d) or they may confuse the order of words. Although Latinos may self-identify as bilingual, careful examination of their fluency in both languages is called for when decisions about language choice for testing are made. Just because a child is Spanish-speaking or has a Spanish surname does not mean that the child would be best assessed in Spanish. Furthermore, test results need careful interpretation, because the individual's ease or difficulty

with either language may have been an important factor throughout the test.

Marcos (1988) pointed out dimensions of bilingualism. Of these, language dominance refers to the degree of linguistic competence a speaker commands in each language. *Subordinate bilinguals* may perform differently in each language and experience more difficulty with the second language. *Proficient bilinguals*, on the other hand, display a native speaker's command of both languages. Bilingual Latinos may fall anywhere on the spectrum of fluency in each language they speak (Council on Scientific Affairs, 1991), a significant factor to be considered when they are tested in Spanish and English. Because language is the most powerful system of symbols used to establish and maintain a culture (Marrero, 1983), for many Latinos, Spanish remains the language that defines and facilitates expression in the Latino culture (Bean & Tienda, 1987). For clinicians interacting with bilingual individuals, comprehension in each spoken language is both relevant and necessary, inasmuch as language and culture are inextricably intertwined (Seay Clauss, 1998).

Bilingualism and Biculturalism

For many Latinos, the world involves two languages and two cultures (Marcos, 1988). Along with a life in the U.S., bicultural individuals maintain close relations with their culture of origin and acquire behaviors that enable them to maintain their life in both cultures (Valdez, 2000). Individuals who lead successful lives in two cultures may be contending with two separate value systems and the acquisition of skills that support a bicultural lifestyle, as well as with two separate languages.

The use of the Spanish language is an important tool for Latinos negotiating the world of family, community, and friends. On the other hand, the use of the English language is crucial to adaptation and success in the English-dominant institutions of school and work. Because bilingualism is an essential element of Latino identity in the U.S. (Curtis, 1990; Marcos, 1988), it is important to consider whether the individual is expressing feelings in one language more effectively than in the other (Rodriguez Gomez & Caban, 1992). In fact, one question that has arisen throughout the literature is whether bilingual Latinos exhibit greater aberrance in English or Spanish (Levine & Padilla, 1980; Rodriguez Gomez & Caban, 1992; Rogler et al., 1983). This question indicates the need for examiners and clinicians to understand the dynamics involved in both the practice of bilingualism and the assessment of Bilingual Latinos. Poor communication and lack of comprehension can result in faulty diagnoses when linguistic misunderstandings lead clinicians to infer psychopathology where none exists (Sue, 1991).

In any two cultural contexts, it is sometimes difficult to determine the appropriateness of the usage or syntax of the more unfamiliar language. Because language plays a key role in the way we adapt to our surroundings, an individual may experience stress if his or her linguistic ability is not sufficient to the task (Dornic, 1986). The challenge of meeting the linguistic demands of life in not one but two cultures may be even more stressful. To further complicate matters, each language, with its associated culture and value system, may place unique constraints on the bilingual person's sense of identity (Northover, 1988). Given these circumstances, bilinguals may encounter lifelong complications simply because of the manner in which they choose to communicate. They may be criticized for or prohibited from using Spanish at work or school, while in family and social settings they may be misunderstood or ridiculed for using English. Errors in translation can also occur. Such considerations suggest that to be successful in both languages, the bilingual person will need to be more flexible than are persons who only speak one language. Thus, an additional dimension to keep in mind when assessing bilingual Latinos is their cross-language flexibility.

The question of whether cross-language priming occurs lexically (automatically) or postlexically (in a controlled fashion; Hernandez, Bates, & Avila, 1996) also has bearing on the assessment of Spanish-English bilingual Latinos. Do bilingual individuals need to translate mentally before responding to a question, or does comprehension occur automatically, regardless of the client's mother tongue? Do bilingual individuals experience speech in the same manner across both languages? According to Hernandez et al. (1996), the fluency of most bilingual individuals fluctuates depending on how often and recently they have used a given language. Therefore the possibility exists that an individual's reading comprehension in one language may be superior to comprehension in the second language, even when both languages are used well.

Investigating language maintenance, Bahrick, Hall, Goggin, Bahrick, and Berger (1994) found that 50 years after immigration, Cuban and Mexican immigrants used Spanish and English equally, preserving dominance in the Spanish language on vocabulary, lexical, and oral tests. Their results give rise to such questions as how fluency in Spanish is preserved over time and how this preservation might affect the performance of bilingual individuals undergoing psychological assessment.

In addition to fluency, emotional expression has also been shown to vary with language. Guttfreund (1990) found that Spanish-English and English-Spanish coordinate bilinguals, people who speak both languages in independent contexts, expressed greater emotion when responding in the Spanish language. Moreover, levels of anxiety and depression varied depending on the language used. Guttfreund further reported that results vary significantly, depending upon whether Latinos were assessed in their first language or in their second. Differences in cross-language test responses by bilingual Latinos have been found on separate English and Spanish administrations of the NEO Personality Inventory and Marlowe-Crowne Social Desirability Scale (Arrigain, Cofresí, & Slane, 2001). These and other studies (Ervin, 1964; Hull, 1990; and Perez-Foster, 1996; all as cited in Arrigain et al., 2001) suggest that each language might have access to a specific set of memories, attitudes, beliefs, and values and that the nuances attached to social person-

ality constructs are very much culture-bound (Arrigain et al., 2001).

Cultural references notwithstanding, a Spanish-English bilingual Latino undergoing assessment needs to understand the language in which the test was written. When the clinician and the client fail to understand each other, or the client fails to understand the assessment tool, miscommunication or lack of comprehension may affect or distort the test results as well as generate apprehension and frustration (Ibrahim, 1985) for those involved in the assessment process. Such language barriers may inaccurately reflect pathology in Spanish-speaking clients. Marcos, Urcuyo, Kesselman, and Alpert (1973) found that assessment participants often responded differently in Spanish and English to the same question and that when Spanish-speakers were interviewed in English "patients do, in fact, act differently in ways which the English-speaking clinician is likely to associate with increased psychopathology" (p. 658). Clearly, for assessments to be accurate, they must be conducted in the language in which the client is most competent and comfortable.

The manner in which mental health services are delivered may also influence the results of assessment measures. Referring to Spanish-English bilingual clients, Dana (1998) recommended that language preference be respected and appropriate "social etiquette" maintained when services are delivered, no matter what language is used. In testing Latinos, the use of Spanish-speaking clinicians/assessors signals a special regard for the linguistic needs of the participants. Such circumstances are not always possible, however. Funds for services in Spanish are lacking, and an ongoing debate over whether assessment instruments should be produced only in the English language has yet to be resolved. At this time, as a result of language incompatibility, culturally diverse groups still have difficulties with and lack access to current mental health services.

Acculturation

Closely linked to language concerns is the issue of acculturation. According to Sattler (2001), the process of acculturation, which may pertain either to an individual or a group, may require modification of both social conduct and value system. Acculturation comprises five stages: traditionalism, transitional period, marginality, assimilation, and biculturalism. Each stage in the acculturative process has its own benefits and difficulties.

Clark and Hofsess (1998) mentioned three models of acculturation. The first, a linear model, may be viewed as a continuum defined by three points: unacculturated, bicultural, and acculturated (Keefe & Padilla as cited in Clark & Hofsess, 1998). According to the linear model, an individual's level of acculturation may fall anywhere between the two extremes of unacculturated and acculturated. Clark and Hofsess referred to the second model as the "two-point culture matrix" (p. 42), in which one axis indicates the immigrant's original culture and the axis that crosses it represents the new culture. The four sections created by the intersecting axes are characterized as (a) unacculturated, (b) bicultural, (c) marginal, and (d) acculturated. The X-axis ranges from "low" to "high" and represents the "native culture," while the Y-axis consists of the same range and represents the "new culture" (Clark & Hofsess, 1998). The final model of acculturation considers particular personality characteristics along with different facets of acculturation, including the two most essential facets, culture and structure (Gordon, 1964, as cited in Clark & Hofsess, 1998).

Consideration of the acculturation process should include the factor of stress, along with other elements of the experience. Acculturation itself may produce stress. Berry, Kim, Minde, and Mok (1987) noted that acculturative stress may affect all aspects of an individual's life, including psychological states, and is marked by a decline in well-being. In determining acculturative stress, changes in the person's condition or circumstances should be systematically connected with recognizable aspects of the acculturation process occurring in that person's life (Berry et al., 1987, p. 492). Williams and Berry (1991) found that some qualities of stress may be predictably associated with acculturation, including anxiety, depression, feelings of marginality and alienation, heightened psychosomatic symptoms, and identity confusion. Hovey (2000) found that Mexican immigrants with elevated levels of acculturative stress showed increased symptoms of depression, a possible result of adjustment difficulties that could include linguistic challenges. When an individual is forced to use a less familiar language, the ability to process information is diminished and the overall ability to communicate becomes restricted. Stress is a likely result (Dornic, 1986). This complicates the assessment process and confirms the need to measure acculturation before the process begins.

Because acculturation encompasses a number of stages and factors, it is important to determine each individual's current level of acculturation. Various instruments exist that provide an acculturation index. For examples, see the following scales as cited in Clark and Hofsess (1998): (a) Scale for Mexican Americans (ARSMA; Cuellar, Harris, & Jasso, 1980), (b) the Revised Acculturation Rating Scale for Mexican Americans (ARSMA-II; Cuellar, Arnold, & Maldnado, 1995), (c) the Language-Based Acculturation Scale (LAS; Deyo, Diehl, Hazuda, & Stern, 1985), (d) Acculturation for Adolescents (Olmedo, Martinez, & Martinez, 1978), (e) the Los Angeles Epidemiological Catchment Area (LAECA; Burman, Hough, Telles, & Escobar, 1987), and (f) the Short Acculturation Scale for Hispanics (Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable, 1987).

The particular acculturation instrument used should be appropriate for the subgroup being tested. Because acculturation involves the adoption of language (Curtis, 1990), levels of comprehension in each language should be investigated simultaneously with levels of acculturation in bilingual individuals. Simple questions such as "What language was spoken at home when you were a child?" "How old were you when you learned your second language?" and "In what language are you most comfortable speaking and thinking?" might provide a broad indicator of the best language to use for assessment.

Test-Taking Behaviors

Differences in test-taking behavior across cultures have also been documented. Sattler (2001) reported that deficiencies in test-taking skills, exposure to test content matter, and increased testing anxiety all contribute to the deviations in test-taking behavior found among persons from different cultures. Expectations of interaction and interactive styles, which vary from culture to culture (Brems, 1998), may further contribute to test-taking perceptions and thus affect test-taking skills across cultures. Bilingual Latinos may possess adequate command of the English language, but their test-taking behaviors may be informed by Latino cultural expectations of interpersonal warmth and personal relating in the test-taking situation. In this case, the brisk, impersonal, and businesslike behavior of a non-Latino assessor may trigger an adverse reaction in the Latino test taker that will affect that individual's testing performance.

Test-Taking Situation

Other cross-cultural testing concerns involve the level of examinees' comfort in the testing environment, differences in familiarity with various test contents, and differences in test-taking behaviors. Brems (1998) proposed that both the physical and psychological elements of the testing situation should be investigated. For instance, according to Brems, some groups, such as the indigenous Alaskan population, are removed from their original environment and transported to a more urban area for testing. Such an experience may overwhelm individuals and affect assessment results. This circumstance may apply as well to indigenous Latinos from rural settings, when they are tested in urban assessment centers. Examiners should also explore the examinee's familiarity with assessment tools and tasks, which can also present a conflict (Brems, 1998). For example, some bilingual Latinos from a lower socioeconomic background may not have access to computers. Computerized testing may handicap such individuals.

While middle-class persons from mainstream settings may be accustomed to methods of assessment (e.g., timed verbal responses) popular in their own culture, members of other cultures may be uncomfortable or even unfamiliar with such methods. Some cultures may not understand or accept the achievement components of a testing context (Sattler, 2001). Additional factors, such as the client's socioeconomic status, educational level, ethnicity, migration history, generation level, and reading level, should also be considered during the assessment of the Latino population (Cervantes & Peña, 1998), along with Latinos' deferential stance toward authority, the importance they place on minimizing interpersonal conflict, the interplay between religiosity and fatalism (Neff & Hoppe, 1993), and age and marital status (Newcomb et al., 1998).

TESTING AND ASSESSMENT VARIABLES

Validity

Literature pertaining to the cross-cultural assessment of bilingual Latinos is sparse and mostly concentrates on issues such as validity. Test bias may be detected in content, criterion, and construct validity. Content validity is an especially significant issue in the assessment of bilinguals and must be addressed when a test is devised in the English language but is administered to an individual who maintains an alternate language (Brems, 1998). Construct validity is an even more prominent concern existent in the literature. Brems noted that an assessment tool possesses construct validity only if the construct measured exists in the culture in which it is being used. Additional concerns include whether the assessment tool demonstrates (a) conceptual equivalence, (b) equivalence in the definition of a construct, (c) equivalence in the way that the test items are perceived across cultures, and (d) measurement of the construct using the same metric means (Hui & Triandis, 1985). For bilingual Latinos, lack of cross-cultural equivalence of constructs may produce different responses in Spanish or English (Arrigain et al., 2001). This may be due to lack of comprehension of a certain construct when the construct manifests in a dissimilar manner across the two cultures to which the individual belongs.

Standardization/Norms

Another concern that has generated interest in cross-cultural assessment is whether the norms of an assessment tool are relevant to and appropriate for use with a cultural group that was not included in the norming process. The majority of assessment tools have been standardized using a Caucasian population and do not accurately represent culturally diverse populations. Thus, it is appropriate to use such tools only with the Caucasian population on which the tests were standardized (Brems, 1998). Conversely, pluralistic norms, or norms that are created for specific cultural groups, allow members of a culturally diverse group to be directly compared with other members of the same group (Sattler, 2001). In this case, bilingual Latinos would need to be compared with other bilingual Latinos of similar acculturation level, language dominance, and similar cultural and socioeconomic backgrounds. The difficulty of creating pluralistic norms for this homogenous population is one among many of the difficulties that test makers need to consider. The consistent debate over whether it is culturally appropriate to use an assessment tool containing primarily Caucasian, middle-class norms with persons from ethnic minority groups has prompted a desire to create more culturally relevant assessment instruments (Rogler et al., 1983). The cultural and linguistic concerns posed by bilingual Latinos add yet another level to this concern.

Translation

Numerous translation techniques and practices have been used for the adaptation of English tests into Spanish forms. The most salient of these include (a) the use of an initial pool of bilingual individuals for the purpose of establishing the linguistic equivalence of the Spanish version (Norris & Perilla, 1996); (b) the back-translation technique to maintain the true meaning of each item (Dimmit, 1995); (c) decentering,

an adaptation of the back-translation technique that entails submitting the original version of an assessment tool to a translator (Marín & Marín, 1991); and (d) an examination of which translation is most appropriate where numerous regional translations exist (Velasquez et al., 2000). Regardless of the translation techniques used, when using translated tests, it is important to remember that tools still contain items that may be misinterpreted due to the translation process itself and geographic variations in the Spanish language.

CLINICIAN/ASSESSOR ISSUES

Ethnocentrism may be defined as the propensity to perceive one's culture more positively than other cultures (Berry, 1986). *Ethnorelativism*, or "multicultural ideology" (Berry, 1986), may be viewed as the opposite of ethnocentrism. Ethnorelativism entails the ability to incorporate aspects of other cultures into one's own; it exceeds mere realization, adaptation, and acceptance (Brems, 1998). The concept of ethnorelativism is particularly important to cross-cultural assessment because it posits that psychopathology is a product of certain behavioral patterns that are characteristic of a culture and diverge from society's norms (Bravo, Canino, Rubio-Stipec, & Woodbury-Fariña, 1991). This view should dominate in situations in which bilingual Latinos are assessed, because persons from this group may manifest dissimilar patterns of behavior that relate to the expectations and norms associated with both cultures.

The reliance on an ethnocentric perspective may lead to the tendency to use stereotypes and prejudice, which are serious impediments to the accurate assessment of culturally diverse individuals. Numerous negative stereotypes suggesting an inferior level of intelligence and unfavorable personality traits (Levine & Padilla, 1980) have been linked to the Latino population and may affect a successful rapport (Sattler, 2001). Hence, it is advisable for examiners and clinicians to increase their awareness of their own stereotypical thinking as it occurs during the assessment process, particularly with Bilingual Latinos who may demonstrate a specific weakness in one of their two languages. For instance, poor vocabulary and lack of comprehension in the English language have stereotypically been equated with lower intelligence. Because stereotyping powerfully affects individuals whose speech is strongly accented and who vary linguistically from the majority (Sattler, 2001), this factor must be considered.

Prejudice is another impediment to the accurate assessment of Spanish-speaking individuals and can have a profound effect on the assessment of bilingual individuals through expectancy and counter-prejudice. If prejudice and discrimination are expected of the examiner, then test-taking and assessment outcome will be affected. For bilingual Latinos, counter-prejudice may present when the clinician is not expected to be interested in them or to understand their problems (Marcos, 1988).

Finally, cultural misunderstandings held by the clinician may negatively affect the assessment outcome. According to Marcos (1988), this applies to those culturally bound attitudes and beliefs held by Latinos that are defined as "unhealthy" by unfamiliar clinicians. For example, Latino children are reared to show respect by looking at the floor while an elder or authority figure is speaking. A culturally unaware clinician may erroneously conclude from the consequent poor eye contact that the child is depressed or has poor interpersonal skills. To avoid such cultural misunderstandings, it is incumbent on clinicians working with Latinos to familiarize themselves with Latino cultural norms and values.

RECOMMENDATIONS

The rapid expansion of the Latino population warrants an accurate and reliable means of psychological assessment. Clinicians working with Spanish-English bilingual Latino clients travel an especially difficult path; there are a number of factors to be considered when psychologically assessing members of this population. Several recommendations have been recognized throughout the literature, addressing culture and language within the testing situation. We provide these as follows, along with some of our own, for counselors to implement in their work with Latinos and bilingual Latinos:

Client Issues

1. Before conducting any assessment, the clinician should ascertain the client's specific language history, language preferences, and evaluate the client's sociocultural background and level of acculturation (Malgady et al., 1987). This ensures that each client is viewed in the context of his or her personal circumstances and situation (Brems, 1998).

2. Language dominance should be assessed a priori, along with bilingual verbal aptitude, through the use of appropriate tools (all as cited in Sattler, 2001) including the Language Assessment Scale, Oral (LAS-O; Duncan & DeAvila, 1994), the Woodcock-Muñoz Language Survey (Woodcock & Muñoz-Sándoval, 1993), and the Language Assessment Scales—Reading and Writing (LAS-R/W; Duncan & DeAvila, 1994). Questions about language preference and language dominance can be asked directly of the client in the absence of the aforementioned tools.

3. To ensure accurate and fair results, the assessment should be conducted in the language most compatible with the bilingual client's language proficiency and dominance.

4. The client's level of acculturation merits examination given its association with expressed symptomatology and its direct influences on a client's language use and comprehension. As previously noted, several acculturation instruments specific to the diverse Latino subgroups are readily available.

5. Because many Latino clients may lack previous testing experiences, to ensure informed participation, a careful explanation in clear and rudimentary language of the purpose and methods of the assessment situation is recommended.

6. Finally, attention to social etiquette concerns, such as correct pronunciation of the client's surnames; use of the honorific *don or doña* for older, unacculturated Latinos; and a warm interpersonal style will help facilitate the client's comfort and best performance in the assessment situation.

Assessment Issues

1. For a test to be valid across cultures, examination of the equivalence of constructs is necessary. Regional differences in language use and the heterogeneity of Latino subgroups also need to be taken into consideration.

2. Translations of assessment tools should be tested to ensure that they are reliable and valid within the target culture, and results should be construed after consideration of relevant cultural conditions (Dimmitt, 1995). Examination of the cross-cultural equivalence of items with translated tests is crucial in this respect.

3. Appropriate assessment tools should be free of culture, be culturally fair, use pluralistic norms, use a test-train-test technique, be created for use with a particular culture, and use an approach that is familiar to that culture (Lewis, 1988). In situations in which the available tests fail to meet these stringent criteria, careful attention to cultural and linguistic issues is crucial to ensure fair and useful interpretation of results.

Clinician Issues

1. Assessors should examine and avoid any personal ethnocentrism (Brems, 1998). Most important, the ubiquity of culture in all assessment situations must be acknowledged in order to prevent culturally based misunderstandings from unduly influencing the assessment findings. In particular, preconceptions regarding accented English, the use of the Spanish language, or poor language skills in English or in Spanish language need to be examined.

2. Assessors should not bring preconceptions based in cultural judgments to a testing situation, nor should they assume that instruments providing effective measures for one cultural group would be equally sensitive in the context of another culture (Jones & Thorne, 1987, p. 494).

3. Ideally, clinicians who are fluent in both Spanish and English should perform assessments of Spanish-English bilingual clients, because these clients may resort to using either language or both in the course of an assessment. Clinicians who speak both languages and are sensitive to the cultural context underlying the client's use of each language have the greatest likelihood of accomplishing a successful and accurate assessment.

4. If this option is unavailable, clinicians should seek to inform themselves about the client's own cultural referents through consultation or further training and make use of culturally sensitive assessment tools that factor in such referents as may emerge in the client's use of language.

SUMMARY

On the basis of a review of the existent literature and on our clinical experiences, we have made several recommendations for consideration in the assessment of the bilingual Latino populations. However, current research remains scant on mental health service delivery to the bilingual Latino population. Specifically, future research is needed to continue to explore various means of effectively providing psychological assessment services to Spanish-English bilingual Latinos. Similarly, the scarcity of trained, bilingual assessors remains problematic. Concerted efforts to recruit and train bilingual counselors to serve the assessment needs of the burgeoning Latino population is strongly recommended.

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Practical Guide for Reporting Effect Size in Quantitative Research in the *Journal of Counseling & Development*

Jerry Trusty, Bruce Thompson, and John V. Petrocelli

The purpose of this article is to assist researchers in meeting the requirement of reporting effect sizes in quantitative research studies submitted to the Journal of Counseling & Development. *This requirement is detailed in the "Guidelines for Authors" included in this issue. The authors provide practical information on generating, reporting, and interpreting effect size estimates for various types of statistical analyses. Information is provided on the meaning of effect sizes within the larger knowledge base.*

Whereas statistical significance tests assess the reliability of the relationship between independent and dependent variables, effect sizes assess the strength of the relationship. When reported and interpreted appropriately, effect size estimates are practical, straightforward, and relevant to research questions and hypotheses (Wilkinson & APA Task Force on Statistical Inference, 1999). Effect sizes can serve as an important mechanism for communicating our professional knowledge base to others within and outside our profession, including our clients (Thompson, 2002a). Many researchers who publish articles in the *Journal of Counseling & Development (JCD)* are doctoral-level professionals. Many *JCD* readers, however, are master's-degree level professional counselors. Therefore, researchers should (a) describe the significance of their findings in relation to counseling practice and (b) present findings in ways that are readily understood by counselors. Effectively providing effect size information is an important means for accomplishing both these goals (see American Psychological Association, 2001, pp. 5, 25–26).

For these various reasons, 23 journals currently require effect size reporting (cf. Harris, 2003; Snyder, 2000). Indeed, as Fidler (2002) recently noted, "Of the major American associations, only all the journals of the American Educational Research Association have remained silent on all these issues" (p. 754).

The purpose of the present article is to review briefly some of the frequently reported effect size choices, how these effect indices can be obtained from computer software, and how they are reported and interpreted. Only a few of the several dozen effect size choices (Huberty, 2002; Kirk, 1996) are summarized here. Readers seeking more detail may consult Snyder and Lawson (1993) or Rosenthal (1994). More contemporary treatments are provided by Kirk (in press), Hill and Thompson (in press), and Thompson (in press). The book by Kline (in press) is a particularly excellent resource.

HOW TO GENERATE, REPORT, AND INTERPRET EFFECT SIZE

Kieffer, Reese, and Thompson (2001) and Thompson and Snyder (1998) investigated the research and statistical techniques used in counseling journals during the past 15 years. These authors reported that of the various statistical procedures (beyond basic descriptive statistics), forms of analysis of variance (ANOVA; e.g., multivariate analysis of variance [MANOVA] and multivariate analysis of covariance [MANCOVA]) were the most frequently used statistical procedures. Also, only a small percentage of *JCD* authors reported effect sizes (Thompson & Snyder, 1998). Therefore, we cover ANOVA and related techniques most thoroughly in this article. Bangert and Baumberger (in press) and Petrocelli (2003) reported that regression analyses and chi-square analyses were also relatively common in *JCD* throughout the last decade. Therefore, we provide guidelines regarding effect sizes for these two types of statistical analysis. Bangert and Baumberger did find a higher incidence of effect size reporting in regression analyses, in the form of reporting multiple correlation squared (R^2).

Because SPSS seems to be the statistical package most commonly used by counseling researchers, all practices in

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this section are described using SPSS Version 11.0. Procedures in other versions of SPSS and other computer software programs (e.g., SAS, Minitab) are similar.

In all instances of reporting strength of association or mean differences, researchers should use the terminology *effect size* in their writing. This language alerts the reader to the fact that an estimate of practical significance is being reported. Otherwise, some readers may not recognize particular statistics as being estimates of effect size.

Effect Size in Analysis of Variance and Related Techniques

For ANOVA techniques, SPSS provides estimates of effect size in the form of eta^2 (η^2). Eta^2 is an estimate of the proportion of variability in the dependent variable(s) explained, or accounted for, by membership in the groups defining the independent variable(s). Eta^2 is equivalent to the R^2 of a dummy-coded variable in regression (Pedhazur, 1982). Eta^2 estimates of effect size are not automatically provided in SPSS; that is, the researcher must specify that this estimate of effect size is desired.

In SPSS, eta^2 is available through C*ompare Means* procedures, but only in the *Means* choice (click on *Analyze, Compare Means, Means*), and not in the *T-Test* choices or the *One-Way ANOVA* choice However, eta^2 is consistently available through the *General Linear Model* procedures. Therefore, if you desire to perform a one-way ANOVA, for example, use *General Linear Model* instead of the *One-Way ANOVA* procedure accessed through C*ompare Means* in the *Analyze* pull-down menu. Otherwise, these and other effect sizes may also be computed by hand (Snyder & Lawson, 1993).

From the *Analyze* pull-down menu in SPSS, select *General Linear Model*. Then select either *Univariate*, *Multivariate*, or *Repeated Measures,* depending on your design. After you specify your dependent variable(s) and independent variables(s)—termed *Fixed Factor(s)* in the box—click on the *Options* button. One choice in the *Display* box is *Estimates of Effect Size*. By clicking (checking) on that option, you will get *partial eta*^{2} estimates of effect size in your output file. The partial eta^2 is an estimate of the amount of variance in the dependent variable(s) attributable to the particular effect of interest, and these statistics should be reported as partial eta^2 statistics (see Tabachnick & Fidell, 2001, pp. 52–53). Partial eta^2 estimates are displayed for each effect in the analysis (i.e., multivariate effects, main effects, interaction effects, effects of covariates). In the case of multiple dependent variables (e.g., MANOVA), partial eta^2 estimates are displayed for each dependent variable. For researchers who use SPSS syntax, the subcommand line is /PRINT = ETASQ, or alternatively, /PRINT = EFSIZE. Whether through the pull-down menu or through syntax, this procedure for obtaining eta^2 estimates is available for all types of analysis of variance designs, including one-way univariate and multivariate designs, factorial designs, and repeated measures designs.

Eta^2 estimates are referred to as *variance-accounted-for* statistics. The interpretation of a partial eta^2 value of .08 for a particular independent variable, for example, would be "Regarding effect size, 8% of the variability (or differences) in the dependent variable scores was explained or predicted with knowledge of group membership on the independent variable." The complement of the Wilks's lambda statistic (1 – Wilks's lambda) has been used to indicate variance-accounted-for in multivariate tests. However, this practice may produce inflated estimates of explained variance, whereas the partial eta^2 produces more reasonable estimates (see Tabachnick & Fidell, 2001, pp. 338–339).

Researchers may choose to use the SPSS *MANOVA command* for performing multivariate analyses. This command is available only through SPSS syntax and not through the SPSS pull-down menus. If the MANOVA command is used, researchers can use the squared canonical correlation as an overall estimate of variance-accounted-for effect size. The subcommand for obtaining the canonical correlation is / PRINT = SIGNIF(EIGEN). Researchers can use structure coefficients (SPSS subcommand: / DISCRIM = CORR) to gauge the relative contributions of particular dependent-variable differences to overall effects.

There are situations in which *standardized-difference* effect sizes are needed in the reporting of results. This is particularly the case in experimental or quasi-experimental designs when the mean difference between experimental and control groups is of interest. Standardized-difference effect size statistics such as Cohen's *d* can easily be calculated by hand, and researchers, by requesting descriptive statistics in analyses, can get all the statistics they need from the SPSS output (e.g., group means, standard deviations) to calculate Cohen's *d* and similar statistics. Thompson (2002a) provided formulas for calculating Cohen's *d* and for converting standardized-difference effect sizes into variance-accounted-for effect sizes, and Olejnik and Algina (2000) provided information on effect size calculations in several analysis of variance designs.

Effect Size in Regression Procedures

As stated earlier, effect sizes are commonly reported in regression analyses in the form of R^2, which is another variance-accounted-for effect size. Similar to the interpretation of eta^2 and the squared canonical correlation, an R^2 of .32, for example, would be interpreted, "Regarding effect size, 32% of the variability in the dependent variable was explained, or accounted for, by the independent variables." R^2 is automatically included in linear regression output in SPSS, and variations and extensions of regression (e.g., ordinal regression, logistic regression, structural equation modeling) include specific types of R^2 statistics.

One shortcoming of an overall R^2 is that effects are not revealed for particular independent or predictor variables. There are various approaches for gauging the effects of particular predictor variables. One method is to report standardized regression coefficients (standardized betas, path

coefficients). Another is to report the change in the R^2 when particular variables are entered hierarchically into regression equations (incremental increase in R^2). Yet another is to remove a predictor from an equation and note the incremental decrease in the R^2. Structure coefficients have also been highly recommended (Courville & Thompson, 2001). Researchers should be aware of caveats regarding the use of standardized betas, increments, and structure coefficients (see Courville & Thompson, 2001; Pedhazur, 1982).

Multicollinearity and suppressor effects in regression equations can have considerable influences on results (see Cohen & Cohen, 1975; Tabachnick & Fidell, 2001), and therefore researchers should be alert for these situations and interpret results accordingly. In addition, it is advisable to report the adjusted R^2 in regression analyses (see Thompson, 2002a).

One purpose of reporting effect sizes is to provide future researchers with a consistent gauge of the strengths of associations. A future researcher who reads your article may be interested only in the relationship between one pair of variables in your analysis; therefore, inclusion of a bivariate (zero-order) correlation matrix along with your regression analysis will likely contribute to the knowledge base (see Pedhazur, 1982). Doing so will be especially useful to researchers conducting meta-analyses; otherwise, future researchers may choose to disregard your study simply because there is no reliable way to estimate the desired effect size (see Rosenthal & DiMatteo, 2001).

Effect Size in Chi-Square Procedures

As in ANOVA or regression procedures, there are numerous indicators of strength of association in chi-square analyses, and there is no one indicator that accounts for every type of association (Norusis, 1993). The use of one indicator or the other depends on the scaling properties of the variables involved. Also, some indices are symmetric (no variable is designated as the dependent variable) or asymmetric (one or the other variable is designated as the dependent variable), and some indices are symmetric only.

Chi-square tests are accessed through the *Crosstabs* choice in the *Descriptive Statistics* procedure in the *Analyze* pull-down menu (click on *Analyze*, *Descriptive Statistics*, *Crosstabs*). SPSS provides numerous chi-square measures of association including Phi (ϕ), Cramer's V, Kendall's tau-b (τ_b) and tau-c (τ_c), Goodman and Kruskal's gamma (Γ), Cohen's kappa (κ), Goodman and Kruskal's lambda (λ), Goodman and Kruskal's tau (τ), and Somers's *d*. Click on the *Statistics* button to access these and other statistics. In SPSS output, these various statistics are presented in terms of the scaling of the variables (e.g., nominal by nominal) and other criteria (e.g., symmetric or asymmetric). Researchers decide, based on variable scaling and the design and purposes of the research, which statistic is most appropriate for reporting effect size.

Interpretations of chi-square effect sizes are dependent on the specific statistic used. For example, Goodman and Kruskal's lambda is appropriate when both variables have nominal (categorical) scaling. Lambda represents the degree of reduction in the error of predicting the values (categories) of one variable based on the values (categories) of another variable. SPSS output provides lambda statistics for the symmetric case (no dependent variable) and both asymmetric cases (each variable as the dependent variable). Researchers may benefit from using an SPSS *Base-System User's Guide* (e.g., Norusis, 1993), a *Base Applications Guide* (e.g., SPSS, 1999), and the *Help* menus in SPSS as resources for selecting and interpreting estimates of effect sizes in chi-square analyses.

ATTRIBUTING FURTHER MEANING TO EFFECT SIZE

Basic reports and interpretations of effect sizes are only one part of the research task. The manuscript is incomplete unless these effects are evaluated in the context of the study and in the larger context of knowledge. It is common for researchers to use Jacob Cohen's benchmarks for *small*, *medium*, and *large* effect to evaluate their effect size results. However, Cohen did not intend for these benchmarks to be used with the rigidity that some researchers apply (Thompson, 2002a, 2002b).

Small effect sizes for very important outcomes can be extremely important, as long as they are replicable. For example, the variance-accounted-for effect size for "not smoking" on cancer incidence is only around 2%, yet, as Gage (1978) pointed out,

> Sometimes even very weak relationships can be important. . . . [O]n the basis of such correlations, important public health policy has been made and millions of people have changed strong habits. (p. 21)

Conversely, large effect sizes may be trivial if they involve trivial outcomes. Spuriously large effect sizes can result from method variance and response biases (Thorndike, 1997) and from specification errors and outliers (Pedhazur, 1982). Misleadingly small effect sizes can result from measurement error and skewed distributions of variables (Tabachnick & Fidell, 2001). Skewed distributions of categorical variables can especially limit the magnitude of variance-accounted-for effect sizes (for an example, see Magidson, 1993, p. 139).

Effect size interpretation should be informed by an explicit factual comparison of detected effects with the effects reported in the related prior literature (Thompson, 2002b). However, interpretation also necessarily involves some subjective value judgment on the part of the researcher. The key is to be explicit in providing the reasoning underlying these judgments. As Huberty and Morris (1988, p. 573) noted, "As in all of statistical inference, subjective judgment cannot be avoided. Neither can reasonableness!"

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When Lightning Strikes: Reexamining Creativity in Psychotherapy

David K. Carson and Kent W. Becker

Creativity is paramount to the therapeutic process. This article explored the role of creativity in counseling and psychotherapy through a critical analysis of several key articles in a special issue of The Journal of Clinical Activities, Assignments, & Handouts in Psychotherapy Practice *(L. L. Hecker, 2002). Implications for counselors/therapists and the future of the field are discussed.*

Few journals have devoted an entire issue to the topic of creativity in psychotherapy. Lorna Hecker edited a recent issue of the *Journal of Clinical Activities, Assignments, & Handouts in Psychotherapy Practice* (*JCAAHPP*; Hecker, 2002), which included a fascinating and diverse treatment of this topic. Although the idea of creativity in counseling and psychotherapy is not new, a more cohesive and "scientific" treatment of this topic has not been commonplace in the literature. The current Trends article provides an overview and critical analysis of several major articles in this special issue of *JCAAHPP*. Implications for counseling practice are also discussed.

CREATIVITY AS VIEWED BY HECKER AND KOTTLER (2002)

According to Hecker and Kottler (2002), in their article "Growing Creative Therapists: Introduction to the Special Issue," neither creativity as a construct nor the role of creativity and creative thinking in mental health practice is commonly emphasized in counselor/clinical training programs. However, creativity is central to the therapeutic process, partly because counseling is a moment-by-moment experience. Yet it is not something that happens automatically, nor are most counselors trained to be able to tap their own creative resources and use them effectively with clients. On the other hand, to a large extent, creativity is a skill (i.e., a way of thinking and working with clients) that can be learned, developed, and fostered over time. Hecker and Kottler laid out three assumptions: (a) that creativity tends to beget creativity, (b) that most counselors/therapists feel "stuck" in the counseling process with at least some clients some of the time, and (c) that usually the problem of "stuck-ness" lies not with clients but with ourselves as clinicians (i.e., not client resistance or lack of motivation). Counseling is a cocreative process between clinician and clients that provides fertile ground for creativity to develop because creativity "is a process typically born from frustration or the need for a solution" (Hecker & Kottler, 2002, p. 2). Indeed, frustrations on the part of therapists and clients "are often the thunderstorms guiding the lightning bolts of creativity" (Kottler & Hecker, 2002, p. 8).

These authors delved more fervently into their own ideas about creativity in their key article "Creativity in Therapy: Being Struck by Lightning and Guided by Thunderstorms" (Kottler & Hecker, 2002). One striking yet profound insight was found early in this article, namely, that it is often when therapists are trying to be creative or innovative that they are least creative in their work with clients. One reason for this is that trying to be creative in therapy can easily detract from the natural flow of interactions and process as clients come to be treated as objects or challenges to be overcome, rather than as people with real feelings and existential struggles.

Other important components of the creative process of therapy, according to Kottler and Hecker (2002), include the central role of convergent and divergent thinking as well as intuition. These three capacities play out in the context of the three major components of creativity in counseling: *person*, *process*, and *product*. That is, creative therapy involves a synergistic combination of the unique personalities involved in therapy, the process of therapy (the way in which change and growth occurs, often involving novel, original or imaginative methods), and the product of therapy (that which is different about people and relationships at the end of therapy). Creative interventions may at times involve play, just seeing things differently than before, and "reckless abandon." Being able to access our own creativity at peak levels in an effort to help clients tap their own creative problem-solving abilities (internal and relational) and creative resources is a prerequisite to effective therapy. Creative problem solving involves the four critical steps of *preparation* (chance and opportunity perhaps favoring the prepared mind and heart), *incubation* (periods of rest in which no conscious

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work is done on the problem), *inspiration* (when lightning hits), and *verification* (confirmatory evidence of movement or change). High-level professional training *and* "training" from our clients (because they are our best teachers) are essential aspects of therapy. In sum, creativity is not an inborn trait but a process we engage in every day that can be nurtured, both within ourselves and our clients.

GLADDING ON CREATIVITY IN ROSENTHAL (2002)

Some of the aforementioned notions are illustrated in an interview Howard Rosenthal (2002) conducted with Sam Gladding in his article "Samuel T. Gladding on Creativity." Although Gladding saw creativity as an elusive concept, he viewed it as involving divergent thinking (a kind of thinking outside the box) in which an "aha" experience is more likely to occur. Counselors act as catalysts to help call forth the creative (often dormant) abilities of their clients in a safe environment. Sometimes this process involves helping clients let things be for a while (i.e., cease from trying too hard to solve a problem or change a situation) so that new possibilities can germinate and eventually spring forth. Counselors, too, sometimes need to learn how to do this in their work with clients. Often creative ideas pop into our heads when we are doing things we enjoy, or doing something out of the ordinary (e.g., reading or writing poetry or listening to a new piece of music). Part of the process of therapy also involves helping clients remove the barriers to their own creativity, both personally and relationally. Interestingly, Gladding noted that therapy does not always have to be "creative" in order to be effective, and it is not the be all and end all of therapy. There are even times when an excessive emphasis on being creative can be obstructive (e.g., if it becomes an obsession). On the other hand, creativity can often be the water that quenches dry throats in the desert and points the way to an oasis (our metaphor, not Sam's!). According to Gladding, in both therapy and life, creativity comes with time, hard work, persistence, calculated risk taking, and often a sense of playfulness.

HAZLER (2002) ON CONFUSION, CREATIVITY, AND CREDIBILITY

One of the most interesting and thought-provoking articles in this issue was written by Richard Hazler (2002), "Confusion, Creativity, and Credibility in Therapy: Confronting Therapist Frailties and Self-Doubts." Confusion, like frustration, can sow the seed of creativity in therapy if only we learn to let it do so. Hazler noted that feeling confused is a common experience in therapy for both therapists and clients. This is not something that should be denied nor should it threaten a sense of competence or purpose as clinicians. Rather, confusion can be used as a powerful weapon of change if acknowledged and channeled. One lesson learned by Hazler in his many years of conducting therapy was this: It is perfectly all right, often necessary, and in the vast majority of cases helpful, to put our ego aside and ask clients for help when we are feeling confused or stuck. This confusion can arise for a number of reasons, including our own internal struggles or distractions that we as therapists bring to therapy, natural impasses that happen in counseling, or client cases that are not all that interesting or captivating. A raw but appropriate honesty and vulnerability allows the sharing of our humanness with clients (i.e., *equalize* relationships). Moreover, often when we stop trying overly hard to find solutions with (or for) our clients, then their own creative abilities spring forth. Hence, confusion can be a powerful technique in therapy, especially when it is balanced with a demonstration of knowledge, competence, and understanding by clinicians. Bluffing it when we feel stuck or confused (e.g., in order to protect our image or clout as therapists) only serves to dig clinicians in deeper with their clients rather than freeing them to consider possibilities. Hazler indicated that because clients bluff for the same kind of ego protective reasons as therapists, dealing with confusion in a timely, appropriate, and forthright manner can help instill trust and genuineness in the therapist–client relationship. The sharing of moment-by-moment inner experiences in therapy can promote common agreements about what is or is not occurring and minimize anxieties and hidden agendas. Some basic guidelines for using confusion as a therapeutic method include checking how long we have worked with clients and the level of trust present, stating our confusion clearly and succinctly, making it known that it is the therapist's confusion or problem and not the client's, following a confusion statement with a direct and specific request for assistance, and making it clear that this kind of confusion is perfectly normal and that good things will likely come from it as it is dealt with openly and honestly. Confusion can thus be a friend of creativity in counseling rather than its nemesis.

CHEN (2002) ON TAI CHI METAPHORS

David Chen's (2002) "Using Tai Chi Metaphors to Increase Creative Practice" was both stimulating and soul enriching. Some of the metaphorical lessons from Tai Chi were the following: (a) Remain grounded yet fluid (i.e., sound principles of practice combined with taking risks); (b) client force or negative energy is best met with a strategic deflection rather than head-on; (c) a soft and gentle technique is often preferred over a blunt approach; (d) moving slowly, flexibly, and deliberately usually brings about the best results; (e) taking time to step back before moving forward, especially during or after a traumatic life event, can help clients begin to heal and decide which direction they want and need to go; (f) in seeking and finding balance in life and relationships, clients need to be aware of opposites (the acceptance of harmonious relationships between yin and yang) rather than pursuing absolutes in human existence; and (g) learning to "let go" and go with the flow of our lives on earth because, paradoxically, this is often when creativity and change are made possible (see lessons on pp. 48–52). Specific principles outlined by Chen include *overcoming the habit of procrastination by going slowly* (i.e., moving carefully and methodically is often the fastest way to get there),

eradicating nervousness by letting go of our ego (i.e., losing your sense of self or ego in therapy and getting completely caught up in the process in order to capture and sometimes magnify the moment with clients); and *profiting from our own mistakes* in therapy as in life (i.e., being able to use our own experiences as wounded healers; see principles on pp. 52–53).

OTHER ARTICLES ON CREATIVITY IN PSYCHOTHERAPY

Other articles in this *JCAAHPP* issue dealt with a variety of principles and techniques of creativity in therapists' work with individuals, couples, and families. Topics included creative meditation and guided imagery to enhance clients' positive feeling states and inner resources; the use of improvisational performance in the practice and teaching of therapy; the creative use of artistic expression in therapy, including stories, riddles, poems, metaphors, reframes, and paradox; capturing creative moments in supervision with trainees through silence, pace, and patience; verbal and nonverbal uses of play and art therapy, and using marbles, masks, and humor. One underlying theme in these articles was that therapy is very much an experience for both clients and therapist (e.g., involving emotional and spiritual connections and the sharing of healing energies). As Schofield (2002) reminded us, creative therapy has the potential to leave an indelible imprint in people's minds and souls. Creative therapy thus becomes an ambitious but worthwhile undertaking.

IMPLICATIONS FOR COUNSELING AND COUNSELOR EDUCATION

Creativity and Counseling Practice

Although creativity in counseling extends well beyond the use of "experiential" interventions, it often involves some kind of corrective relational or emotional experience in the lives of clients (Carson, 1999a, 1999b; Carson & Becker, 2003). This is especially the case in couples and family therapy (Carson, Becker, Vance, & Forth, 2003). There are several advantages to allowing for and providing clients with various opportunities for experiencing in therapy (see Carpenter, 2002): (a) that human beings of all ages learn most things from observing and experiencing (experience being the best teacher) and that they remember best not the things they have talked about or been told (as in traditional talk therapy) but rather things they have seen and experienced, particularly in relation to significant others; (b) that people (including clients) get closer to their feelings more quickly and genuinely through experiencing more than conversing; (c) that experiencing makes it more difficult for clients to use their defenses to guard against change; and (d) that experiential interventions are often playful and fun and can be implemented before, or apart from, clients realizing that they have already been engaged in a therapeutic interchange (e.g., "Before we start working, lets do this for fun." "If you could be your favorite animal, what would you be?" "What would your mother/father/child/teenager be?"). In fact, getting locked into a "talk construct" can actually prevent change as, for example, couples or family members collude with one another (consciously or subconsciously) to maintain homeostasis. However, when counselors use kinetic family drawings, use jump ropes in sculpting to help family members understand boundaries/connections/alliances, or have clients journey to The Magic Shop or Emotional Post Office (Carpenter, 2000, 2002), it becomes more difficult for them to resist change.

In our view as authors then, creativity is needed to promote positive or corrective emotional experiences of clients in counseling. These experiences can in turn facilitate divergent thinking, creative problem solving, flexibility, imagination, and humor (Carson & Becker, 2003; Deacon & Thomas, 2000). Hence, creativity contributes to the "flow" of therapy. Flow may occur, for example, when counselors help clients run with an idea or feeling in the moment, or when the clinician gets clients out of their chairs and moving, acts in a completely unexpected way, or interjects a critically timed comment or nonverbal behavior. Flow is that which happens when clients and counselor are completely enveloped in the moment. As Csikszentmihalyi (1996) noted, it is a process in which time is forgotten, self-consciousness is transcended, and there is little worry over failure.

Creativity in counseling has a lot to do with the ability of counselors to apply traditional approaches to help in new and fresh ways (Murray & Rotter, 2002). Often these interventions are simple but bold and spontaneous. These applications involve improvising, the willingness to take risks, and being able to think and act quickly on our feet. These actions, which may be verbal or nonverbal, are often based on intuition. Thus, seeing, hearing, or feeling what is not being openly expressed by clients, as well as listening carefully to and trusting our own intuitive voice, is paramount to the creative process in therapy. Here, even a "wrong" (i.e., clients telling us that we are off base) can become or be used as a "right" (e.g., "Thanks for letting me know I'm off target on this one. If you could give my incorrect voice a correct one, what would it say about this question or issue?").

Creativity in counseling is also important when one considers the increasing need for clinicians to use brief, short-term, and often more solution-focused approaches with their clients, partly because of the stipulations posed by managed care (Kiser & Piercy, 2001). Careful, accurate assessment of couple and family difficulties, as well as individual diagnoses, usually takes time. Too often in today's marketplace, however, counselors lack this luxury. Creative thinking and maneuvering thus become very important. Furthermore, given the fast-paced and quick-fix oriented society in which we live, clients seem to expect more from counseling in less time (Carson, 1999b). Experienced clinicians also know that the timing of any intervention, statement or response (again, be it verbal or nonverbal), requires a great deal of creative thinking, awareness and sensitivity. In addition, because counselors are seeing a greater diversity of clients and presenting problems than ever before, textbook or "one size fits all" approaches are usually going to fail. Clinicians must therefore think and act more creatively than they ever imagined

possible, but not in a way that exhausts their own inner resources or does the work of clients for them. As Jacobs (1994) argued, a creativity-based approach to therapy, by definition, implies that clients are actively involved in the counseling process and, together with the therapist, responsible for setting into motion the mechanisms for change. In sum, creative and experiential interventions often help us "cut to the chase" in our therapeutic endeavors with clients.

Another implication of creativity in therapy has to do with the need for counselors to be continually cultivating and nurturing their own creativity. Counselors are powerful models of action and emotion for their clients, and creative behavior often resonates with clients on different levels of awareness and experience (somatically, emotionally, intuitively, etc.). Moreover, as those working in the helping professions, it is imperative that we encourage and assist one another, both formally and informally, in our ongoing creativity development. There are barriers to the development and expression of our creativity as therapists (both within and outside the therapeutic process) that must be effectively controlled, and in some cases eliminated. For example, time and energy constraints make it difficult to be as creative as we would like to be. Often excessive paperwork and dealing with managed care/insurance companies drain and discourage us over time. Also, clinicians' personal inhibitions and doubts can block creativity with clients (including fear of liability if we do something too radical). Dealing with resistant or rigid clients or just laboring in the field over a period of time can erode the desire to be creative and innovative. Finally, work-related restrictions (e.g., cautious or controlling supervisors or administrators) can restrict the unleashing of creativity with clients (i.e., fear of repercussions). Counselors must explore ways to reduce if not exclude these barriers to creativity so they can offer clients the most effective treatment possible (see Carson et al., 2003).

Creativity and Counselor Education

Creativity is also an important issue in counselor education. Academia and creativity are often at odds with one another. To be successful as a graduate student often requires self-constraint as a means to survive the tests and rigors of graduate school. The very mechanisms that are perpetuated in higher education may be counter to the conditions necessary for developing counselors who are able to explore and find their "creative voices," whether they pertain to faculty and supervisors or counselors-in-training. The time to introduce conversations about creativity is not postgraduation, but rather at the first moment that an individual decides to become a professional counselor. Rather than being viewed as the "icing on the cake," creativity should be viewed as a necessary foundation for effective counseling and counselor training. Helping trainees to discover, develop, and be able to freely express creative talents (and personality) in working with clients is crucial.

It is also important that trainees understand the extent to which creativity invites intimacy. The use of therapeutic creativity requires courage and the willingness to become more intimately involved in the lives of others. While a misplaced or poorly timed technique creates distance between the therapist and client, therapeutic creativity opens the door for everyone in the room to become more connected within the human condition. With this invitation come both the benefits and the risks of increasing levels of intimacy. Becoming more connected with clients includes the responsibility of managing a more complex set (or sets) of relationships.

In addition, counselors-in-training need to grasp the concept that creative interventions carry power. As a number of authors in this special issue of *JCAAHPP* have commented, just as in nature, therapeutic lightning is always followed by thunder. In counseling, the rumblings of the thunder that follow a creative strike come in various tones, from loud and shaking to soft and hidden. As when we were children, it is our responsibility to be present and count the seconds between the lightning and the thunder. This will help gauge the impact of creative interventions. While some of this power can be seen and heard in the counseling session, some (and sometimes much) of the power is released over time. Helpers need to be present for the "flashy" lightning shows, as well as for the fear, excitement, and anxiety that often precede and accompany the arrival of the thunder.

Finally, trainees must understand the importance of recognizing resistance and impasse as both an obstacle and an opportunity in counseling. Change is dependent on movement or shifting occurring on some level (physical, personal, spiritual, relational, attitudinal, etc.). Movement is often not necessary unless an obstacle presents itself. It is the obstacle that often introduces the opportunity to change. Therefore, it is important that counselor educators and supervisors help trainees welcome obstacles, for without them there would be no reason for clients to move, and thus no direction or energy *for* change.

CONCLUDING REMARKS

Perhaps above all, creativity in counseling involves an acceptance of the mysteries and incongruities of client pain and conflict as well as the complexity of the counseling process itself. Creative clinicians know that they do not always have to find or delineate the solutions to people's problems and that just as their clients have "up and down days," so will counselors. This acceptance of our state of existence is not passive or benign, but rather active, soul-searching, and non-blame oriented. In the coming years, creativity in the world of counseling and psychotherapy (including theory-building, research, and practice) may rise only to the level that counselors cultivate their own creative gifts and talents and learn to encourage and appreciate the diversity of creativity (both extraordinary and everyday) seen in clients, colleagues, friends, and loved ones.

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PROFILE

Carl Rogers's Life and Work: An Assessment on the 100th Anniversary of His Birth

Howard Kirschenbaum

This article summarizes the life and work of America's most influential counselor and psychotherapist, Carl Rogers. He developed the client-centered, person-centered approach; popularized the term client; *pioneered the recording of counseling cases; conducted landmark research on counseling and psychotherapy; and was a leader in the humanistic psychology movement, and more. Later, he applied the person-centered approach to resolving intergroup and international conflict. Work on the client-centered approach continues, and current research validates many of Rogers's earlier contributions.*

Carl Rogers (1902–2002) was America's most influential counselor and psychotherapist—and one of its most prominent psychologists. On the occasion of the 100th anniversary of his birth, it seems fitting to review his life, work, and professional contributions and to assess his historical and current influence on counseling and counseling psychology.

EARLY YEARS

Born in Oak Park, Illinois, a suburb of Chicago, Rogers was the third son in a family of five brothers and a sister. His parents, Walter and Julia Rogers, were conservative, Protestant Midwesterners who led family prayers daily and tried to keep their children free from society's corrupt influences. Hence, Carl had few real friends outside the family. He was a sensitive child, easily hurt by the family's teasing. The expression of feelings was not encouraged in the Rogers family, so Carl's emotions and imagination were often expressed in creative school papers and childhood games. (Biographical detail throughout is derived from Kirschenbaum, 1979, 1995; Rogers, 1967; and Rogers & Russell, 2002.)

Walter Rogers owned a successful construction company business, and when Carl was a teenager, his father purchased a working farm and manor house in Glen Ellen, Illinois, where he moved the family. Here Carl developed a love of nature and a serious working knowledge of scientific method, as he and his younger brothers conducted agricultural experiments on a plot they managed. As a result, Rogers decided to become a farmer.

He enrolled in the University of Wisconsin at Madison, following in his father and older siblings' footsteps. There he made his first close friends, and after a series of Christian revival meetings, he experienced the call to religious work, switching majors from agriculture to history as a better preparation for the ministry. In his junior year, he was selected as 1 of 10 American students to attend an international Christian youth conference in China—a trip that lasted 6 months and helped broaden his religious and social philosophy. Now motivated more by the "social gospel" than theological conviction, he applied to the liberal Union Theological Seminary in New York City. Upon college graduation, he married his childhood friend and college sweetheart, art student Helen Elliott—a union that would last 55 years.

NEW YORK CITY–CHOOSING A PROFESSION

In addition to studying at the Seminary, Rogers also took psychology courses at the adjoining Teachers College of Columbia University. There his religious doubts combined with his fascination with psychology and progressive education. Influenced by instructors Leta Hollingworth, Goodwin Watson, and William Heard Kilpatrick, the leading interpreter of John Dewey's education philosophy, Rogers transferred to Teachers College to pursue a doctorate in clinical psychology.

At Columbia he was exposed to the testing and measurement movement of E. L. Thorndike, but this was balanced by his clinical fellowship at the Institute for Child Guidance, where he encountered Freudian thought, a lecture by

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Alfred Adler, Rorschach testing, and other psychoanalytic and psychiatric approaches. Seeking to integrate psychological measurement with clinical practice, Rogers came to appreciate the importance of understanding clients' inner world while also objectively assessing the outcomes of treatment.

Rogers's (1931a) doctoral dissertation, in which he created a test for measuring personality adjustment in children 9 to 13 years of age, combined both subjective and objective measures, from children's self-reports of their feelings to assessment by outside observers. On the basis of his dissertation, Rogers's (1931b) Personality Adjustment Inventory was published by the YMCA's press and sold a half million copies over a period of 50 years.

ROCHESTER–YEARS OF EXPERIMENTATION

While working on his dissertation, Rogers needed to find a job to support himself, Helen, 2-year-old David, and Natalie, who was on the way. In 1928, however, jobs for clinical psychologists were not easy to come by, so he ended up taking a position in Rochester, New York, some 300 miles from New York City, where his academic colleagues predicted he would never be heard from again. There he spent the next 12 years—as director of the Child Study Department of the Rochester Society for the Prevention of Cruelty to Children and then director of the new Rochester Guidance Center.

Rogers's years in Rochester provided a laboratory in which he worked with thousands of troubled children and adults and gradually developed his own ideas about counseling and psychotherapy. During this period, he was influenced by students of Otto Rank, especially Jessie Taft (1933) whose "relationship therapy" shifted emphasis from past content to a focus on the patient's self-insight and self-acceptance within the therapeutic relationship. Later, he often described three experiences in Rochester that gradually influenced his thinking (Rogers, 1961c, 1967).

In one therapeutic relationship, he was working with a young boy who had a compulsion to set fires. At the time, Rogers was impressed with the work of a noted psychotherapist whose theory was that juvenile delinquency could be traced to unresolved sexual conflicts. Over several sessions, Rogers used leading questions and skillful interpretations to help the boy see how his pyromania was the result of a sexual impulse regarding masturbation. Rogers thought the case was solved, but when the boy was released on probation, he continued to set fires. Rogers said this incident caused him to be more skeptical about expert theories and began to think that *he* might have a role in discovering new knowledge about helping people.

On another occasion, Rogers observed a renowned hypnotherapist work with a young bed wetter. The therapist gradually succeeded in inducing a trance state in the boy, but when he began making posthypnotic suggestions related to ceasing the bed-wetting, the boy became resistant to the point of no longer entering the trance state. Rogers was impressed at how strong the human will is and how patients will resist even the most skillful therapist interventions when it goes against their purposes or they have not chosen to change themselves.

In the most telling anecdote, Rogers had been working with the mother of a troubled boy. He explored with her, skillfully he thought, how her rejection of her son was causing much of the difficulty, but she continued to resist his interpretation. Finally, he acknowledged to her that they were not making any progress, and they agreed to end their sessions. On her way out the door, she turned to him and asked, "Do you ever take adults for counseling here?" Upon his affirmative reply, she returned to her chair, sat down, and began pouring her heart out about the troubles she was experiencing with her marriage and her sense of failure. As they explored these issues, over time, she began to make real progress with helping her son. This incident, Rogers (1961c) wrote,

> helped me to experience the fact—only fully realized later—that it is the *client* who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely on the client for the direction of movement in the process. (p. 11)

In his last years in Rochester, Rogers (1939) wrote his first book, *The Clinical Treatment of the Problem Child*. It described the range of methods for working with young people—from institutional and foster home placement; to modifying their school program and using clubs, groups, and camps; to treatment interviews using education, persuasion, and release; and to deeper therapies. On the strength of the aforementioned book and his part-time teaching experience at the University of Rochester, he was offered and accepted a full-professorship at Ohio State University.

OHIO STATE UNIVERSITY–THE NONDIRECTIVE APPROACH

At Ohio State, Rogers's students were not satisfied with his simply reviewing all the methods for helping children or counseling adults. They wanted to know what *he believed* was effective. And so Rogers began to articulate his own views on counseling and psychotherapy, which resulted in a second book of that same title, *Counseling and Psychotherapy: Newer Concepts in Practice* (Rogers, 1942). It was a book that challenged the field of psychotherapy to its core, and as most introductory counseling textbooks state, the book (and author) virtually founded the field of professional counseling (Capuzzi & Gross, 2001; Gibson & Mitchell, 1999; Gladding, 2000; Nugent, 2000). How could one book have such a profound influence?

First, although Rogers was not the first author to use the term *client* for the recipient of therapy, with *Counseling and Psychotherapy,* Rogers popularized it. More than a semantic distinction, the word connotes a departure from the medical model of illness, emphasizing that a person seeking help should be not treated as a *dependent patient* but as a *responsible client* and that those in psychological distress were not necessarily "sick," therefore requiring treat-

ment by medical specialists. Rather, Rogers demonstrated that all people could be helped by the growth-producing process of counseling and that professionals from many fields could be trained to provide this help. Thus, counselors, social workers, clergy, medical workers, youth and family workers, and other helping professionals could use counseling methods.

Second, Rogers introduced his "nondirective" method. He credited others with working in this same direction, but his own statement of the position was the most extreme, and what he called "a newer psychotherapy" (Rogers, 1942, p. 27) became identified with him. His method was based on a core hypothesis about human growth and personality change, which he summarized a few years later:

> This hypothesis is that the client has within himself the capacity, latent if not evident, to understand those aspects of his life and of himself which are causing him pain, and the capacity and the tendency to reorganize himself and his relationship to life in the direction of self-actualization and maturity in such a way as to bring a greater degree of internal comfort. The function of the therapist is to create such a psychological atmosphere as will permit this capacity and this strength to become effective rather than latent or potential. (Rogers, 1950, p. 443)

Although other therapies might profess similar belief, Rogers's method of creating the therapeutic psychological atmosphere was radically different from other approaches commonly used. Rogers's initial "nondirective method" totally avoided questions, interpretation, suggestions, advice, or other directive techniques. Rather, it relied exclusively on a process of carefully listening to the client, accepting the client for who he or she is—no matter how confused or antisocial that might be at the moment—and skillfully reflecting back the client's feelings. The acceptance and reflection of feelings would create a level of safety for deeper exploration and a mirror in which to further understand and reflect on the client's own experience, which would lead the individual to further insight and positive action.

Not only was Rogers's "nondirective method" a more extreme statement of what he called the "newer direction" in psychotherapy, it blurred the boundary between counseling and psychotherapy. Before Rogers, it was assumed that "counseling" applied to mild problems of adjustment or career guidance, whereas "psychotherapy" was needed for more deep-seated psychological problems. *Counseling and Psychotherapy* suggested that the same nondirective method of helping could be applied to all problems along the adjustment continuum. Consider for example, the case of Loretta—a hospitalized woman with a diagnosis of schizophrenia whom Rogers was counseling. In the following recorded counseling session, Loretta was discussing with Rogers whether she was ready for a change in her work assignment in the hospital. The next 6 minutes of the session are given verbatim. The client speaks rapidly. Rogers, on the other hand, takes his time responding, letting the meaning of her words sink in as she tries to understand her experience.

L: I don't think I'm going to like working in the laundry—that I know. Cause I didn't like it either the other two times. And I don' think I care too much working in the food center over there either because I've worked there before, and I didn't care for it. Well, I didn't have anything, I, the first day I worked all right; the second day I worked. But a half an hour and I blacked out and I tried it three more days and I blacked out each day, so I just quit trying to work there then. There was too much electricity or something.

R: Uh-hum, uh-hum. You feel . . . something was wrong over there, too much electricity or something. *It really had a bad effect on me when I was working* . . .

L: It did! I blacked out completely. If I hadn't gone and sat down I would have fainted.

R: You feel really you were, you were in kind of a desperate way at those points.

L: No, I didn't feel desperate. I just, I didn't understand that I didn't know why I blacked out.

R: I see.

L: It did frighten me though. I just couldn't work so . . .

R: You felt something very odd was happening to you, more.

L: Cause I don't have epilepsy seizures or anything like that so I couldn't imagine what it was. And I don't, I'm not, I don't usually have fainting spells.

R: It made you feel real puzzled. *What is happening to me?*

L: What it was, yeah. I tried to work and I couldn't work and they wanted me to work, so. . . . Sometimes I think you get put back on treatment if you refuse to work.

R: Uh-huh. So maybe, maybe shock treatment is really something they may use for punishment if you don't do the things they want you to do . . .

L: Well, it would appear that way from what everybody says, but I don't think it was even—I don't know even why they even gave it to me in the first place. I was just beginning to come to enough to realize that I was in an institution, I think, and the next thing I knew they said, "You're outa here on treatment," and I said, "Why? I didn't do anything. I haven't had any fights or anything with anybody." And they said, "Well, doctor's orders," and I said, "Well, I haven't even talked to a doctor," because I hadn't talked to one, at least I didn't know it if I had. . . . And so . . .

R: So to you it seemed, *Here I was just beginning to come to life a little bit, to really to know a little bit what was going on* . . .

L: I was just beginning to realize I was in the hospital when they put me on it. And they put me to work the same day.

R: And then you feel that for no reason you could discern, zingo, you were right . . .

L: And I began talking very badly and everything and I still have forgotten some of the things they said.

R: It feels that as though that somehow sort of brought out the worst in you, is that what you mean?

L: If I had a worst part. Uh, uh, it was like it wasn't even me talking

R: Uh, huh. Almost seemed as though this was . . .

L: And then I went home weekends and I got in trouble there because I talked so much. Of course I was getting sodium amytol too, so it might have been the combination of the two—not just the one thing.

R: But there, too, I guess I get the feeling that you're wishing you could understand that part of yourself, why there's this something that was not you talking, or was it just the effect of the drugs or what was it that made you . . .

L: It was the combination, I think, of all. . . . As you notice my, I move my feet . . . as I . . .

R: Yes I did notice that.

L: said, my knees tickle.

R: Uh-hum.

L: And I don't know if it's the drugs I'm getting or what, but it's something I can't help. It isn't that I'm so terribly nervous that I can't sit still; that isn't it. I do that at group meetings or anything, and I can't control them. And it's rather embarrassing.

R: Uh, hum. And you would like me to understand that it isn't just tenseness or something.

L: No.

R: It's, uh, simply . . .
L: I can't control.
R: [An] uncontrollable tickling sensation.
L: In my knees and therefore, and my feet just move. If I'm sitting up there in the corner alone that isn't so much, but my knees still tickle.
R: Uh-hum.
L: But when I get in the group and that's my . . . so I don't know, they just move.
R: It seems as though being in a group makes this worse.
L: Well, I have it when I'm alone sometimes, too. I think it's the medication I'm getting.
R: You feel probably it's just the drugs.
L: I think it's the green medication I'm getting. I don't even know what it is, cause I haven't asked. I inquired once but then I . . .
R: Uh-hum.
L: [After a long pause] . . . I think these meetings are very enlightening.
R: Do you?
L: Well, if you can't think quite clear at the time, you can think about it later on.
R: Uh-hum. Uh-hum. And in that sense they, they're somewhat helpful in that you can . . .
L: I think I've been helped a lot, more by talking than I have by the pills and that.
R: Uh-hum, uh-hum. . . . It really seems as though getting things out to some degree in talk . . .
L: Seems to alleviate whatever the situation is.
R: Uh-hum
L: If it's a created situation, that seems to alleviate [it] . . . . (Rogers, n.d.)

One reason that Rogers was able to demonstrate the propositions of nondirective therapy so cogently was that he was the first person ever to record and publish complete cases of psychotherapy. This fourth innovation of *Counseling and Psychotherapy* was illustrated in the last 170 pages of the book—"The Case of Herbert Bryan," which included, verbatim, every client statement and every counselor statement for the eight sessions of counseling. This was a remarkable achievement before the invention of tape recorders. It required a microphone in the counseling room connected to two alternating phonograph machines in an adjoining room, which cut grooves in blank record disks that had to be changed every 3 minutes. With graduate student Bernard Covner, Rogers and his team recorded thousands of disks involving scores of clients. These recordings became pivotal in the clinical training of psychotherapists, which, in the 1940s, Rogers may have been the first to offer in an American university setting.

The recordings and transcripts also allowed Rogers and his students to begin undertaking scientific research on the process of therapy—another important feature of *Counseling and Psychotherapy*. For example, Rogers could classify counselor responses as to degree of directiveness, count their frequency of occurrence, and correlate them with subsequent client statements of insight. He made many counselors uncomfortable by reporting how directive counselors used 6 times as many words as nondirective ones.

CHICAGO—THE CLIENT-CENTERED APPROACH AND RESEARCH

Because he wanted to do much more research on the process and outcomes of counseling and psychotherapy, Rogers left Ohio State after only 4 years to move to the University of Chicago, where he developed and ran the internationally renowned Counseling Center and taught in the Psychology Department from 1945 to 1957.

But first he spent an interim year training United Service Organization (USO) workers to counsel returned servicemen who were having problems adjusting to civilian life (Rogers & Wallen, 1946). On the last evening of each of the weeklong workshops, there was a social event in which participants entertained and performed skits. Invariably there would be a skit satirizing Carl Rogers in his tenth floor office counseling a suicidal client (see Kirschenbaum, 1979):

"Dr. Rogers," the client would say, "I'm feeling suicidal."
"You're feeling suicidal?" Rogers would answer.
"Yes, I'm walking over to the window, Dr. Rogers."
"I see. You're walking over to the window," Rogers answers.
"Look, Dr. Rogers, I'm opening the window," the client says.
"You feel like opening the window?" Rogers reflects.
"Yes, I'm putting one foot out of the window, now."
"You're halfway out, is that it?"
"Yes, now I'm jumping Dr. Rogers"
"Uh, huh, uh, huh, you're jumping," says Rogers.

And, sure enough the client jumps, making a whooshing sound as he falls through the air before landing with a crash.

Thereupon Rogers walks over to the window, looks out and reflects, "Whooooosh . . . Plop!"

As he continued at the University of Chicago to teach, write, and conduct research on what he soon was calling the "client-centered approach" to counseling and psychotherapy, Rogers soon came to recognize that the satire he endured so many times the previous year, and would endure all his life, had a serious point to make. Although he always remained primarily nondirective in his own practice, Rogers soon recognized that the counselor's *attitudes* were as important as his particular techniques. The techniques or methods were the way to implement the facilitative attitudes of *accepting* and *understanding*. Moreover, if these attitudes of the counselor were not *genuine*, all the reflecting of feelings in the world would not be of much help to the client.

Still later, Rogers clarified that it was the therapeutic *relationship*, which the attitudes helped create, that was most growth producing, and he continued to refine the three key "conditions" in the client-centered relationship that brought about positive change in clients. The first condition is to accept the client as he or she is, as a person of inherent worth possessing both positive and negative feelings and impulses. Rogers adopted a term from his student Standal (1954) and called this acceptance and prizing of the person "unconditional positive regard." Second is *empathy*—"the therapist's willingness and sensitive ability to understand the client's thoughts, feelings and struggles from the client's point of view . . . to adopt his frame of reference" (Rogers, 1949, p. 84.). Third is *congruence*—to be genuine, real, authentic, or congruent in the relationship. Rogers (1956) wrote, "It is only as [the therapist] is, in that relationship, a unified person, with his experienced feeling, his awareness of his feelings, and his expression of those feelings all congruent or similar, that he is most able to facilitate therapy" (pp. 199–206).

Rogers's appreciation of congruence was advanced by his own struggle in 1949–1951, when a difficult relationship with a schizophrenic client caused Rogers to become confused about his own sense of self. This led to a near breakdown, a "runaway trip" of several months with Helen, and a year or so of receiving counseling himself. The childhood teasing, suppression of feelings, and isolation from peers had left their mark. Through counseling, Rogers developed a newfound self-esteem, capacity to experience more of his feelings, and ability to be increasingly congruent in personal and professional relationships.

In one of his most important essays, Rogers (1957a) wrote that when a counselor communicates this congruence, unconditional positive regard, and empathic understanding so that the client perceives them at least to a minimal degree, then the "necessary and sufficient conditions for therapeutic personality change" (p. 95) are present. Rogers argued and demonstrated that the client has within himself the ability and tendency to understand his needs and problems, to gain insight, to reorganize his personality, and to take constructive action. What clients need, said Rogers, is not the judgment, interpretation, advice or direction of experts, but supportive counselors and therapists to help them rediscover and trust their "inner experiencing" (a concept borrowed from Gendlin, 1958), achieve their own insights, and set their own direction.

Rogers's (1951) next book, *Client-Centered Therapy: Its Current Practice, Implications, and Theory*, and subsequent articles described these principles of effective therapy and presented ample case studies from recorded sessions to illustrate his points. Beyond *audio* recording of therapy sessions, Rogers also was among the first to make cinematic recordings of counseling and psychotherapy. The American Academy of Psychotherapists became a leading distributor of training tapes and movies, with Rogers the most frequent therapist portrayed. A still widely distributed set of training films showed Rogers, gestalt therapist Frederick Perls, and rational-emotive therapist Albert Ellis each demonstrating his method with the same client.

The audiovisual recording of actual therapy sessions provided the data, and the Ford, Rockefeller, and other foundations provided the financial support (about $650,000, which was a small fortune in the 1940s and 1950s) with which Rogers and his colleagues conducted more scientific research on one therapeutic approach than had ever been undertaken before (e.g., Rogers & Dymond, 1954). Rogers and his team devised and used numerous instruments for measuring the variables of client-centered therapy and its outcomes, including measuring the therapist's acceptance, empathy, and congruence; the client's expression of feelings, insight, self-concept, self-acceptance, and self ideal; the client's positive actions, emotional maturity, and social adjustment; and numerous other variables. In 1956, the American Psychological Association (1957) awarded Rogers its first "Distinguished Scientific Contribution Award"

> for developing an original method to objectify the description and analysis of the psychotherapeutic process, for formulating a testable theory of psychotherapy and its effects on personality and behavior, and for extensive systematic research to exhibit the value of the method and explore and test the implications of the theory. His imagination, persistence, and flexible adaptation of scientific method . . . have moved this area of psychological interest within the boundaries of scientific psychology. (p. 128)

As the award citation suggests, Rogers was interested in psychological *theory* and in the effects of therapy on *personality* as well as behavior. Building upon the Gestalt and phenomenological movements in psychology, and on the work of his students Victor Raimy (1943, 1948) and Donald Snygg and Arthur Combs (1949), he developed a "self-theory" of personality, which is still included in many psychology textbooks. The theory describes how an individual's concept of self emerges; how the process of socialization causes individuals to distrust their feelings and sense of self; how experiences that are inconsistent with the concept of self become denied and distorted causing personal distress and psychological problems; and how the therapeutic relationship can help the individual restructure the sense of self, allowing previously denied and distorted experience into awareness, leading to reduction in stress and openness to new experiencing.

Rogers's impact on psychology and the helping professions came about not only through research, teaching, and practice, but also through leadership in many professional associations. Earlier in his career he was active in the social work field—serving in national positions in the American Association of Social Workers and the American Association of Orthopsychiatry. In the 1940s and 1950s, he was president of the American Psychological Association, the American Association of Applied Psychology, and the American Academy of Psychotherapists, among other distinguished positions and honors.

WISCONSIN–RESEARCH AND HUMANISTIC PSYCHOLOGY

Seemingly at the peak of his career, after 12 years at Chicago, Rogers surprised the profession by moving in 1957 to the University of Wisconsin. By now the children were grown. David had begun medical school, on his way to a distinguished career, including dean of medicine at Johns Hopkins and president of the Robert Wood Johnson Foundation. Natalie would go on to become an art therapist ("client-centered expressive therapist") and an author. Helen Rogers continued with her love of painting while taking primary responsibility for raising the family and running the household. When the children left home, she and Carl took long winter vacations in the Caribbean and traveled widely—on holidays, to visit their children and eventually six grandchildren, and in connection with professional activities.

In moving to Wisconsin, Rogers had joint appointments in the Departments of Psychology and Psychiatry. This would allow him to conduct further research on therapy with patients diagnosed with schizophrenia residing in the Mendota state psychiatric hospital, work that he hoped would have an impact on the psychiatric profession. The massive and well-funded research project went forward, and after years of delay because of complications involving authorship and the unethical behavior of one of the team members, it was eventu-

ally published (Rogers, Gendlin, Kiesler, & Truax, 1967). The results were important. The client-centered therapists achieved *no better* patient outcomes than therapists of other orientations; however, regardless of orientation, those therapists who demonstrated higher levels of unconditional positive regard, empathy, and congruence achieved better patient outcomes than therapists who provided lower levels of the three conditions. This was but one of several important findings.

While at Wisconsin, Rogers (1961a) wrote his most famous book, *On Becoming a Person: A Therapist's View of Psychotherapy*. Aimed at both a professional and lay audience, in a personal style, the collection of essays written over the past decade or more explored Rogers's learning about counseling and psychotherapy and its application to other helping professions and to the areas of creativity, philosophy, and the behavioral sciences. One reason the book was so popular, and remains widely read today, was a growing interest by the public in psychology in general and in what Abraham Maslow described as a "third force" in psychology, which became prominent in the latter half of the twentieth century.

"Humanistic psychology," as it came to be known, differed from psychoanalysis and behaviorism in at least three ways. First, this psychology gave more emphasis and credence to the individual's *phenomenal field*, for example, the client-centered therapist's empathizing with the client's frame of reference rather than evaluating or diagnosing from the outside, or the existential psychotherapist's helping the patient find "meaning" in life—meaning as perceived by the *client*. Second, this psychology focused not just on remediation of psychological problems but on psychological *health*, *wellness*, *creativity*, *self-actualization*, or what Rogers (1957b, 1961b) described as "the fully functioning person." The goal was more than "adjustment," but helping people experience their full human potential. Third, it was a psychology interested in what distinguishes human beings from other species. Choice, will, freedom, values, feelings, goals, and other *humanistic* concerns were all central subjects of study.

Because Rogers's career and that of leading behavioral psychologist B. F. Skinner were parallel—in timing, productivity, and influence—their views inevitably were contrasted. Meeting on several occasions, including a 6-hour debate-dialogue in 1962 (Rogers & Skinner, 1989), their earliest exchange on "Some Issues Concerning the Control of Human Behavior" (Rogers & Skinner, 1956) became one of the most reprinted articles in the behavioral sciences, and Rogers became a leading spokesperson for the humanistic psychology movement.

CALIFORNIA—THE PERSON-CENTERED APPROACH

As Rogers's professional interests and influence increasingly extended beyond the fields of counseling and psychotherapy, and as his frustrations with the research project in Wisconsin continued, in 1963 the Rogers moved to La Jolla, California, where Rogers joined the staff of the Western Behavioral Sciences Institute. After 10 years, he and others then formed their own organization, Center for Studies of the Person, where Rogers remained for another 15 years.

In California, for a quarter century, Rogers continued to promulgate the client-centered approach and to apply his theory and method to other fields—education, parenting, group leadership, and the health professions, to name a few. In each instance, he demonstrated how the facilitative conditions of positive regard, empathy, and congruence could unleash growth, creativity, learning, and healing in children, students, group members, clients, and others. Drawing on earlier essays, he expanded his ideas into many new books that explored the implications of his thinking in diverse fields.

Applied to education, Rogers's work on "student-centered learning" illustrated how a teacher or, as he preferred, a "facilitator of learning" could provide the trust, understanding, and realness to free his or her students to pursue significant learning. Rogers's work coincided with and contributed to the "open education" movement in the United States, Great Britain, and elsewhere. His book *Freedom to Learn: A View of What Education Might Become* (Rogers, 1969) went through two new editions over the next 25 years (including posthumously, Rogers & Freiberg, 1994).

His book on marriage, *Becoming Partners: Marriage and Its Alternatives* (Rogers, 1972), used case studies of couples to explore new forms of relationships that young people were implementing in the 70s. He somewhat naively and somewhat accurately predicted the relegation of traditional marriage to only one of many alternatives for what he sometimes called "the person of tomorrow." Rogers and William Coulson's (1968) book on the behavior sciences, *Man and the Science of Man*, included proceedings and commentary from an international conference they organized on the philosophy of science, including major addresses by scientist, philosopher, and Nobel laureate Michael Polanyi; Jacob Brownowski; and Rogers.

But most of all, during the late 1960s and the 1970s, Rogers and his colleagues explored the applications of client-centered thinking to groups and group leadership. In the 1940s and 1950s, Rogers, Thomas Gordon (1951), and colleagues at the University of Chicago had experimented with "group-centered leadership," whereby the leader's acceptance, understanding, genuineness, and willingness to let the group set its own directions stimulated great energy, creativity, and productivity among group members. In the late 1950s and 1960s, Gordon, Richard Farson, Rogers, and associates extended this approach to what Rogers called the "basic encounter group"—an unstructured group experience in which so-called "normal" group members came to greater self-understanding, spontaneity, improved communication, and genuineness in relationships. Rogers led scores of encounter groups in professional, business, religious, medical, academic, personal growth, and organizational settings. *Look* magazine called Rogers an "elder statesman of encounter groups." Rogers's (1970) book, *Carl Rogers on Encounter Groups*, was a major seller, and Bill McGaw's (1968) filmed encounter group, *Journey Into Self*, featuring Rogers and Dick Farson as the group facilitators, won an Academy Award (an "Oscar") for best full-length feature documentary in 1968.

Recognizing the ever-widening applicability of the client-centered, student-centered, group-centered approach, Rogers and his colleagues at Center for Studies of the Person increasingly used a broader term—*person-centered*—to describe their work. (In the counseling literature, "person-centered" and "client-centered" are often used interchangeably today.)

INTERNATIONAL CONFLICT RESOLUTION AND PEACE

In the 1970s and 1980s, Rogers experimented with a person-centered approach to resolving intergroup and international conflict. Through workshops and filmed encounter groups with multicultural populations, such as Catholics and Protestants from Northern Ireland and Blacks and Whites in South Africa, Rogers demonstrated how positive regard, empathy, and congruence—the same growth-promoting conditions useful in all helping relationships—can enhance communication and understanding among antagonistic groups. He and his colleagues led person-centered workshops for groups of 100 to 800 participants around the world, including Brazil, Mexico, South Africa, Hungary, Soviet Union (Rogers, 1987), and other newly emerging democracies. They organized a gathering of international leaders in Rust, Austria, about resolving tensions in Central America—an experience that vividly demonstrated the potential of the person-centered approach for resolving international conflict (Rogers, 1986).

Testimonials suggested that these efforts in professional development and citizen diplomacy helped foster peace and democratization in several countries. Of the Austria gathering, Rodrigo Carazo (2002), former President of Costa Rica and of the United Nations University for Peace, later wrote,

> Previous efforts for achieving peace in Central America, which were plenty, culminated in the Austria meeting. . . . Carl made it possible. There, for the first time, I repeat, representatives from all groups in conflict met and the first step in reaching peace in Central America was taken. This was the real beginning of many things toward peace. There is a picture of Carl Rogers in the central building of the University for Peace. Carl Rogers is in our memory and the master in our heart.

For Rogers's 85th birthday party, former U.S. President Jimmy Carter sent these words:

> To Carl Rogers—Congratulations and sincere best wishes on your 85th birthday celebration. It's wonderful that so many of your friends and supporters can be with you tonight. Your work as a peacemaker is internationally known and highly regarded. As you embark on still another mission, this time to South Africa, please know that you are in our thoughts. God speed your journey. The world can use more global citizens like you. With warm regards, Jimmy Carter. (Kirschenbaum, 2003)

In acknowledgment of his efforts to bring about international understanding and conflict resolution, although he was not ultimately selected, Carl Rogers was nominated posthumously in 1987 for the Nobel Prize for Peace.

In his later years, personally, Rogers continued to pursue lifelong hobbies of photography, making mobiles, and gardening. When Helen became ill in her 70s, Carl cared for her until her death in 1979. Thereafter he remained involved in his work—writing (e.g., Rogers, 1980), traveling the world, leading groups and workshops on the person-centered approach, and developing the Carl Rogers Peace Project. He had rich friendships with both men and women, and his daughter Natalie was a frequent colleague and companion. Rogers was active until his death at age 85, on February 4, 1987, from complications resulting from a fall and hip injury in his home in La Jolla.

CONTINUING INFLUENCE

Carl Rogers's career spanned six decades. For most of these, he presented a vivid role model of the person-centered approach, demonstrating his theories and methods through teaching, lecturing, live demonstrations, workshops, and audiovisual recordings. By all accounts, he embodied his theories by being an exceptional listener and communicator and a decent, honorable person. He wrote some 15 books and well over 200 professional articles, book chapters, and research studies. Millions of copies of his books have been printed, including over 60 foreign language editions. Two volumes of his major writings and dialogues with intellectual leaders of the twentieth century were published after his death (Kirschenbaum & Henderson, 1989a, 1989b), and a long-awaited, lengthy, oral history (Rogers & Russell, 2002) has recently been released.

In 1972, Rogers had received the American Psychological Association's Distinguished Professional Contribution Award, becoming the first psychologist ever to receive that organization's highest scientific honor and its highest professional honor. The citation read as follows:

> His commitment to the whole person has been an example which has guided the practice of psychology in the schools, in industry and throughout the community. By devising, practicing, evaluating and teaching a method of psychotherapy and counseling which reaches to the very roots of human potentiality and individuality, he has caused all psychotherapists to reexamine their procedures in a new light. Innovator in personality research, pioneer in the encounter movement, and respected gadfly of organized psychology, he has made a lasting impression on the profession of psychology. (APA, 1973, p. 71)

Not everyone agrees that Rogers's lasting impression is a positive one. As critic Christopher Lasch (1979) began his book review of the first English-language biography of Rogers (i.e., Kirschenbaum, 1979), "As a founding father of humanistic psychology, the human potential movement and the encounter group, Carl Rogers has a lot to answer for" (p. 30).

Critics of Rogers's work have argued that client-centered therapy is superficial (De Mott, 1979; Friedenberg, 1971), unworkable with some populations, and unmindful of multicultural and feminist issues (Usher, 1989; Waterhouse, 1993), the social context, and recent advances in behavioral, drug, and alternative therapies; that Rogers's views on human nature are unrealistically optimistic and underestimate human evil (May, 1982); that encounter groups and humanistic psychology have fostered widespread selfishness, narcissism, and moral permissiveness (Coulson, 1988, 1989; Lasch, 1979); and that Rogers's experiments with organizational change were naïve (Kirschenbaum, 1979) and counterpro-

ductive (Coulson, 1988). Such criticisms have sometimes been fair; for Rogers, like any other individual, was a product of his times, with personal and historical limitations. Just as often, criticisms of Rogers and his work have been wanting, because the critic was unfamiliar with the full scope of Rogers's theories, research, and ever-widening practice.

Critics notwithstanding, Rogers more than anyone helped spread professional counseling and psychotherapy beyond psychiatry and psychoanalysis to psychology and other helping professions. Near the end of his career, surveys in the *Journal of Counseling Psychology* (Heesacker, Heppner, & Rogers [no relation], 1982) and *American Psychologist* (Smith, 1982) still ranked Carl Rogers as the most influential author and counselor/psychotherapist.

A generation later, the client-centered/person-centered approach continues to exert a significant influence on the world of counseling and psychotherapy. Although database searches show many more citations for cognitive and behavioral therapy than references to the client-centered/person-centered approach, attention to the person-centered approach remains strong, with more books, articles, and research studies appearing in the 15 years since Rogers's death than in the 40 years before (Kirschenbaum & Jourdan, in press).

Moreover, Rogers's work continues to serve as a foundation for the counseling profession (Capuzzi & Gross, 2001; Gibson & Mitchell, 1999; Gladding, 2000; Nugent, 2000). It also plays a major part in the practice of the vast number of counselors, clinical psychologists, and psychotherapists who describe their practice as "eclectic" or "integrative," including the client-centered approach as a major component in their repertoire (Aspy, Aspy, Russel, & Wedel, 2000; Bergin & Garfield, 1994; Sharf, 2000). And it continues to exert a significant influence on numerous helping professions from social work to pastoral counseling to the health professions.

It is interesting that, as meta-analyses of psychotherapy research continue to emerge (see summaries in Sexton, Whiston, Bleuer, & Walz, 1997; Wampold, 2001), the data increasingly suggest that the success of counseling and therapy is not due to any particular method, whether cognitive behavioral, psychodynamic, client-centered, or other. Rather, the research demonstrates that there are a number of "common factors" in the context of the therapy relationship that account for successful outcomes (e.g., Grencavage & Norcross, 1990; Lambert, 1992). What are these common factors? Many of them point back to the therapist's support, empathic understanding, and ability to form a therapeutic alliance with the client. Ironically, Rogers's core conditions for therapeutic change, decades later, are being validated by the latest generation of scientific research (e.g., Elliott, Greenberg, & Lietaer, 2003; Norcross, 2002). Although this research suggests that positive regard, empathy, and congruence may not be absolutely necessary in every case, nor sufficient for all counseling relationships, what the research does affirm is the following: first, Rogers's initial insights about the importance of the therapeutic relationship; second, the usefulness and practicality of the core conditions for forming the essential therapeutic alliance; and third, the definite or probable efficacy of empathy, positive regard/acceptance, and congruence for achieving positive counseling outcomes.

Since Rogers's death in 1987, perhaps the greatest new interest in his work has been outside the United States. In Europe, the person-centered approach has become one of the leading counseling and therapeutic approaches of the twenty-first century, with major organizations and centers for person-centered research and practice throughout Western and Central Europe. Equally significant, there has also been a great deal of interest in the person-centered approach in emerging democracies in Eastern Europe, Russia, and Latin America. As a Japanese counselor explained in the 1960s, Rogers helped "teach me . . . to be democratic and not authoritative." Rogers (1977) eventually recognized the political implications of his theories and methods and explored these in *Carl Rogers on Personal Power: Inner Strength and Its Revolutionary Impact*. His life's work demonstrated how supportive, growth-producing conditions can unleash healing, responsible self-direction, and creativity in individuals and groups in all walks of life. As countries around the world strive to resolve intergroup tensions and practice self-government and self-determination, many have recognized in Rogers's work not only useful methods for helping professionals, but also a positive, person-centered, empowering, democratic philosophy consistent with their national aspirations. At Rogers's memorial service (and earlier), Richard Farson (1975) described Carl Rogers as "a quiet revolutionary."

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GUIDELINES FOR AUTHORS

The ***Journal of Counseling & Development (JCD)*** publishes articles that inform counseling practice with diverse client populations in a variety of settings and that address issues related to counselor education and supervision, as represented by the membership of the American Counseling Association (ACA). Articles should be scholarly, be based on existing literature, and include implications for practice. Manuscripts typically fall into one of the following categories, although other kinds of submissions may be appropriate for *JCD* readers:

Practice. These manuscripts focus on innovative approaches, counseling programs, ethical issues, and training and supervision practices. They are grounded in counseling or educational theory and empirical knowledge. Some evidence of effectiveness in practice is provided.

Theory. These manuscripts provide a new theoretical perspective on a particular issue or integrate existing bodies of knowledge in an innovative way. A review of the literature, one type of conceptual piece, provides a critical overview of existing conceptual and empirical knowledge in a particular area. All theoretical pieces include implications for counseling practice.

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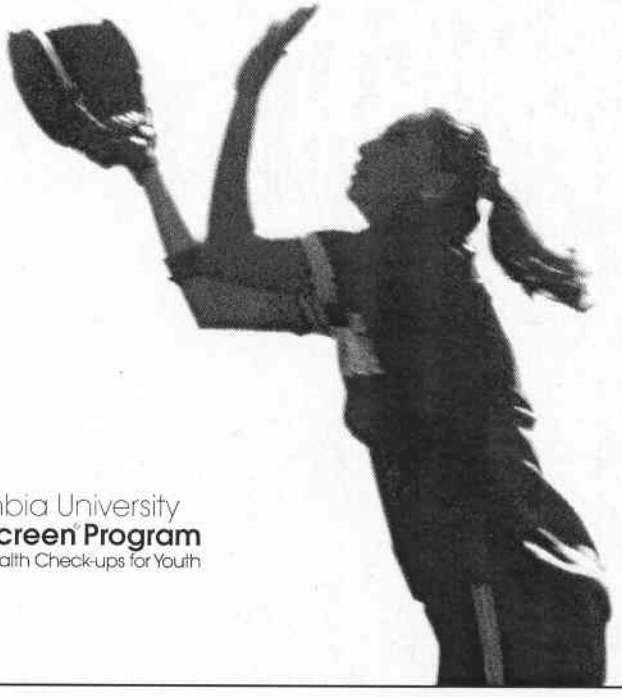
CATCH THEM BEFORE THEY FALL

Suicide is the third leading cause of death among young people ages 10-18. Each year an additional 520,000 youth require medical services for a suicide attempt. It's clear that something must be done.

In July, the President's non-partisan New Freedom Commission on Mental Health did its part. To find youth at risk, the Commission recommends that schools and primary health-care providers offer every child a mental health screening. The next steps are up to you.

The Carmel Hill Center at Columbia University has prepared a report that explains how every parent, policymaker, educator, health professional and community leader can help save young lives. For a free copy of "Catch Them Before They Fall: How to Implement Mental Health Screening Programs for Youth," visit www.TeenScreen.org



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